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Organization**

REGIONAL OFFICE FOR **Europe**

**Regional consultation meeting on the
development of the Tuberculosis
Action Plan for the WHO European
Region, 2016–2020**

Copenhagen, Denmark, 27 November 2014

Meeting report

ABSTRACT

The post-2015 global End TB Strategy was endorsed by the sixty-seventh session of the World Health Assembly in May 2014. This Strategy now needs to be adapted to the regional context under a new tuberculosis (TB) action plan covering the period 2016–2020.

This regional consultation was held to discuss the draft Tuberculosis Action Plan for the WHO European Region, 2016–2020 (TB-AP 2016–2020). Participants shared lessons learned from implementing the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015 (MAP 2011–2015) and provided expert commentary on the structure and main proposed interventions of the new regional Action Plan. The new Plan is built around the three pillars of the WHO End TB Strategy:

1. integrated, patient-centred care and prevention
2. bold policies and supportive systems
3. intensified research and innovation.

The Plan is expected to be finalized in May 2015 and submitted for approval by the WHO Regional Committee in September 2015.

Keywords

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Abbreviations and acronyms

DOT	Directly observed treatment
ECDC	European Centre for Disease Prevention and Control
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
MAP 2011–2015	Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015
MDR-TB	Multidrug-resistant tuberculosis
TB	Tuberculosis
TB-AP 2016–2020	Tuberculosis Action Plan for the WHO European Region, 2016–2020
XDR-TB	Extensively drug-resistant TB

Executive summary

The post-2015 global End TB Strategy was endorsed by the sixty-seventh session of the World Health Assembly in May 2014. This Strategy now needs to be adapted to the regional context under a new tuberculosis (TB) action plan covering the period 2016–2020.

This regional consultation was held to discuss the draft Tuberculosis Action Plan for the WHO European Region, 2016–2020 (TB-AP 2016–2020). Participants shared lessons learned from implementing the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015 (MAP 2011–2015) and provided expert commentary on the structure, new targets and main proposed interventions of the new regional Action Plan. The new Plan is built around the three pillars of the WHO End TB Strategy:

1. integrated, patient-centred care and prevention
2. bold policies and supportive systems
3. intensified research and innovation.

The meeting included presentations, plenary discussions and group work organized around the aforementioned three pillars, with a specific focus on:

1. prevention, diagnosis, treatment, care and patient support, and intra/intersectoral collaboration;
2. political commitment, civil society and community engagement, universal health coverage and social protection, and social determinants; and
3. research on new tools, strategies and interventions, and on methods for optimizing implementation and impact.

All feedback will be reviewed by the WHO Regional Office for Europe when revising TB-AP 2016–2020. This consultation will be followed by a public consultation in February–March 2015, a final review in May 2015 and submission for approval by the WHO Regional Committee for Europe in September 2015.

Introduction

The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015 (MAP 2011–2015) was endorsed by the sixty-first session of the WHO Regional Committee for Europe in Baku, Azerbaijan, on 15 September 2011.

MAP 2011–2015 considers a number of activities to be undertaken by Member States, with assistance from the WHO Regional Office and partners, in seven areas of intervention.

After more than three years of implementation, significant progress can be reported towards the 2015 targets indicated by MAP 2011–2015. However, now that we are approaching the final year of implementation, it is time to rethink how Member States, WHO and partners should move forward in further preventing and controlling tuberculosis (TB) and drug-resistant TB in the WHO European Region.

The post-2015 global End TB Strategy was endorsed by the sixty-seventh session of the World Health Assembly in May 2014. This Strategy now needs to be adapted to the regional context under a new TB action plan covering the period 2016–2020. The new Action Plan will be consistent with the seven areas of intervention specified in MAP 2011–2015 and will cover all 53 Member States of the Region. It will also be aligned with Health 2020, the European health policy framework, as well as with the framework action plans developed by the European Centre for Disease Prevention and Control (ECDC).

Objectives of the meeting

The aim of the regional consultation meeting (see Programme, Annex 1) was to discuss the first draft of the Tuberculosis Action Plan for the WHO European Region, 2016–2020 (TB-AP 2016–2020), developed in consultation with the advisory committee established under the secretariat of the WHO Regional Office for Europe.

The specific objectives of the regional consultation meeting were to:

- discuss lessons learned from the implementation of MAP 2011–2015;
- discuss the structure of TB-AP 2016–2020 and the main interventions foreseen at country and regional levels in line with the post-2015 global End TB Strategy and the main regional reference documents; and
- identify methods and tools for monitoring the implementation of TB-AP 2016–2020 in collaboration with Member States and major stakeholders, including civil society, in countries and at the regional level.

Ultimately, the goal of the one-day consultation was to record participant (Annex 2) feedback in order to revise and finalize TB-AP 2016–2020 with a view to obtaining approval by the Regional Committee for Europe in September 2015. A list of background documents is provided in Annex 3.

Session 1: Past, present and future of TB prevention and control

Chairs: Masoud Dara (WHO Regional Office for Europe) and Peter Henrik Andersen (Denmark)

Scope and purpose of the meeting: **Masoud Dara** presented the background, scope and purpose of the meeting. The aim of the regional consultation meeting was to discuss in detail the first draft of the Tuberculosis Action Plan for the WHO European Region, 2016–2020 (TB-AP 2016–2020).

The achievements and remaining challenges of the current [Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015](#) will feed into TB-AP 2016–2020. The new Action Plan will be in line with the global [End TB Strategy](#) and the [Health 2020](#) policy framework.

The discussions throughout the day considered the structure of TB-AP 2016–2020, as well as what was missing and what needed to be modified. The ultimate goal of the one-day consultation was to obtain sufficient input to finalize the Action Plan in early 2015.

Three working groups were presented. It was explained that the groups would simultaneously discuss the content of the three pillars of the Action Plan:

Pillar 1: Integrated and patient-centred care and prevention (prevention, diagnosis, treatment, care and patient support, and intra/intersectoral collaboration);

Pillar 2: Bold policies and supportive systems (political commitment, civil society and community engagement, universal health coverage and social protection, and social determinants); and

Pillar 3: Intensified research and innovation (research on new tools, strategies and interventions, and on methods for optimizing implementation and impact).

The End TB Strategy: role of WHO in supporting implementation of the new global strategy:

Mario Raviglione (WHO Global TB Programme) presented the [End TB Strategy](#). The global TB burden was described with reference to the recently launched [Global tuberculosis report 2014](#). There are 9 million new cases of TB and 1.5 million TB-related deaths annually. There are 480 000 cases of multidrug-resistant TB (MDR-TB) annually, causing more than 200 000 deaths. There are 1.1 million HIV-associated cases (80% in sub-Saharan Africa), and TB kills 360 000 people with HIV annually.

The number of TB cases and deaths is slowly declining (1990–2013). Total mortality peaked in 2002 at 1.7 million. This demonstrates some progress, including a 45% reduction in mortality since 1990, but TB incidence has declined at a very slow rate of 1.5% annually. This figure partly reflects better data collection, particularly from Nigeria.

There are five priority actions to eliminate TB:

1. reach missed cases (3 million not in the system)
2. address MDR-TB as a crisis
3. accelerate the response to TB/HIV
4. increase financing to close resource gaps
5. intensify research and ensure the rapid uptake of innovations.

A global map of the prevalence of MDR-TB was presented. The highest prevalence is in the countries of the former Soviet Union. In absolute numbers, more than 60% of MDR-TB cases are in India, China, Pakistan, and two of the countries of the WHO European Region: Russian Federation and Ukraine.

There is significant progress in MDR-TB detection, but treatment challenges compromise gains. In 2013, only five of the 27 high-burden MDR-TB countries achieved treatment success rates of $\geq 70\%$. An estimated 300 000 cases occur every year. A total of 136 000 cases were reported in 2013 (40% more than the previous year). In terms of diagnosis, a better public health response is urgently needed. In 2013, 97 000 people with TB were started on second-line treatment for MDR-TB. Forty-eight percent of MDR-TB patients detected globally in 2011 had a successful treatment outcome recorded in 2013.

WHO proposes five key actions to address MDR-TB:

1. prevent the development of MDR-TB through good basic care
2. promote rapid testing
3. provide access to drugs
4. prevent transmission through infection control
5. increase political commitment with financing.

In response to this situation, the World Health Assembly approved a new global strategy in May 2014. The global End TB Strategy framework has the vision of a world free of TB. The goal is to end the global TB epidemic (defined as reducing the case-load to below 10 cases per 100 000 people). There are three targets: achieving a 95% reduction in deaths due to TB (compared with 2015); achieving a 90% reduction in TB incidence; and ensuring that no affected families face catastrophic expenses due to TB.

There are three pillars to the End TB Strategy:

1. integrated, patient-centred care and prevention
2. bold policies and supportive systems
3. intensified research and innovation.

At the country level, WHO will provide technical assistance to adapt, plan and implement the new Strategy and will also provide support for resource mobilization.

Stop TB Partnership: overview of progress, challenges and further developments for empowering civil society in the operationalization and implementation of the global TB strategy: **Lucica Ditiu** (Stop TB Partnership) emphasized that the next five years are crucial. Progress on TB diagnosis, prevention and treatment has been too slow and needs to be accelerated. Meeting participants, as experts in their settings, were encouraged to look for ways to fundamentally change the TB response in their countries. Strategies need to be rethought, if the nearly 3 million new cases of TB annually are to be identified.

The Stop TB Partnership Global Plan to Stop TB (2016–2020) presents the steps and investment needed to reach the targets, and the estimated cost of activities. The Plan's features are:

- country groupings based on epidemiology, health systems, and socioeconomic and political characteristics; and
- investment packages consisting of interventions appropriate for each country group, with modelling conducted for cost and impact.

Under the new Global Plan, the world will be divided not only geographically, but also according to epidemiology and health systems. There are nine country groups, including one for China by itself and another for India by itself. The investment packages take into account diagnosis, treatment and health systems in each of the country groups.

In closing it was emphasized that despite current efforts, TB incidence is only slowly decreasing. There is a need to follow the example of the HIV response in terms of promoting greater community and civil society involvement.

Progress on implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant TB in the WHO European Region, 2011–2015: **Masoud Dara** (WHO Regional Office for Europe) stated that the progress report on the implementation of MAP 2011–2015 is being prepared. Preliminary results were presented. The TB burden in the WHO European Region is unequally distributed among countries and is particularly high in parts of eastern Europe, such as the Russian Federation and Ukraine. MDR-TB is now the major challenge and its incidence is on the rise. It is not realistic to think that tools being employed currently will reduce MDR-TB. Since the TB Action Plan was implemented, the MDR-TB detection rate has increased, particularly

in central Asia. All signs point to a growing global burden of MDR-TB and extensively drug-resistant TB (XDR-TB). The burden is usually considered in one of two ways: the percentage of all TB cases that are multidrug-resistant and extensively drug-resistant or the absolute number of MDR-TB and XDR-TB cases. In the last six years, MDR-TB has increased in the Region from 10% to 16.9% among new TB cases and from 38% to 48% among retreatment cases.

TB is the leading cause of death among people living with HIV. There was a notable increase in antiretroviral therapy coverage among HIV-positive TB patients, with coverage reaching 51.1% in 2013. There was also an increase in cotrimoxazole preventive therapy enrolment, with coverage reaching 55.7% in 2013.

Accomplishments and challenges were presented in relation to in the seven main areas of MAP 2011–2015:

1. prevent the development of M/XDR-TB cases
2. access to drug resistance and HIV testing
3. access to MDR-TB treatment
4. TB infection control
5. strengthen surveillance
6. advocacy, partnership and policy guidance
7. address the needs of special populations.

Next steps for the Regional Office's technical work include:

- high-level advocacy work
- strengthening countries' surveillance capacity and use of data for improving services
- focusing on how to improve treatment success for M/XDR-TB patients
- documentation and support to scale up good practices
- country-specific technical assistance on human rights and ethics
- intensified support on health finance reforms
- scaling up pharmacovigilance
- technical assistance on the introduction and rational use of new TB drugs
- operational research capacity-building.

Draft of the Tuberculosis Action Plan for the WHO European Region, 2016–2020:

Ibrahim Abubakar (University College London, United Kingdom) introduced the draft TB-AP 2016–2020, noting that participants were provided with printed copies.

The post-2015 global End TB Strategy should be adapted into regional and national plans. An important consideration has been the fact that the plan needs to be both comprehensive and

adaptable to various settings, such as low- and high-incidence settings. Specific targets for the European Region (to 2020) are:

- a 35% reduction in TB deaths
- a 25% reduction in the TB incidence rate
- a 75% treatment success rate among the MDR-TB treatment cohort.

The Action Plan has the following strategic directions:

1. strengthen the health system response in regard to TB and drug-resistant TB prevention, control and care;
2. facilitate intersectoral collaboration, including civil society collaboration to address disease determinants and underlying risk factors;
3. work in national, regional and international partnerships;
4. foster collaboration for the development and use of new diagnostic tools, medicines, vaccines, and other treatment and prevention approaches; and
5. promote the rational use of existing resources, identify gaps and mobilize additional resources.

This regional consultation is part of the process of developing the Action Plan. A public consultation will be held in February–March 2015, followed by a final review by national counterparts during the National TB Programme Managers' Meeting in The Hague, Netherlands on 27–29 May 2015. The last step in the process will be endorsement by the sixty-fifth session of the Regional Committee for Europe in September 2015.

A comment from the audience was made regarding more of a focus on research in the current draft. It was noted that while new tools are needed, so are new approaches to get more people into treatment. This point is addressed in the draft Action Plan.

Session 2: Pillar 1 (Integrated and patient-centred care and prevention)

***Chairs:* Alena Skrahina (Belarus) and Martin van den Boom (WHO Regional Office for Europe)**

Introduction to following sessions (objectives and goal): **Masoud Dara** (WHO Regional Office for Europe).

The purpose of this next session, to look at Pillar 1 of TB-AP 2016–2020 and work in groups, was briefly explained.

Ambulatory care from day one: **Anvar Khusanov** (Uzbekistan) gave a presentation on how TB outpatient care was introduced in Uzbekistan. In a country where the budget of a TB facility depends on the number of inpatient beds, TB care has now been decentralized and moved into primary health care clinics. A special infrastructure has been introduced in which DOT points are offered in outpatient primary health care. There are 3000 health care facilities that perform DOT daily. Unfortunately, the treatment of MDR-TB cases is only around half of all cases, in part because they currently only treat severe cases.

When comparing inpatient and outpatient care, it was noted that it is easier to provide uninterrupted supervised treatment in inpatient care, but this costs more and requires the availability of beds.

The following information was shared about the current state of TB care in Uzbekistan:

- Guidelines on outpatient treatment are being developed.
- There is 100% availability of first- and second-line drugs.
- The introduction of modern diagnostic tools has resulted in improved TB diagnostics, and five interregional laboratories have been established.
- Construction and refurbishment work has been performed in all TB facilities, taking into account infection control requirements.

Next steps include a national programme for 2016–2020 and a regional proposal note to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

Algorithm for MDR-TB case detection, treatment and support: **Wouter Arrazola de Oñate** (Belgium) presented the experience of Belgium, a low-incidence country for MDR-TB, focusing specifically on an algorithm for MDR-TB case detection, treatment and support. Algorithm diagnosis of MDR-TB was recommended, if there is no suspicion of MDR-TB at the initial consultation or if there is a suspicion of MDR-TB based on the patient's history, origin or contact source. A simplified MDR-TB treatment algorithm was also presented. The main challenges have included:

Diagnosis

- delay 1st consultation – symptoms screening
- delay 2nd consultation – full drug susceptibility testing.

Treatment

- availability (should not be a problem in Europe)
- financing of treatment

- institutional care (isolation/low care)
- psychosocial care
- preventive therapy for children who come into contact with people who have MDR-TB.

In order to meet the aforementioned challenges, financing was secured via the BELTA-TBnet project, which pays for everything not covered by health insurance. Furthermore, an MDR-TB expert group provides recommendations. A comparison of experiences before and after the BELTA-TBnet project, which began in 2005, indicates that treatment success has more than doubled, but also that more severe MDR-TB resistance outcomes occur.

A major challenge in Belgium is the lack of knowledge about TB in hospitals. There are 120 local hospitals; some have never seen a TB patient. There is a need to share knowledge and provide training in hospitals and laboratories. Migrants, including those who are undocumented, are treated through the Belgian programme. As part of the effort to reach high-risk groups, active screening programmes are implemented in prisons and at points of entry to the country. There are also active screening programmes for asylum-seekers and for poor and homeless people.

The road ahead for Belgium includes more systematic use of GeneXpert, if MDR-TB is suspected at the first consultation. The following are also needed:

- therapeutic drug monitoring to reduce side-effects during the 24-month treatment period
- creation of a long-term institutional care structure that is humane and non-threatening
- improved psychological support and social assistance
- shorter treatment regimens.

Session 3: Pillar 2 (Bold policies and supportive systems)

Chairs: Wouter Arrazola de Oñate (Belgium) and Pierpaolo de Colombani (WHO Regional Office for Europe)

Health financing reform as a tool for improving inpatient and outpatient services in Armenia:

Karapet Davtyan (Armenia) explained inpatient and outpatient service financing in Armenia. Inpatient service financing was based on the number of bed days (load) occupancy. Outpatient service financing was a per capita financing mechanism: the size of the population covered through primary health care. This system was found to be costly and inefficient.

Armenia improved TB inpatient service financing through fixed costs associated with hospital maintenance and variable costs associated with the number of TB cases. As part of this reform, four low-workload TB clinics closed. Furthermore, the TB dispensary and control office were merged to create a national TB control centre. A government decree was passed to enforce all changes.

Expected outcomes from the changes were:

- fewer TB hospitalizations
- optimization of inpatient TB departments
- strengthening of primary health care services
- early detection and diagnosis of TB cases
- better treatment outcomes
- improved performance indicators for both inpatient and outpatient TB services
- improvements in the quality of inpatient and outpatient TB services
- greater satisfaction among patients and health care providers.

Contracting out TB services to an NGO: **Gerard de Vries** (Netherlands) reported on the creation of the nongovernmental organization KNCV Tuberculosis Foundation (60 staff at head office plus 150 elsewhere) in the Netherlands. Founded in 1903, KNCV plays a substantial role in responding to TB nationally and ran national surveillance (funded by the government) until the leading role was taken over by RIVM (Dutch national centre for disease control) in 2012. KNCV is partially funded from private sources, such as the national lottery. KNCV now supports RIVM on TB issues in addition to working on the following seven activities:

1. committee for practical TB control
2. evaluation of interventions
3. surveillance
4. coordination and technical advice
5. training/knowledge exchange
6. public health information
7. advocacy.

Session 4: Pillar 3 (Intensified research and innovation)

***Chairs:* Ibrahim Abubakar (University College London, United Kingdom) and Colleen Acosta (WHO Regional Office for Europe)**

Research priorities in the WHO European Region: looking ahead to 2020: **Colleen Acosta** (WHO Regional Office for Europe) presented TB research priorities in the WHO European Region based on challenges identified by WHO and on the 2020 TB Action Plan targets. While national research strategies need to be defined, basic research is required in order to obtain a better understanding

of human TB, new diagnostics and vaccines. At the same time, operational research should be conducted in order to determine how to use new tools effectively, understand risk factors and social determinants, improve financial mechanisms and strengthen health systems. Specifically, intercountry operational research was highlighted as the key to identifying the highest impact interventions, transmission modelling, GeneXpert yield, gender and age discordance in the detection and treatment of TB, and the efficacy of mobile health.

The global End TB Strategy identifies intensified research (and innovation) as one of its three pillars. Key research products have included 11 articles on operational research in eastern Europe in *Public Health Action* (October 2014).

Audience members were asked if their countries had TB research agendas, and they were also asked how Pillar 3 should be reflected in TB-AP 2016–2020. In the discussion, it was noted that partners such as in-country researchers are needed and that TB research should extend beyond the realm of national TB programmes.

Networking among TB experts: **Knut Lönnroth** (WHO headquarters) reported on a recent WHO/Karolinska Institute meeting that focused on networking among TB experts. The meeting addressed questions such as how WHO should best respond to country needs with regard to TB research, and how financial and other resources can be used most effectively. The need for greater funding for TB research was also addressed, including the need to make the case for such research. Discussions focused on operationalizing Pillar 3, and a 10-year action plan was considered. The plan's vision is to accelerate the decline of TB incidence and to achieve other goals in the End TB Strategy. One key action is to have a national TB research plan, linked to the national TB plan and the national health research plan in each country.

Several concrete suggestions were made. These included forming an ad hoc expert group to provide guidance on developing national TB research plans; mapping TB research activities; and establishing formal research networks and hubs. Dialogue with the Global Fund is needed, and also a forum to bring together stakeholders: funders, researchers and industry.

In the ensuing plenary discussion, concern was raised about the risk of TB-specific research plans placing TB in a silo. Ideally, TB should be a component of national health research plans, but if not, plans for TB research should be developed. A representative of the Global Fund commented that there is a wealth of research, but implementation plans are often lacking and these should build on existing evidence.

Session 5: Summary and closure

Chairs: Masoud Dara (WHO Regional Office for Europe) and Ibrahim Abubakar (University College London, United Kingdom)

Plenary discussion: reporting back from the working group sessions (15 minutes per group): The discussions from the three parallel working groups on the three pillars of TB-AP 2016–2020 were presented. The full list of suggested changes will be carefully reviewed by WHO staff as they revise the Action Plan. Below is a summary of the main points.

Pillar 1: Integrated, patient-centred care and prevention

The discussion in the working groups addressed the following questions:

- Apart from MDR-TB case management and ambulatory care models, which additional technical areas from the presentations are important and should be considered under Pillar 1?
- How should these technical areas be reflected in the new regional strategy?

The suggested amendments to Pillar 1 from the working groups were:

- General comments for the full Action Plan:
 - Include “improve access to health care”.
 - There is no definition of “integrated patient care” (could be a paragraph in the document, not under the interventions section).
 - Effective patient communication – patients must have access to quality, understandable information.
 - Add aspects regarding affordability and cost-effectiveness in accordance with WHO recommendations and guidance.
 - When discussing TB diagnostics, the Action Plan (1.a.1) should be broader than just mentioning GeneXpert and avoid brand names of the tools.
 - When clearly specifying hard-to-reach populations, include stateless people.
- 1.A: Split into systematic screening and early diagnosis. Consider the need for drug susceptibility testing for second-line anti-TB drugs as well.
- 1.A/1.B: Bringing and facilitating the services from diagnostics to treatment to care (including information/education, peer involvement and improved communication by health care workers to these groups, for example through mobile testing/laboratories).
- 1.a.1: Include: “Use proper/rational algorithm for rational/effective diagnosis”.
- 1.a.6: Remove “scheme”, leaving only “quality assurance”.
- 1.a.7: Need to include definitions of *active case finding*, *contact tracing* and *systematic screening*, as these are overlapping terms.

- 1.a.8: Include other diagnostic procedures, according to WHO, such as smear/cultures/chest radiography.
- 1.a.9: Divide into two items: one (1.A) for diagnosis and the other (1.B) for treatment.
- 1.B: Promote the European Respiratory Society/WHO Regional Office for Europe consilium or other effective and consultative mechanisms of discussion of MDR-TB cases (country and regional levels).
- 1.b.1: Move “paediatric drug formulations” to 2.c.12 and move 1.b.3. and 1.b.4 to section 2C (on medicines).
- 1.b.2: Add “uninterrupted drug supply”.
- 1.b.3: Replace “where indicated” with DOT or other WHO recommended alternatives (e-health).
- 1.b.5:
 - Social support not only for high-prevalence countries, but where necessary should be an additional point.
 - Under the “models of care” subsection: prioritize the patient-centred ambulatory care model as compared to the inpatient model of care. Consider adding “ambulatory treatment” to 1.B (under the main area of intervention) as the preferred model of care, ensuring that the standard of care fulfils the minimum requirements, and that both complement each other.
- 1.b.8:
 - Assure engagement instead of call for technical assistance – split in two.
 - Not only for vulnerable populations, but for all.
 - Family members should be added to the second sentence.
 - Specify hard-to-reach populations and how to reach those populations, including through a mobile screening system which has a laboratory and x-ray machine to provide rapid access to diagnosis.
 - Introduce and expand opioid substitution therapy for inpatient and outpatient treatment.
 - Restore social status/life of the patients/families and mitigate collateral damage due to TB. Recommend that countries socially reintegrate TB patients as early as possible, even during treatment. Ensure that individuals are protected by law from dismissal from their job/education due to TB (add similar language to 1.b.5).
- *Screening x-ray/radiography*: access and quality need to be improved, and as cost-effectively as possible (i.e. the analysis should ideally be where the test is performed – the nearer to the patient, the better).
- 1.c.2:
 - Add “counselling” to testing.
 - Define roles and responsibility for each counterpart in collaborative care.

- 1.c.4: Add “early” antiretroviral therapy or as per the most recent WHO recommendations/guidance.
- 1.C: Address the management of comorbidities (diabetes, drug and alcohol abuse).
- Prevention activities need to be expanded under prevention section.
- Risk groups screened at the primary health care level and also by and through other outreach mechanisms where (cost-) effective.
- Early case finding should be prioritized (applying intensified TB case finding and screening of population in targeted risk groups).
- Work with countries to identify risk groups/hard-to-reach populations, as per WHO guidance.
- 1.c.5: Make a more explicit mention of the role of Member States in implementing existing guidelines/best practices:
 - Add alcohol, smoking and nutrition, possibly as a separate bullet point.
- 1.d.3: Should be embedded in and supported by the existing health care system.

Pillar 2: Bold policies and supportive systems

The discussion in the working groups addressed the following questions:

- Apart from reforming health financing and engaging nongovernmental organizations, which additional technical areas from the presentations are important and should be considered under Pillar 2?
- How should these technical areas be reflected in the new regional strategy?

The suggested amendments to Pillar 2 from the working groups, with additions from the plenary discussion, were:

- A gap in all sections of TB-AP 2016–2020 is that the financing of non-health aspects, such as social protection, support and care, are poorly addressed.
- 2.a.2: Add to the end “with the aim of improving public-private practice partnerships”.
- 2.b.5: Consider moving this paragraph to 2.c.1 in order to create a more coherent assessment framework, as this refers to efficiency and responsiveness.
- 2.b.7: Add “supervised training” and “continuous training”.
- 2.c.2 and 2.c.5: ECDC needs to harmonize the collected variables and definitions with WHO.
- 2.c.12: Questioned the use of fixed-drug combinations, as there are difficulties with this in most countries. The suggestion was to add “whenever possible” and call for a more sustainable supply of single-dose regimens.
- 2.d: Include the need for HIV programmes to include TB infection control measures.
- 2.e.5: There is no mention of private providers.

- 2.e.7: Cross-border TB care – add the need to be enrolled for treatment in the host country.
- Section F should be expanded.
- There is no distinction between countries of destination and countries of origin in Section F.

Pillar 3: Intensified research and innovation

The discussion in the working groups addressed the following questions:

- Do countries have a TB research agenda?
- How should Pillar 3 be reflected in the new regional strategy?

The suggested amendments to Pillar 3 from the working groups, with additions from the plenary discussion, were:

- In general, TB-AP 2016–2020 needs to take funding issues more into account. It should encourage Member States to provide funding and support (education) for research. WHO should map the funding streams in Europe.
- Research directions should be determined by WHO with input from key stakeholders. Member States should share operational research results. In effect, there should be reporting to Member States from WHO and vice versa. Civil society can play an important role in raising the profile of TB and the needed research. Research is more than just operations, and the new Action Plan should address research more generically.
- A gap was identified with regard to models of care that allow for individualized approaches.
- Regarding operational research, it was suggested that:
 - Member States should inform/share their results with other countries;
 - results should be publicly available for civil society and in accessible language within advocacy, communication and social mobilization activities;
 - operational research should address stigma, patient satisfaction and misunderstandings about TB among the general population;
 - the Regional Office should formulate the directions of operational research and should support countries with technical assistance to build capacity and access funding;
 - WHO should report back to countries on operational research findings; and
 - Member States should work on overall operational research priorities in partnership with each other.
- There is a need to include activities on research ethics, case-based surveillance and surveillance for social determinants.

- Engage research networks. Examples from the Russian Federation and Belgium were mentioned.
- Two examples of research activities from Member States were provided:
 - Russian Federation, with strong research capacities and activities, but without an overall national TB research plan; and
 - Azerbaijan, with a research plan (capacity and willingness), but no funding allocated for it.
- It was noted that language barriers hinder the publication of research findings.
- Mapping of the collaborations between major research institutes in a particular Member State should be carried out and new research collaborations should be initiated.
- Motivate funding agencies to link with civil society for research advocacy.
- 3.a.1: Questioned the need/capacity for the development of a research plan in all countries; the national TB programme within each country should develop research priorities and promote scientific collaboration within the country, as well as consider collaboration with other countries.
- 3.a.2: Add “establish and develop”, as in most countries there is no research agenda at all.
- 3.a.3: It should be clear that this activity is for all 53 countries.
- 3.b.1: Put the word “platform” before “priorities”.
- 3.b.2: Add “coordinate with other existing plans”.
- 3.b.3: Remove “operational” to keep it broader and support research in a more general way.
- This section should specifically mention “translate research into applied action”.
- 3.b.5: Include prevention among best practices to be documented.

Overall reflections on TB-AP 2016–2020 included:

- Change the terminology in TB-AP 2016–2020 from “technical assistance” to “technical cooperation”.
- Reflect research in a global context, especially taking into account the funding issues (to include both operational and basic research).
- Elevate the authority of TB programmes on the agenda.
- Strengthen the education of health care workers and others.
- Avoid excessive programme reviews and coordinate with ECDC and other key actors.

Summarizing the feedback from the consultation meeting: **Ibrahim Abubakar** (University College London, United Kingdom) presented 38 points based on the working group presentations on the three pillars of TB-AP 2016–2020.

Masoud Dara officially closed the meeting by reporting that there were 76 participants and that the event was webcast live. He reminded the participants that the Action Plan is not a WHO plan,

but rather the plan of WHO Member States and partners. An advisory committee will revise the Action Plan and then an open consultation process will provide the opportunity for further refinement.

The next meeting will be the National TB Programme Managers' Meeting/Wolfheze Workshops, The Hague, Netherlands, 27–29 May 2015 when TB-AP 2016–2020 will be finalized.

Annex 1. Programme

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA



ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Regional consultation meeting on the development of the Tuberculosis Action Plan for the WHO European Region, 2016–2020

Copenhagen, Denmark, 27 November 2014

PROGRAMME

Thursday, 27 November 2014

08.30 – 09.00 Registration

Session 1: Past, present and future of TB prevention and control

Chairs: Dr Masoud Dara (WHO/Europe) and Dr Peter Henrik Andersen (Denmark)

- | | |
|-----------------------|---|
| 09.00 – 09.15
S1P1 | Opening and welcome
Ms Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe
Dr Hans Kluge, Director, Division of Health Systems and Public Health,
Special Representative of the Regional Director on M/XDR-TB |
| 09.15 – 09.20
S1P2 | Scope and purpose of the meeting
Dr Masoud Dara, Programme Manager, Tuberculosis & M/XDR-TB |
| 09.20 – 09.35
S1P3 | The End TB Strategy: role of WHO in supporting implementation of the new global strategy
Dr Mario Raviglione, Director, WHO Global TB Programme, Geneva,
Switzerland |
| 09.35 – 09.50
S1P4 | Stop TB Partnership: overview of progress, challenges and further developments for
empowering civil society in the operationalization and implementation of the global TB
strategy
Dr Lucica Ditiu, Executive Secretary, Stop TB Partnership |
| 09.50 – 10.00
S1P5 | Progress on implementation of the Consolidated Action Plan to Prevent and Combat
Multidrug- and Extensively Drug-Resistant TB in the WHO European Region, 2011–2015
Dr Masoud Dara, Programme Manager, Tuberculosis & M/XDR-TB |
| 10.00 – 10.30
S1P6 | Draft of the Tuberculosis Action Plan for the WHO European Region, 2016–2020
Dr Ibrahim Abubakar (UK, Chair of the TB-AP Advisory Committee) |

10.30 – 11.00 **Coffee and tea break**

Session 2: Pillar 1 [Integrated and patient-centred care and prevention]

Chairs: Dr Alena Skrahina (Belarus) and Dr Martin van den Boom (WHO/Europe)

- 11.00 – 11.10 Introduction to following sessions (objectives and goal)
S2P1 Dr Masoud Dara (WHO/Europe)
- 11.10 – 11.25 Ambulatory care from day one
S2P2 Dr Anvar Khusanov (Uzbekistan)
- 11.25 – 11.40 Algorithm for MDR-TB case detection, treatment and support
S2P3 Dr Wouter Arrazola de Oñate (Belgium)
- 11.40 – 12.40 Discussion in working groups: Apart from MDR-TB case management and ambulatory care
S2P4 models, which additional technical areas from the presentations are important and should be considered under Pillar 1? How should they be reflected in the new regional strategy?

12.40 – 13.30 **Lunch**

Session 3: Pillar 2 [Bold policies and supportive systems]

Chairs: Dr Wouter Arrazola de Oñate (Belgium) and Dr Pierpaolo de Colombani (WHO/Europe)

- 13.30 – 13.45 Health financing reform as a tool for improving in/outpatient services in Armenia
S3P1 Dr Karapet Davtyan (Armenia)
- 13.45 – 14.00 Contracting out TB services to an NGO
S3P2 Dr Gerard de Vries (Netherlands)
- 14.00 – 15.00 Discussion in working groups: Apart from reforming health financing and engaging
S3P3 nongovernmental organizations, which additional technical areas from the presentations are important and should be considered under Pillar 2? How should they be reflected in the new regional strategy?

15.00 – 15.15 **Coffee and tea break**

Session 4: Pillar 3 [Intensified research and innovation]

Chairs: Dr Ibrahim Abubakar (UK, Chair of the TB-AP Advisory Committee) and Dr Colleen Acosta (WHO/Europe)

- 15.15 – 15.30 Research priorities in the WHO European Region: looking ahead to 2020
S4P1 Dr Colleen Acosta (WHO/Europe)
- 15.30 – 16.30 Discussion in working groups on the following questions: Do countries have a TB research
agenda? How should Pillar 3 be reflected in the new regional strategy?

Session 5: Summary and closure

Chairs: Dr Masoud Dara (WHO/Europe) and Dr Ibrahim Abubakar (UK, Chair of the TB-AP Advisory Committee)

16.30 – 17.15 Plenary discussion: reporting back from the working group sessions (15 mins per group)

17.15 – 17.30 Summarizing the feedback from the consultation meeting

Dr Ibrahim Abubakar (UK, Chair of the TB-AP Advisory Committee)

Closure

Dr Nedret Emirođlu (Deputy Director, Division of Communicable Diseases, Health Security and Environment)

Annex 2. List of participants

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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Regional consultation meeting on the development of the Tuberculosis Action Plan for the WHO European Region, 2016–2020

Copenhagen, Denmark, 27 November 2014

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Annex 3. Background documents

- The draft of the Tuberculosis Action Plan for the WHO European Region, 2016–2020.
<http://discussion.euro.who.int/forum/topics/public-consultation-tb-action-plan-for-the-who-european-region-20>
- Progress report on the implementation of the Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis in the WHO European Region, 2011–2015
http://www.euro.who.int/_data/assets/pdf_file/0006/195504/RC62sc3-Eng.pdf?ua=1.
- Global strategy and targets for tuberculosis prevention, care and control after 2015
http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_12-en.pdf?ua=1.
- Framework towards TB elimination in low-incidence countries
http://www.who.int/tb/publications/elimination_framework/en/.
- Health 2020. A European policy framework and strategy for the 21st century
<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century>.