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Consolidated action plan to prevent and combat multidrug- and extensively drug-resistant tuberculosis in the WHO European Region 2011–2015

The Consolidated Action Plan to Prevent and Combat Multidrug- and Extensively Drug-Resistant Tuberculosis (M/XDR-TB) in the WHO European Region 2011–2015 has been developed to strengthen and intensify efforts to address the alarming problem of drug-resistant TB in the Region.

The Plan has been prepared in Region-wide consultation with representatives of the 53 European Member States, experts, patients and communities suffering from the disease. The participatory process of developing the Plan was led by the Regional Director's Special Project to Prevent and Control M/XDR-TB and was overseen by an independent steering group composed of representatives of key technical and bilateral agencies, Member States and civil society organizations.

Following a detailed assessment of interventions in the WHO European Region to tackle TB and MDR-TB, and considering the Member States' responses to the Regional Director's request for input and feedback at the Eighteenth Standing Committee of the Regional Committee's second session (Andorra 18–19 November 2010), the first draft of the Consolidated Action Plan was prepared. The WHO Regional Office for Europe organized a three-day workshop in Copenhagen from 6 to 8 December 2010 and finalized the second draft of the Plan with the participation of country representatives and key experts in the field. The Plan was posted on the internet between 25 February and 11 April 2011 for consultation with the public and civil society and sent on 5 May 2011 to Member States for their review and inputs. Their comments and suggestions have been included in the final version of the Plan.

The targets and objectives in the WHO European Region's Consolidated Action Plan are in line with those of the MDR-TB section of the Global Plan to Stop TB 2011–2015 and World Health Assembly resolution WHA62.15, which urges all Member States to prevent and control M/XDR-TB and strengthen partnership and involve civil society organizations. The Consolidated Action Plan is built on the core principles of the Health 2020 strategy, with its vision of equitable access to health care, and in line with the Beijing Call for Action on Tuberculosis Control and Patient Care and the Berlin Declaration on Tuberculosis. A joint platform with partners will be established to closely follow up and assist in the implementation of the Consolidated Action Plan.

The Consolidated Action Plan is submitted for endorsement by the WHO Regional Committee for Europe, along with an accompanying resolution.

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Contents

Executive summary

In response to the alarming problem of multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB) in the WHO European Region, the Regional Director has established a Special Project to Prevent and Combat M/XDR-TB in the Region. In order to scale up a comprehensive response and to prevent and control M/XDR-TB, a consolidated action plan has been developed for 2011–2015 for the 53 Member States, the WHO Regional Office for Europe and partners. The Consolidated Action Plan to Prevent and Control M/XDR-TB in the WHO European Region 2011–2015 has six strategic directions and seven areas of intervention. The strategic directions are cross-cutting and are designed to safeguard the values of the Health 2020 strategy and highlight the corporate priorities of the WHO European Region. The areas of intervention are aligned with the Global Plan to Stop TB 2011–2015 and include the same targets as set by the Global Plan and World Health Assembly resolution WHA62.15, namely to provide universal access to diagnosis and treatment of MDR-TB.

A detailed version of the Consolidated Action Plan has been developed, to provide national TB and communicable disease programmes and divisions, and technical and bilateral agencies, with an operational roadmap for implementation of MDR-TB prevention and control activities. The WHO Regional Office has assisted Member States in the WHO European Region with a high MDR-TB burden to develop national MDR-TB response plans based on the Beijing Call for Action on TB Control and Patient Care. The Consolidated Action Plan will guide Member States in further elaboration and integration of national MDR-TB response plans in their national TB and/or national health strategic plans.

With implementation of the Consolidated Action Plan, the emergence of 250 000 new MDR-TB patients and 13 000 XDR-TB patients would be averted, an estimated 225 000 MDR-TB patients would be diagnosed and at least 127 000 of them would be successfully treated, hence interrupting the transmission of MDR-TB; 120 000 lives and US$ 5 billion would be saved.

Introduction

1. Multidrug- and extensively drug-resistant tuberculosis (M/XDR-TB) is a man-made phenomenon that emerges as a result of inadequate treatment of tuberculosis and/or poor airborne infection control in health care facilities and congregate settings. Of the estimated 440 000 (range 390 000–510 000) multidrug-resistant TB (MDR-TB) patients in the world, 81 000 (range 73 000–90 000) are considered to be in the WHO European Region (18.4% of the global burden).[1] The rates of MDR-TB prevalence in the WHO European Region remain very alarming. In 2009, the proportion of MDR-TB among new and previously treated TB patients was 11.7% and 36.6% respectively.[2] Despite the still very low coverage with susceptibility testing for second-line drugs (SLDs), most countries in the Region have reported XDR-TB.

2. The top nine countries in the world with MDR-TB exceeding 12% among new TB cases, and the top six exceeding 50% among previously treated TB cases, are in the WHO European Region. High correlation between MDR-TB and HIV has been documented in several Member States.[3] MDR-TB has been also reported in the Region linked to more downstream and upstream determinants of health such as imprisonment, migration and low socioeconomic status, and it is a concern for most countries in the Region, irrespective of their TB burden.

3. In 2009, of an estimated 81 000 (range 73 000–90 000) MDR-TB patients, only 27 760 cases (34.2%) were notified,[2] owing to low availability of mycobacteriology culture and drug susceptibility testing or molecular diagnostic methodologies. Of these notified cases of MDR-TB, only 61.8% (17 169 patients)[4] were reported as receiving adequate treatment with quality SLDs. In order to diagnose XDR-TB, there is a need to have access to SLD susceptibility testing, which is not readily available for all patients. Despite this, the total number of notified XDR-TB patients almost tripled from 132 in 2008 to 344 in 2009.[2] In non-European Union (EU)/European Economic Area (EEA)[5] countries, where such services are extremely limited, XDR-TB notification increased 6.7 times (from 41 to 278).[2]

4. Currently, the treatment of MDR-TB patients is lengthy and takes up to 24 months, with the use of SLDs and/or surgery, often accompanied by adverse events, which imposes a further burden on patients and their families. The latest available data indicate that out of 3823 MDR-TB patients receiving quality SLDs in the WHO European Region in 2007, 2194 (57.4%) were

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[1] *Global tuberculosis control: WHO report 2010*. Geneva, World Health Organization, 2010 (document WHO/HTM/TB/2010.7, http://whqlibdoc.who.int/publications/2010/9789241564069_eng.pdf).

[2] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. *Tuberculosis surveillance in Europe 2009.* Stockholm, European Centre for Disease Prevention and Control, 2011 (http://ecdc.europa.eu/en/publications/Publications/1103_TB_SUR_2009.pdf).

[3] *Multidrug and extensively drug-resistant TB (M/XDR-TB): 2010 global report on surveillance and response.* Geneva, World Health Organization, 2010 (document WHO/HTM/TB/2010.3, http://whqlibdoc.who.int/publications/2010/9789241599191_eng.pdf).

[4] *Towards universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis by 2015, WHO progress report 2011.* Geneva, World Health Organization, 2011 (document WHO/HTM/TB/2011.3, http://whqlibdoc.who.int/publications/2011/9789241501330_eng.pdf).

[5] The 30 EU and EEA countries are: Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom. The 24 countries in the rest of the European Region ('non-EU/EEA') are: Albania, Andorra, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Croatia, Georgia, Israel, Kazakhstan, Kyrgyzstan, the Former Yugoslav Republic of Macedonia, Moldova, Monaco, Montenegro, Russian Federation, San Marino, Serbia, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan.

successfully treated. The treatment success rate for MDR-TB patients in EU countries is reported to be as low as 32% (355 out of 1111), with unfortunately many patients dying (19.5%), failing treatment (23%) or lost to follow-up (25.5%).[2]

5. The Regional Office, in collaboration and coordination with other partners, has provided guidance and technical assistance to Member States to improve TB, MDR-TB and TB/HIV prevention, control and care, including planning and programme management, airborne infection control, surveillance, monitoring and evaluation, development of human resources capacity, quality-assured laboratory diagnosis, guidelines and policy development, provision of quality medicines through the Global Drug Facility (GDF) and Green Light Committee (GLC), advocacy, communication and social mobilization.

6. Bacille Calmette Guérin (BCG) – the only vaccine so far available against TB – was first used in 1921; it has limited efficacy for protection against the disease and cannot be administered to people living with HIV. The most effective drugs against TB were discovered in the 1950s; since then, other agents have been introduced with often more frequent and serious adverse events. There is an urgent need for more effective medicines and vaccines, and European scientific institutes can play an important role in research and development of new medicines and vaccine.

7. Recently, an automated rapid nucleic acid amplification test has been endorsed by WHO as a rapid method for diagnosis of TB and rifampicin resistance; however, this technology and other WHO-endorsed diagnostic methods are not yet widely available in most high MDR-TB burden countries in the Region.

8. In the Berlin Declaration on Tuberculosis, endorsed in 2007, all Member States committed themselves to urgently respond to the problem of tuberculosis in the Region and properly address M/XDR-TB. Adequate interventions addressing drug-resistant TB require proper national planning and effective implementation, comprehensive approaches in and across countries, and strong support from national and international partners. Ministers from the 27 high M/XDR-TB burden countries of the world met in Beijing, China, from 1 to 3 April 2009 to urgently address the alarming threat of M/XDR-TB. This was reflected in a call for action on M/XDR-TB, to help strengthen health agendas and ensure that urgent and necessary commitments to action and funding are made in order to prevent this impending epidemic. In the same year, the World Health Assembly in its resolution WHA62.15 urged all Member States to prevent and control M/XDR-TB. High-burden MDR-TB countries in Europe have developed summary national M/XDR TB response plans. These national plans need to be further elaborated and endorsed, in line with the present regional Consolidated Action Plan.

9. The WHO Regional Director for Europe has confirmed WHO’s strong commitment to fight against TB and M/XDR-TB as a regional priority and to develop an action plan to prevent and combat M/XDR TB in the Region; this position was endorsed by the Regional Committee at its sixtieth session in Moscow in September 2010.

Outline

Vision

10. Elimination of tuberculosis (less than one TB patient per one million population) by 2050 (Global StopTB vision).

Goal

11. To contain the spread of drug-resistant TB by achieving universal access[6] to prevention, diagnosis and treatment of M/XDR-TB in all Member States in the WHO European Region[7] by 2015.

Targets

12. The Consolidated Action Plan aims:

- to decrease by 20 percentage points the proportion of cases of MDR-TB among previously treated patients by the end of 2015;
- to diagnose at least 85% of estimated MDR-TB patients by the end of 2015;[8] and
- to successfully treat at least 75% of patients notified as having MDR-TB by the end of 2015.

Strategic directions

13. The six strategic directions of the Consolidated Action Plan are:

(1) identifying and addressing determinants and underlying risk factors contributing to the emergence and spread of drug-resistant TB (areas of intervention 1, 4, 6 and 7);

(2) strengthening the health system response in providing accessible, affordable and acceptable services using patient-centred approaches. In order to reach the most vulnerable populations, it is important that services remain truly free of charge for patients. Innovative mechanisms are to be introduced to remove barriers to equitable access to diagnosis and treatment of drug-resistant TB and create incentives and enablers for patients to complete their treatment (areas of intervention 1, 2, 3, 4, 5, 6 and 7);

(3) working in national, regional and international partnerships on TB prevention, control and care (area of intervention 6);

(4) fostering regional and international collaboration for development of new diagnostic tools, medicines and vaccines against TB (areas of intervention 2, 3 and 6);

(5) promoting rational use of existing resources, identifying gaps, and mobilizing additional resources to fill the gaps (area of intervention 6); and

(6) monitoring the trends of M/XDR-TB in the Region and measuring the impact of interventions (area of intervention 5).

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[6] "Universal access" is defined as evidence-based practices and quality services that are available, accessible, affordable and acceptable by people irrespective of their age, sex, sexual orientation, religion, origin, nationality, socioeconomic status or geographic background.

[7] The Sixty-second World Health Assembly on May 2009 adopted resolution WHA62.15 on MDR/XDR-TB, urging all Member States "to achieve universal access to diagnosis and treatment of multidrug-resistant and extensively drug-resistant tuberculosis as part of the transition to universal health coverage, thereby saving lives and protecting communities".

[8] In 2009 only 34.5% of estimated MDR-TB patients were notified. With universal access to diagnosis, one would expect most sputum culture-positive patients to be identified, notified and reported, while many culture-negative TB patients may still not be detected.

Areas of intervention

14. Based on the objectives in the Global Plan to Stop TB 2011–2015[9] to achieve a reduction in the burden of drug-resistant TB, the seven areas of intervention of the Consolidated Action Plan are to:

(1) prevent the development of M/XDR-TB cases;

(2) scale up access to testing for resistance to first- and second-line anti-TB drugs and to HIV testing and counselling among TB patients;

(3) scale up access to effective treatment of drug-resistant TB;

(4) scale up TB infection control;

(5) strengthen surveillance, including recording and reporting, of drug-resistant TB;

(6) expand country capacity to scale up the management of drug-resistant TB, including advocacy, partnership and policy guidance; and

(7) address the needs of special populations.

Milestones

15. The milestones of the Consolidated Action Plan are as follows.

- A regional mechanism of coordination and collaboration among partners for provision of technical assistance and scale-up of response to M/XDR-TB is established by the middle of 2012.
- WHO-endorsed rapid molecular diagnostic tests for MDR-TB[10] are available and in use for all eligible patients in the Member States by the end of 2013.
- All high MDR-TB burden countries have introduced an electronic case-based database for notification and recording of treatment outcome of MDR-TB patients at national level by the end of 2014.
- All high MDR-TB burden countries are reporting more than 50% of estimated MDR-TB cases by the end of 2013.
- All 18 European high TB priority countries have completed a knowledge, attitude, and practice (KAP) survey and undertaken a health system assessment focused on needs related to TB and MDR-TB by the end of 2013.
- All 18 European high TB priority countries have adopted and budgeted national M/XDR-TB action plans embedded in their national TB strategic plans by the end of 2012.
- All Member States have provided an uninterrupted supply of quality first- and second-line drugs for treatment of all TB and M/XDR-TB patients by the end of 2013.
- All Member States are monitoring and reporting treatment outcomes of M/XDR-TB patients according to internationally recommended methodologies by the end of 2013.

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[9] It has been decided to refer to the objectives in the Global Plan as “areas of intervention” and to define specific objectives under each of these areas, to ensure they are “smart” (specific, measurable, achievable, realistic and time-bound).

[10] A rapid test is defined as one which provides a diagnosis within 48 hours of the specimen being tested and can therefore influence the initial treatment that a patient is placed on.

- All previously treated TB patients are being tested for resistance to first- and second-line drugs by the end of 2012.
- At least one new medicine for M/XDR-TB patients with a more effective and shorter treatment regimen is available by the end of 2015.

Expected achievements[11]

16. With the implementation of the Consolidated Action Plan it is expected that:

- 225 000 MDR-TB patients will be diagnosed within three days of presenting to a health care service with TB symptoms;
- 127 000 MDR-TB patients will be treated successfully;
- 250 000 MDR-TB cases will be averted;
- 13 000 XDR-TB cases will be averted;
- 120 000 lives will be saved; and
- US$ 5 billion will be saved.

Prevent the development of M/XDR-TB cases

Identify and address social determinants related to M/XDR-TB

17. The WHO Regional Office for Europe and its partners, in collaboration with the Member States, will conduct studies on the social determinants and the reasons for treatment default of TB and M/XDR-TB by the end of 2012. Member States will include actions in their national health strategies to address the social determinants of M/XDR-TB by the end of 2013. Member States will define measures to engage national and local governments and relevant partners in the provision of psychosocial support for TB and M/XDR-TB patients by the end of 2013.

Improve patient adherence to treatment

18. The Regional Office, in collaboration with its partners, will document successful models of care (inpatient, outpatient, home/community-based treatment) in different settings and provide a compendium of models of care and minimum packages of interventions to prevent and retrieve treatment interruptions and defaults by the end of 2012. Member States will strengthen and/or establish measures to improve treatment default prevention and retrieval by the end of 2012. These efforts and their impacts are to be reported during the meeting of national TB programme managers in 2013. Member States will specify the strategies and mechanisms for expanding ambulatory treatment and provision of psychosocial support for TB and M/XDR-TB patients by the first quarter of 2014.

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[11] The method to determine the expected achievements has been developed in collaboration with the Royal Tropical Institute in Amsterdam. Costs for MDR-TB case detection and treatment, as well as for stewardship, and epidemiological data used were taken from the following sources; WHO, the European Centre for Disease Prevention and Control, the Foundation for Innovative Diagnostics, UNAIDS and academic publications. If data on TB epidemiology in Europe were not available in these sources, then assumptions based on expert opinions and linear progression of targets and milestones defined in the Plan were used.

Increase the efficiency of health financing for TB control

19. The Regional Office and its partners, in collaboration with the Member States, will conduct an in-depth analysis of existing health financing mechanisms and available resources for TB control and recommend measures to improve the efficiency and address gaps in health financing for TB prevention and control by the end of 2013.

Apply the full capacity of primary health care services in TB prevention, control and care

20. Member States will specify the strategies and mechanisms for integrating outpatient treatment in primary health care (PHC) services by the end of 2012. The Regional Office and its partners will provide technical assistance to Member States on measures to strengthen PHC involvement in TB prevention and control.

Consider management of M/XDR-TB contacts

21. Currently, there is no preventive therapy available for individuals who have been recently infected with/exposed to M/XDR-TB strains. The Regional Office and its partners will conduct an evidence-based review of current practices in management of contacts of M/XDR-TB patients by mid-2013. In collaboration with other partners, the Regional Office will put forward a set of recommendations on contact tracing and management of M/XDR-TB contacts by the beginning of 2014.

Scale up access to testing for resistance to first- and second-line anti-TB drugs and to HIV testing and counselling among TB patients

Strengthen the TB laboratory network

22. The Regional Office, in collaboration with supranational TB reference laboratories and other partners, will provide technical assistance to Member States for expanded and accelerated quality-assured culture, drug susceptibility testing and new diagnostic technologies, including WHO-endorsed rapid molecular tests, by 31 March 2012. Member States and donor organizations will prioritize funding for the introduction of new techniques for the diagnosis of M/XDR-TB. The Regional Office, through supranational TB reference laboratories, will support human resources capacity-building with regional workshops, annual country visits and short-term fellowships for national laboratory staff from high-priority countries. High TB priority Member States will prepare a three-year TB laboratory development plan by March 2013. Member States will ensure that quality assurance of TB laboratories, including biosafety measures, is in place by the end of 2013.

Diagnostic testing and counselling for HIV of all TB patients

23. Member States will train and orient staff responsible for TB and M/XDR-TB on the importance of HIV testing and counselling by the end of 2012 and will ensure that HIV testing and counselling are offered to all TB patients on a provider-initiated and opt-out basis by the end of 2012. The Regional Office and other partners will provide technical assistance to high TB priority countries with collaborative TB/HIV activities, based on a needs assessment.

Scale up access to effective treatment of drug-resistant TB

Ensure uninterrupted supply of quality medicines

24. The Regional Office and partners will provide reliable estimates of second-line drug needs and five-year projections by March 2012. The Regional Office and partners will introduce a generic indicator-based tool for conducting an ongoing drug utilization review as part of routine programme performance monitoring by the end of 2012. WHO and partners will ensure that regional prequalification of medicines is in place by the end of 2013. Member States will procure and make available adequate quality medicines for directly observed treatment (DOT) of TB and M/XDR-TB as early as possible. WHO encourages Member States to ensure fast-track registration of already WHO-prequalified products in their respective countries by the end of 2012. Member States will adopt and expand countrywide use of first-line fixed dose combination drugs by the end of 2012. WHO and partners will promote the development of paediatric formulations of second-line drugs by the end of 2012.

Management of adverse events

25. The Regional Office will develop a regional generic guide for managing drug-related adverse events by mid-2012. Member States will ensure that measures to manage adverse events are available to all MDR-TB patients by mid-2012.

Development of new medicines

26. The Regional Office and partners will develop a long-term regional strategy for the development of the TB medicines market by the end of 2013. The Regional Office and Member States will facilitate research into and development of new medicines and vaccines for TB on a continuous basis and report on progress to the Regional Committee every other year from 2013 onwards.

Scale up access to treatment

27. Member States will ensure the availability of resources for universal access to treatment by 2012 and will report on progress to the Regional Committee each year from 2012. The Regional Office and partners (including WHO collaborating centres), in close consultation with high TB priority countries, will develop a joint plan of technical assistance to Member States in achieving universal access to treatment (including treatment of children) by the end of 2012. Member States will ensure that their treatment guidelines are updated according to the latest available evidences and WHO recommendations by the end of 2012. Member States will ensure adequate training, coaching and support of health care staff for scale-up of treatment of M/XDR-TB patients by the end of 2011. The Regional Office, in collaboration with other partners, will develop a set of evidence-based criteria for surgery of eligible M/XDR-TB patients by the end of 2012.

Scale up TB infection control

Improve administrative and managerial aspects of TB infection control

28. Member States will introduce or strengthen surveillance of TB infection and/or disease among health care workers working in high-risk facilities by mid-2013. The Regional Office

and partners will develop a joint plan of technical assistance to Member States to improve TB infection control (TB-IC) by the end of 2012, including country visits, risk assessments and training of staff. Member States will ensure that all health care facilities serving TB patients or suspected TB patients are assessed in terms of TB-IC and have sound standard operating procedures for TB-IC by the end of 2013. Member States will ensure contact tracing of TB patients for early diagnosis of infection and disease by the first quarter of 2012. Member States will include in-service and pre-service training of health care staff on TB-IC by the end of 2012. Member States will ensure that respiratory protection programmes are in place for TB and M/XDR-TB services by mid-2012.

Strengthen environmental measures for TB infection control

29. The Regional Office and partners will organize training of trainers on environmental measures, including engineering and facility design for airborne infection control, by the end of 2012. Member States will conduct cascade training of staff responsible for environmental aspects of airborne infection control by the end of 2013. Member States will ensure that minimum requirements of engineering and environmental measures for airborne infection control are in place in TB and M/XDR-TB facilities and congregate settings by the end of 2013.

Ensure accessibility to personal protective measures

30. The Regional Office will share with Member States procurement specifications, including recommended use practices, for personal protective measures by mid-2012. Member States will ensure that adequate numbers of quality respirators are available and used appropriately by the end of 2012.

Strengthen surveillance, including recording and reporting, of drug-resistant TB

Strengthen surveillance

31. Member States will strengthen TB data collection and interpretation, in order to improve programme performance on a continuous basis. The Regional Office and partners will assist high TB priority countries in establishing surveillance of drug-resistant TB, including resistance to second-line drugs, and social determinants by March 2013. The Regional Office and partners will organize training and support for surveillance staff and programme managers in ensuring collection of minimum MDR-TB indicators of high TB priority countries by the end of 2012.[12]

Improve recording and reporting

32. The Regional Office will strengthen the monitoring mechanism for comprehensive follow-up of the Berlin Declaration by mid-2012. The Regional Office in collaboration with partners will assist Member States in finalization and implementation of electronic systems to enhance recording and reporting by the end of 2013. High TB priority countries will conduct

[12] *Multidrug-resistant tuberculosis (MDR-TB) indicators. A minimum set of indicators for the programmatic management of MDR-TB in national tuberculosis control programmes*. Geneva, World Health Organization, 2010 (document WHO/HTM/TB/2010.11, http://whqlibdoc.who.int/hq/2010/WHO_HTM_TB_2010.11_eng.pdf,).

training and coaching of national TB programme managers in monitoring and evaluation and in using data to improve TB programme performance by the end of 2012.

Expand country capacity to scale up the management of drug-resistant TB, including advocacy, partnership and policy guidance

Improve programme management

33. All Member States will have a dedicated M/XDR-TB patient management unit or staff as appropriate by the end of 2012. All high TB priority countries will finalize and endorse their comprehensive national MDR-TB response plan by the end of 2012. The Regional Office will assist high TB priority countries in updating and finalizing their national MDR-TB response plan by the end of 2012. Member States will ensure external review of their national TB programme/interventions every three to five years, led by the Regional Office and/or the European Centre for Disease Prevention and Control (ECDC) and including partners and civil society organizations, for transparent and objective assessment of programmatic gaps. The Regional Office, in coordination with Member States and partners, will formalize twinning of cities and TB and lung disease control programmes across the Region and will facilitate collaboration and coordination among Member States by the end of 2013. Member States will ensure that representatives of patients and/or communities affected by the disease are included in programme planning and assessment of the quality of services by the end of 2012. The Regional Office, in collaboration with other partners, will provide operational guidelines for implementing high-level political statements and will measure progress on a regular basis by the end of 2012. The Regional Office and other partners will improve programme management capacity (in both civilian and prison services) with modern training and coaching on annual basis, particularly on the efficient use of resources. Member States will ensure transparency in programme management, with the selection and recruitment of dynamic and competent staff on a continuous basis. Member States will use the internet or other media to increase public awareness of TB and M/XDR-TB and the availability of treatment from 2011 onwards. The Regional Office will analyse successful models of programme management and draw up recommendations to be included as criteria in the forthcoming "programme certification" exercise by WHO, including ISO 9001-certified project management standards, by the end of 2012. Member States will engage TB provider networks and/or programmes in health system reform initiatives.

Human resources development

34. High TB priority Member States will develop and/or integrate strategic plans for human resources development (HRD) for the implementation of Stop TB strategies and national MDR-TB response plans by the end of 2013. High TB priority Member States will revise and/or develop job descriptions, conduct workload assessment and determine the staff needs, supervision and monitoring necessary for M/XDR-TB prevention, control and care by the end of 2012. Member States will develop or update competency-based training programmes for all aspects of management of MDR-TB. The Regional Office in collaboration with other partners will strengthen and enable regional centres of excellence and knowledge hubs for M/XDR-TB prevention and control by the end of 2012. The Regional Office and partners will provide technical assistance in improving human resources for health. The Regional Office will adapt, translate and distribute training modules on "Management of drug-resistant tuberculosis" for MDR-TB referral centre staff by the end of 2011. The Regional Office will ensure that a virtual TB library and training materials in Russian are available and updated from 2012 onwards.

Policy guidance

35. Member States will ensure that they have adopted/adapted the latest available evidence in their national TB control policies by the end of 2012. The Regional Office in collaboration with partners will assist Member States in adopting/adapting international TB policies by the end of 2013. The Regional Office will provide technical assistance to Member States to improve health financing, governance, stewardship and rational use of resources for TB control by the end of 2013.

Partnership and coordination

36. High TB priority Member States will establish national Stop TB partnerships or similar mechanisms to ensure proper coordination of and concerted action by all stakeholders, including civil society organizations (CSOs), patients' associations, charities and other sectors, by the end of 2013. The Regional Office and partners will provide technical assistance to Member States to establish and strengthen their national Stop TB partnerships by the end of 2013. Member States will ensure that sound collaborative mechanisms are in place for improved diagnosis and treatment of TB and M/XDR-TB patients in prison services, refugee camps or other relevant settings, and that there is a continuum of care within health services, by the end of 2013. The Regional Office will establish a regional mechanism for coordination and collaboration among national and international partners by the end of 2012. The Regional Office and Member States will promote partnerships in research and development of new diagnostic tools, medicines and vaccines against TB on a regular basis.

Advocacy, communication, social mobilization and civil society involvement

37. High MDR-TB burden countries will conduct knowledge, attitude and practice (KAP) surveys (countrywide or focused on specific population groups) on TB and M/XDR-TB, to determine behaviour change objectives, target groups and needs for interventions related to advocacy, communication and social mobilization (ACSM) by the end of 2013. High TB priority countries will develop ACSM strategies and incorporate these in their national TB strategic plans by the end of 2013. Member States will conduct training of staff on ACSM by the end of 2013. Member States will identify and bring together, for common planning of ACSM and MDR-TB activities, all CSOs with an interest in TB by the end of 2012. Member States will support the development and engagement of patient advocates for social mobilization and patient health education by the end of 2013. The Regional Office and partners will facilitate the development of ACSM technical materials appropriate to the Region and available in at least Russian and English by the end of 2013. Following KAP surveys, Member States will develop appropriate TB health education campaigns by the end of 2013. Member States will support and link into national programmes both national and local CSOs, as well as local community traditional networks (where they exist), by the end of 2013. Member States will engage other sectors and CSOs in planning, decision-making, implementation and monitoring and evaluation processes, and work on the social determinants that increase vulnerability to TB. The Regional Office and partners will advocate for further involvement of European research institutes to develop new diagnostic tools, medicines, vaccines and embark on basic research on TB and M/XDR-TB on a continuous basis.

Ethics and human rights

38. The Regional Office will provide guidance to Member States in revising the frameworks for ethics and human rights in the context of TB and other infectious diseases by the end of

2012. Member States, the Regional Office and partners will include ethics and human rights in the curricula of TB/MDR-TB training for all health staff by the end of 2014. The Regional Office in collaboration with partners will develop indicators for patient-centred care by the end of 2012. Member States will establish palliative care for M/XDR-TB patients who fail treatment by the end of 2012. Member States will involve CSOs in performing client satisfaction assessments within TB services by the end of 2013. The Regional Office will issue guidance for Member States to develop their frameworks for compassionate use of medicines by the end of 2012. The Regional Office in collaboration with partners will organize a regional conference on patient-centred care and human rights in TB and HIV by the end of 2013.

Address the needs of special populations

Improve collaborative TB/HIV activities

39. All Member States, with technical assistance from the Regional Office and other partners, will establish a functional coordinating mechanism and joint strategic approaches to facilitate the delivery of integrated TB/HIV (and drug dependence) services, including in prisons, by the end of 2013. The Regional Office will document best practices and experiences in effective integration and service delivery models for TB/HIV/drug dependence services by the end of 2012. Member States will ensure that HIV services incorporate intensified TB case-finding, infection control and isoniazid prevention by 2013. Member States will ensure that TB services incorporate HIV testing and counselling, co-trimoxazole preventive therapy and antiretroviral therapy by 2013.

Strengthen MDR-TB control in prisons

40. Member States will ensure that early diagnosis and effective treatment of M/XDR-TB will be available in penitentiary services by the first quarter of 2013. The Regional Office, using the successful model of its Health in Prison Project, will assist Member States in improving TB control in penitentiary services on a continuous basis. Member States will ensure continuity of TB care for released prisoners in civilian services by the end of 2012.

Improve access for hard-to-reach and vulnerable populations

41. Member States will improve access to TB prevention, control and care for hard-to-reach and vulnerable populations, especially migrants and homeless people and those with difficult lifestyles such as alcoholics and injecting drug users, by developing outreach programmes and involving CSOs. All Member States will ensure that TB services incorporate or refer to services that provide interventions for people who use drugs, including drug dependence treatment, by the end of 2013. The Regional Office and Member States will establish a mechanism for cross-border TB control and care by the end of 2013. The Regional Office and Member States will develop a special response for TB prevention and control in children and accelerate in-country adaptation of updated childhood TB guidelines by mid-2012. Member States will include and prioritize childhood TB in their national TB strategic plans or national health plans by the end of 2013.

Endorsement

42. The Consolidated Action Plan to Prevent and Control Multidrug- and Extensively Drug-resistant Tuberculosis in the WHO European Region, 2011–2015 is presented for endorsement

as an annex to a draft resolution on M/XDR-TB that is being submitted for consideration by the Regional Committee at its sixty-first session.

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