WHO European Ministerial Forum: "All against Tuberculosis"

Berlin Declaration
on Tuberculosis

ABSTRACT

The WHO Regional Office for Europe held the WHO European Ministerial Forum on Tuberculosis: "All against Tuberculosis" on 22 October 2007 in Berlin, Germany, to accelerate progress towards achieving the global targets for tuberculosis (TB) control in the WHO European Region and Target 8 of Millennium Development Goal 6, to "have halted and begun to reverse the incidence" of TB by 2015. Over 300 participants attended the Forum, including health ministers, justice ministers and high-level decision-makers from 49 of the 53 Member States in the WHO European Region, along with representatives of other United Nations bodies, intergovernmental agencies and nongovernmental organizations (NGOs). The participants discussed:

- the threat of TB in the Region
- the response in the Region and what needed to be done to fill the gaps in this response
- TB as a public health problem in national health systems
- mechanisms for both controlling or eliminating TB and securing the necessary resources for the task.

They accepted an offer of partnership from over 45 civil-society organizations. Finally, the participants adopted the Berlin Declaration on Tuberculosis to prompt further progress in the fight against TB in the WHO European Region.

Keywords

TUBERCULOSIS – prevention and control
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CONTENTS

Page

Foreword v

Berlin Declaration on Tuberculosis 1

Report on the Forum 5

- Introduction 5
- The threat of TB to the European Region 6
- Response of the European Region 7
- Filling the gaps in response 10
- TB as a public health problem and mechanisms to control or eliminate it: ministers' views 14
- Berlin Declaration on Tuberculosis 18

Annex 1. Sessions and presentations 19

Annex 2. An Offer of Partnership from Civil Society to the Ministers of the European Region 21

Annex 3. Participants 25

Foreword

The resurgence of tuberculosis (TB) has created an emergency in the WHO European Region. TB is found in every country in the Region. No citizen – in Europe or the world – is immune to the disease, and action against it must be intersectoral in order to succeed.

Political solidarity is therefore essential to mobilize all sectors of government and all partners and stakeholders to work together in countries and internationally. Partnerships based on such solidarity can strengthen country health systems to contain TB, ensuring screening in the field, training for service providers (particularly those delivering primary health care) and the provision and observation of treatment. International efforts are also needed to cope with drug-resistant TB strains. In promoting solidarity and supporting countries' work to prevent and control TB, the WHO Regional Office for Europe works with, for example, the European Union, the Global Fund to Fight AIDS, Tuberculosis and Malaria and a range of nongovernmental organizations in the Stop TB Partnership.

At the WHO European Ministerial Forum: "All against Tuberculosis", the Region's countries declared a new solidarity and commitment to scaling up intersectoral action against TB by adopting the Berlin Declaration on Tuberculosis. Will this Declaration make a difference to the more than 445 000 TB patients in the WHO European Region? It will if governments carry out the decisions made in Berlin. And we in WHO are committed to helping with programmes that target areas where we have something substantial to contribute and where we can make a difference. The good news is that many of the challenges discussed in Berlin can be tackled with good political will and commitment. We called this Forum to draw attention to TB problems that health systems in our Member States have to face, so that governments can do something about them.

Marc Danzon
WHO Regional Director for Europe

Berlin Declaration on Tuberculosis

1. We, the Ministers of Member States in the European Region of the World Health Organization (WHO), meeting with the WHO Regional Director for Europe and high-level partners at the WHO European Ministerial Forum on Tuberculosis, held in Berlin on 22 October 2007, **note with concern** that tuberculosis (TB) has re-emerged as an increasing threat to health security in the WHO European Region.

- In 2005, there were 445 000 new cases of TB and 66 000 TB-related deaths in the Region.
- There are high TB incidence rates within the Region.
- Even in countries with a relatively low burden, there has been a reversal of the previous decline.
- Throughout the Region, the presence of TB is often related to social and economic factors and migration.
- Poor adherence to accepted TB control practices has created high levels of man-made multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB).
- No new diagnostics, drugs or vaccines have been developed over the past several decades.
- Many countries in the Region face a shortage of competent and motivated human resources for TB control.
- In the Region, TB is the most prevalent cause of illness and mortality in people living with HIV/AIDS, and few countries address TB/HIV coinfection in a comprehensive manner.
- TB does not respect borders.

2. We **note** that, despite some achievements over the past decade, TB control and efforts towards elimination of the disease in the Region need to be improved.

- The Region has a high proportion of unfavourable treatment outcomes resulting from poor implementation of internationally accepted TB control strategies.
- The use of currently available quality-controlled diagnostics and appropriate evidence-based treatment strategies needs to be further strengthened.
- TB control in groups at high risk such as migrant populations, the homeless, prisoners and other socially vulnerable groups must be addressed.
- Focused action is needed to tackle MDR/XDR-TB and TB/HIV coinfection.
- Prevention, including infection control, is a factor of continued importance in TB control, especially among vulnerable groups.
- Timely collection, transmission, validation and analysis of quality TB surveillance data are essential for proper TB control and elimination interventions.

3. We **recognize** that:

- many countries have national plans for TB control;
- a plan has been adopted to stop TB in the high-priority countries of the WHO European Region over the period 2007–2015 and a European Union action plan on TB is currently being developed;
- Member States in the WHO European Region can contribute considerably in skills and finance to the development of new tools for TB diagnosis, treatment and vaccination;
- national and international funding and support for TB activities in the European Region have grown;
- the previous United Nations Secretary-General appointed Dr Jorge Sampaio, former President of Portugal, as his Special Envoy to Stop TB;
- the Stop TB Partnership for Europe and central Asia has been launched with substantial support from the Stop TB Partnership.

4. We **note with concern** the gaps to be bridged in order to fully implement the Stop TB Strategy for effective TB control and **agree** on the following priorities:

- universal access to the Stop TB Strategy should be promoted by strengthening the health sector and involving the full spectrum of health care providers, private and public, civilian and penitentiary, all of whom should follow the International Standards for Tuberculosis Care and promote the Patients' Charter;
- civil society and affected communities should be considered as essential partners in and integrated into TB control;
- the shortfall in funds, as identified in the Global Plan to Stop TB 2006–2015, should be met through increased, properly prioritized, sustained and targeted local, national and international funding;
- TB control should be given high priority within national development plans presented for external financing;
- better use should be made of currently available effective tools, and new diagnostics, drugs and vaccines should be developed through basic research and product development, including by public-private partnerships, private industry and national research institutes;
- TB should be integrated into HIV treatment and care programmes, as the two diseases together represent a deadly combination that is more destructive than either disease alone;
- special efforts should be made to ensure that highly vulnerable documented and undocumented migrant and other populations have access to adequate culture-sensitive services providing quality care for TB;
- greater partnership and coordination across the health, penitentiary and social services sectors should be promoted, as well as intercountry collaboration.

5. We therefore **commit ourselves** to responding urgently to the current situation.

(i) We will **strengthen**:

- political will;
- the public health and social services systems;
- commitment from the full range of care providers;
- human resource capacity that is adequate in both quality and quantity for effective TB care;
- the evidence base for TB policy and practices through enhanced TB surveillance and monitoring;
- collaboration between TB and HIV programmes;
- collaboration with the private sector;
- coordination at national and international levels;
- civil society involvement.

(ii) We will **adopt** the Stop TB Strategy in all its components, thereby:

- ensuring the expansion and enhancement of high-quality implementation of the directly observed treatment, short course (DOTS) approach;
- addressing MDR-TB, XDR-TB, HIV-related TB and other challenges, particularly in high-risk populations;
- integrating TB care delivery with general health services and reinforcing activities aimed at strengthening health systems;
- securing commitment from all care providers;
- empowering people with TB and their communities, and removing stigma;
- allowing and promoting research into and the development of new diagnostics, drugs and vaccines, as well as programme-based operational research.

(iii) We will **endeavour** to secure sustainable financing by:

- implementing the resolutions on TB prevention and control adopted by the World Health Assembly in 2005 and 2007;[1]
- in collaboration with the G8 countries, supporting the Global Plan to Stop TB 2006–2015;
- attracting funding from appropriate multilateral mechanisms at the global and European levels, such as the Global Fund to fight AIDS, Tuberculosis and Malaria, UNITAID, the Bill and Melinda Gates Foundation, and other intergovernmental and philanthropic organizations, as well as bilateral mechanisms.

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[1] World Health Assembly resolutions WHA58.14 on sustainable financing for tuberculosis prevention and control and WHA60.19 on tuberculosis control: progress and long-term planning.

(iv) We will **channel** such financing towards:

- ensuring the implementation of regional and national plans to stop TB, including the WHO plan to stop TB in the high-priority countries of the WHO European Region;
- addressing the funding gap between the total resources available and the resources needed to control TB, as well as accelerating the development of new diagnostics, drugs and vaccines, with the aim of achieving the 2015 target related to TB within the Millennium Development goals.

6. We **commit** ourselves to closely monitoring and evaluating the implementation of the actions outlined in this Declaration, and call upon the WHO Regional Office for Europe, in partnership with the European Union and other relevant regional institutions and organizations, to establish adequate fora and mechanisms, involving civil society, communities and the private sector, among others, to assess progress at regional level every second year, starting in 2009.

Report on the Forum

Introduction

The WHO Regional Office for Europe held the WHO European Ministerial Forum on Tuberculosis: "All against Tuberculosis" on 22 October 2007 in Berlin, Germany, to accelerate progress towards achieving the global targets for tuberculosis (TB) control in the WHO European Region and Target 8 of Millennium Development Goal (MDG) 6, to "have halted and begun to reverse the incidence" of TB by 2015. The Forum's objectives were:

- to strengthen political commitment to implementing the WHO Stop TB Strategy throughout the Region and to include TB control in the strengthening of health systems;
- to obtain commitment from all Member States to ensure full and appropriate financing of TB control, in line with World Health Assembly resolution WHA 58.14 on sustainable financing for tuberculosis prevention and control;
- to adopt the Berlin Declaration on Tuberculosis; and
- to endorse the European Stop TB Partnership.

Over 300 participants attended the Forum, including health ministers, justice ministers and high-level decision-makers from 49 of the 53 Member States in the WHO European Region, along with representatives of United Nations bodies, intergovernmental agencies and nongovernmental organizations (NGOs). In addition, the Open Society Institute organized a civil-society meeting on 21 October, which brought together representatives of communities particularly affected by TB and health professionals that worked with them. The meeting focused on mobilizing a broad network of NGOs to accelerate progress, strengthen advocacy and increase funding against TB in Europe. The participants prepared an offer of partnership that was presented to the participants in the WHO European Ministerial Forum. Annex 1 lists the sessions and presenters at the Forum; Annex 2 gives the Offer of Partnership and Annex 3 lists the Forum participants.

In the keynote address, Dr Jorge Sampaio, the United Nations Secretary-General's Special Envoy to Stop TB and former President of Portugal, urged European health ministers to use their political clout to address the TB challenge in the European Region, despite the pressure to reduce expenditure on public health. The HIV/AIDS, TB and malaria pandemics posed a threat to global health and security, and the European Commission (EC), the European Centre for Disease Prevention and Control (ECDC) and the WHO Regional Office for Europe had identified TB as a serious threat to public health in the Region. Research was urgently needed to find new diagnostic methods and drugs for TB. The emerging challenges of HIV-associated TB and MDR- and XDR-TB had created the need for joint initiatives, integrated services, supportive health systems and effective programmes. The health gaps between rich and poor populations and countries must be bridged for security, efficiency, political and ethical reasons.

Improved coordination in the fight against AIDS and TB was a key to improving health worldwide, and strengthening health systems worldwide was a key to achieving the MDGs. Controlling TB required strong political leadership, appropriate financial resources, new partnerships and a strategy of both thinking globally and acting locally. Investing in TB control could be a pilot case in developing new and better capabilities to address priorities in health security.

Throughout their discussions, the participants kept in mind the toll exacted by TB, noting that 420 people in the Region became sick, 66 people died and 280 were cured during the Forum.

The threat of TB to the European Region

Too many people became ill and died from TB, a curable disease. Worldwide, there were 8.8 million new cases and 1.6 million deaths from TB in 2005.

In the WHO European Region, the western countries were still far from eliminating the disease and the situation in eastern countries was close to tragedy. In 2005, there were 445 000 new cases and 66 000 deaths, or 7 deaths per hour. Incidence showed a clear east–west gradient: while the average for the Region was 50 cases per 100 000 population; figures for groups of countries ranged from 13 cases per 100 000 for the 15 countries belonging to the European Union (EU) before 2004 to 25 per 100 000 for countries joining the EU in 2004, to 51 in Bulgaria, Croatia, Romania, The former Yugoslav Republic of Macedonia and Turkey and to 103 in other countries bordering the EU. Incidence in the Region's 18 high-priority countries for TB control (Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, Romania, the Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan) was comparable to rates in the developing world. Further, both high and low rates in the Region were stagnating.

Even though 85% of TB cases were found in the eastern part of the Region, TB posed challenges to all countries. The reasons why included poor TB control programmes, poor response to MDR- and XDR-TB (linked to poor case management and weak laboratory structures), HIV/AIDS coinfection, lack of integration of TB control programmes in national health systems and primary health care, and insufficient involvement of civil society.

The Region was striving to reach ambitious goals. In addition to the MDG target, the goals of the Stop TB Partnership were to reduce TB prevalence and death by 50% from 1990 levels by 2015 and to eliminate TB (reaching a rate of less than 1 case per million population) by 2050. Unfortunately, the European Region (as well as the African Region) was not on track to achieve the MDG target, and faced a number of impediments. First was drug-resistant TB; the Region's 18 high-priority countries included the 13 with the world's highest rates of MDR-TB. Second, migration – a health issue taken up by the Portuguese EU Presidency – ensured the circulation of cases in the Region and globally; this meant that TB control must be global to succeed. Third, the increases in TB prevalence and deaths since 1990 made it harder to reach the goals of halving the 1990 levels by 2015.

In addition, to illness and death, TB and the stigma connected with it caused much suffering. Thus, the affected individuals and communities were important stakeholders in TB control efforts.

Experience of countries

Experience in countries illustrated some of the problems and responses in the Region. In the Republic of Moldova, for example, economic problems had reduced the health budget to US$ 10 per person, so the TB situation had worsened. Morbidity and mortality had doubled and vulnerable groups were at higher risk. In 1997–2000, 30% of TB patients had received medication, so the number of chronic and drug-resistant cases had risen, as had incidence in prisons. In addition, TB/HIV coinfections rose steeply between 1998 and 2006.

Cooperation between the Government and international and bilateral organizations had improved the situation since 2001. Thanks to donor assistance, there were early diagnosis and treatment for over 65% of new cases. Treatment meeting international standards was now available. Since 2004, compulsory health insurance had given the population access to early detection and treatment. Government and donor investment in treatment had increased, and people with drug-resistant TB were being treated. Training for medical students had been improved and a public information campaign on TB had been launched in 2005. A new treatment programme began in 2006. In the first nine months of 2007, TB morbidity had fallen by over 9%; ensuring treatment for all categories of TB patients remained important. Cooperation was achieving good results; donor assistance remained essential. Now that priorities had been established, the Republic of Moldova had new opportunities to tackle TB and work towards the MDG target.

In Kyrgyzstan, the fight against TB was a priority; assistance from international organizations had enabled the country to apply DOTS and improve training for doctors, drug supplies and quality control in laboratories. The Government had issued clear directives on TB; the ministries of health, justice, finance and defence were working together to ensure a coordinated approach to TB interventions, and TB services were delivered through primary health care. TB drugs were now given to 100% of new cases.

Nevertheless, the situation remained serious. Since 1994, TB had increased in all population groups: a twelvefold increase in morbidity. There were 110.9 cases per 100 000 population; 59% of patients were in serious condition, often connected with late diagnosis and drug resistance. While mortality had fallen, chronic cases comprised 84% of the dead. MDR-TB patients comprised 19.1% of the total. Information in the population was low. Resources were scarce: funds for drugs and early detection were insufficient; more new X-ray units were needed and trained personnel tended to migrate to other countries. Kyrgyzstan gave priority to preventing the spread of MDR-TB, and continued to coordinate its work with international organizations.

Response of the European Region

WHO was pursuing the Stop TB Strategy[2] and the Global Plan to Stop TB 2006–2015[3] to achieve the MDGs. The Strategy had six components:

1. pursuing high-quality DOTS expansion and enhancement
2. addressing TB/HIV, MDR-TB and other challenges
3. helping to strengthen health systems
4. engaging all care providers
5. empowering people with TB and communities
6. enabling and promoting research.

The aim was to treat 50 million patients, save 14 million lives and develop new tools to enable TB elimination worldwide. More resources – US$ 15 billion – were needed for TB control and elimination in the European Region, to accomplish six essential tasks:

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[2] The Stop TB Strategy [web site]. Geneva, World Health Organization, 2007 (http://www.who.int/tb/strategy/stop_tb_strategy/en/index.html, accessed 28 October 2007).
[3] The Global Plan to Stop TB 2006–2015[web site]. Geneva, World Health Organization, 2007 (http://www.who.int/tb/features_archive/global_plan_to_stop_tb/en/index.html, accessed 28 October 2007).

1. eliminating poor TB care and control practices, and strengthening health services
2. pursuing cross-European collaboration on such tasks as surveillance
3. ensuring care for migrant populations
4. addressing the determinants of TB
5. supporting TB control globally
6. intensifying research for new tools.

The Region faced important challenges to TB control. The first was poor access to services; only 60% of the population was covered by DOTS in 2005. Problems with the health system infrastructure included overly hierarchical, segmented institutions and poor standards of care. Drug resistance, HIV coinfection and overcrowded, poorly equipped prisons (breeding grounds for TB and other diseases) also hindered TB control. In addition, awareness of TB was low, and distorted by stigma and prejudices among people and policy-makers.

Nevertheless, the Region also had opportunities for TB control. These included the commitment of the WHO Regional Committee for Europe[4] and the WHO Regional Office for Europe to tackling the problem, The Plan to Stop TB in the 18 High-priority Countries in the WHO European Region, 2007–2015,[5] health-system reforms in many central and eastern European countries, support from the Stop TB Partnership and the creation of the European Stop TB Partnership, and the availability of global resources from such sources the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Plan to Stop TB in the 18 High-priority Countries outlined cost-effective interventions of public health impact to be sustained in collaboration with the general health system, and strengthening health systems was one of its main components. It had ambitious objectives for 2010:

- expanding DOTS population coverage to 100%
- increasing the rate of case detection to 70%
- increasing the rate of cure of drug-susceptible TB cases to 85%
- expanding laboratory capacity for anti-TB-drug-susceptibility testing to 90%
- increasing the rate of treatment of MDR-TB cases to 70%
- ensuring HIV counselling and testing for 100% of patients
- ensuring proper TB care at the primary health care level for 70% of patients.

Achieving all these objectives required sharp increases from current rates. Sustainable financing was needed at the national level. Only 45% of the US$ 14.8 billion needed for the Plan was estimated to be available. Governments needed to increase allocation from only US$ 1 to US$ 3.1 per person, or from 0.1% to 0.3% of their annual expenditure per capita for health to fill in the financial gap. The WHO Regional Office for Europe was tackling these issues in connection with the conference on strengthening health systems planned for 2008: linking work to improve

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[4] *WHO Regional Committee for Europe resolution EUR/RC52/R8 on scaling up the response to tuberculosis in the European Region of WHO*. Copenhagen, WHO Regional Office for Europe, 2002 (http://www.euro.who.int/Governance/resolutions/2002/20021231_5, accessed 28 October 2007)
[5] *Plan to Stop TB in 18 High-priority Countries in the WHO European Region, 2007–2015*. Copenhagen, WHO Regional Office for Europe (in press).

the effectiveness of health systems with that to reduce poverty and social exclusion was hoped to reduce illness and death from TB.

In the EU, current challenges in TB control had prompted the European Commissioner for Health to ask ECDC to propose a TB action plan to be launched by the EC. These challenges included:

- the heterogeneity of TB incidence in the EU (ranging from 4 to 135 cases per 100 000 population, although the average was 18 per 100 000), which meant that the strategies used needed to be tailored to reflect this diversity;
- the high TB burden in vulnerable groups (prisoners, people living in urban pockets of poverty, immigrants and elderly people) in low-incidence countries, which required intensified action for TB detection and control;
- the proportion of the TB burden originating in the native population (over 80%), even though cases of foreign origin comprised over 40% of the total in 12 EU Member States; and
- the prevalence of MDR-TB throughout the EU and the emergence of XDR-TB.

The action plan being developed therefore addressed two groups of countries: those with low and moderate incidence, and those with high incidence. The EU must collaborate with the countries from which the TB cases originate, and take part in global collaboration.

The plan's long-term goal was to control and ultimately eliminate TB in the EU. It had three aims:

- to increase political and public awareness of TB as a public health issue in the EU;
- to support and strengthen Member States' efforts in line with national epidemiological situations and challenges; and
- to support the countries from which cases originated.

The framework document in the pipeline had eight areas for strategic development:

1. strengthening awareness and health systems' capacity with appropriate resources and trained personnel (public and private) to detect TB and provide appropriate treatment;
2. continuing surveillance to provide useful information for public health action;
3. strengthening laboratory services for detection and control;
4. providing prompt and high-quality care for all, which prevented transmission;
5. addressing MDR- and XDR-TB, providing high-quality care and management to stop their spread;
6. addressing TB/HIV coinfection, as HIV boosted the progression of TB, especially when other factors such as MDR-TB were present;
7. developing new vaccines, drugs and diagnostic methods, a task to which MDR/XDR-TB and TB-HIV added urgency;
8. building collaboration with high-incidence countries outside the EU and partnership with all stakeholders.

WHO was an important partner in the development of the plan. ECDC and the WHO Regional Office for Europe had already agreed to maintain a joint surveillance system for TB and HIV for the whole European Region. A single reporting platform would be used, with common criteria and shared work. This supported the monitoring of progress in TB control. The EU action plan would be in line with the Plan to Stop TB in the 18 High-priority Countries in the WHO European Region (5 of the 18 – Bulgaria, Estonia, Latvia, Lithuania and Romania – were EU Member States) and the Global Plan to Stop TB. The eight areas for strategic development in the EU action plan complemented the strategies and interventions proposed in the WHO European Plan.

The next steps for the EU plan were to present the framework document to EU health ministers in December 2007 and to develop technical action in countries in 2008.

Filling the gaps in response

Other partners and stakeholders were making important contributions to the fight against TB in the WHO European Region, including donor and international organizations, EU research programmes, countries and civil-society organizations. While they focused on a range of issues to maximize the effectiveness of the response to TB, they worked with many partners and called for further cooperation, coordination and innovative thinking. As the tools used to prevent and treat TB were 40–80 years old, many stakeholders sought new ones; much more funds were needed for this task.

For example, the Bill and Melinda Gates Foundation, as part of its work against infectious disease, invested in the development of new TB vaccines. As a result, six would undergo phase II trials in 2008 and one was expected to undergo clinical trials in the next three years. The Global Alliance for TB Drug Development sought new drugs for treatment. The Gates Foundation also invested in the development of new diagnostic methods through a collaborative foundation; this included a donation of US$ 740 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria over the last three years.

EU framework programmes supported multilateral, transnational research projects in the EU to complement Member States' efforts, and they prioritized TB. The sixth framework programme had devoted €61 million to TB research. The seventh framework programme (FP7) had a budget of €6.1 billion for 2007–2013, with the largest share going to cooperative projects with the participation of several Member States. Its main aims were: improving health of European citizens, increasing the competitiveness of European health-related industries and businesses and addressing global health issues, including emerging epidemics. Work under all three of its main pillars – biotechnology, generic tools and medical technologies for human health; translating research for health and optimizing the delivery of health care to European citizens – supported TB research. The first proposals in 2007 included the development of fast tests to diagnose MDR-TB and latent TB infection. FP7's priorities for TB were to have:

- several candidate vaccines in phase I clinical trials or beyond and a second generation of candidates ready for clinical development;
- promising drug compounds ready for clinical development;
- a European network for management of MDR- and XDR-TB established; and
- improved delivery of TB vaccines and drugs to patients in developing countries.

The total funding needed for the Global Plan to Stop TB 2006–2015 was US$ 56 billion, but only 40–50% had been secured. Countries provided over half of the funds for implementation; the rest came from multilateral organizations (such as the Global Fund, the World Bank, UNITAID and WHO) and bilateral organizations (such as country agencies for development in the Canada, Italy, the Netherlands, the United Kingdom and the United States of America). From 2002 to 2007, the Global Fund had disbursed US$ 7.7 billion, 16% of which had been devoted to TB; this figure reflected countries' requests.

As of September 2007, US$ 111 million had been disbursed in the European Region, and grants had been approved for Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, the Republic of Moldova, Romania, the Russian Federation, Serbia (and the United Nations Administered Province of Kosovo), Tajikistan, The former Yugoslav Republic of Macedonia and Uzbekistan. Most TB grants performed better than those for AIDS and malaria; procurement systems were robust. Programmes supported by the Global Fund reported a 140% increase of DOTS from mid-2005 to mid-2006. TB programmes needed to be expanded; challenges in funding this expansion included:

1. increasing resources
2. making a strategy for and maintaining advocacy
3. building demand for more ambitious grants to implement the Global Plan
4. integrating civil society in effective partnerships at all stages
5. ensuring capacity (technical assistance)
6. harmonizing and aligning grants
7. ensuring the eligibility of middle-income countries for funding from the Global Fund
8. ensuring the sustainability of funding from donors and countries.

The International Federation of Red Cross and Red Crescent Societies (IFRC) had established a global agenda to support the achievement of the MDGs. Pursuing the agenda's four goals – to reduce the impact of disasters, to reduce the impact of diseases and public health emergencies, to increase the ability of communities, civil society and IFRC to address the most urgent situations of vulnerability, and to promote respect for diversity and human dignity and reduce intolerance, discrimination and social exclusion – included reducing the suffering caused by TB. Member national societies could make important contributions in prevention, case finding and social care, for example, to increase successful treatment; these societies gave care and support beyond the clinic door. The fight against TB needed to be inclusive, involving patients and the community; to accelerate TB control, the focus needed to be shifted to the community and all partners needed to be involved in decision-making and planning.

IFRC was committed to fight TB and pursue the MDGs, with partnership as a key strategy. IFRC had hosted the secretariat of the Stop TB Partnership since 2006, to promote a collective response to the serious threat of TB; in 2008, the WHO Regional Office for Europe would become the Partnership's host.

Countries were the most important partners. The Russian Federation, for example, was taking urgent measures and devoting additional resources to combat TB. Although rates remained high, the situation in the country had stabilized; 80 000 lives had been saved and TB among prisoners

had declined steeply, owing to a return to the preventive approach. Case finding had been improved after an investment of Rub 4 billion. In 2006, 117 646 cases of TB were detected, along with 12 948 TB/HIV coinfections and 4056 cases of primary MDR-TB. The state provided drugs to treat those with coinfections. A national system of TB monitoring had been put in place, working at the federal, district and regional levels. Under regional and federal programmes, the state provided treatment equipment and trained personnel. Unfortunately, the number of TB specialists had declined, but the state was trying to train more. The TB subprogramme for 2007–2011 had a total budget of US$ 1.06 million; 62.8% would be part of the regional budgets, and 79.6% would be spent on drugs. Several billion dollars per year, however, would be available in a national priority health project to strengthen the health system between 2006 and 2010. In 2006 and 2007, more diagnostic equipment was installed in health facilities: over 4000 units of ultrasound equipment, over 3000 X-ray machines and nearly 300 units of laboratory equipment.

In 2005, the Russian Federation doubled its contribution to the Global Fund (US$ 40 million). By 2010, it would have returned about US$ 270 million to the Global Fund. The country was pursuing the commitments made through the G8: to stop TB, to maintain support for the Global Plan to Stop TB 2006–2015 and to work for improved coordination of actions to control HIV/TB coinfection. The Russian Federation's long-term objectives to improve TB care were:

1. to develop a national TB control strategy
2. to improve the TB monitoring system
3. to build human resource capacity
4. to upgrade the laboratory infrastructure and equipment
5. to improve TB treatment outcomes and MDR-TB prevention
6. to continue the implementation of highly effective TB control projects and programmes supported by the World Bank and the Global Fund.

The Government of Germany had adopted national targets and was committed to pursuing the international targets for TB. It would devote €500 million to fight the disease in 2008 and pledged €4 billion to the period to 2015. In addition to celebrating World TB Day in March 2007, Germany had hosted the Global Fund's donor meeting in September. The country also funded many activities in developing countries in Africa, Asia and the Caucasus. It strongly supported an integrated approach and bilateral support to countries in strengthening their health systems and improving the detection of and response to TB.

In addition, Tajikistan had expanded its TB services and programmes in implementing a grant from the Global Fund.

As TB in societies' vulnerable groups was a problem throughout the WHO European Region, civil-society organizations had much to offer to the fight against the disease. Such organizations had special experience and links with vulnerable and marginalized groups (such as Roma communities) and were committed to the partnership approach. They could help government reach vulnerable groups and help design innovative programmes; governments could provide additional resources and support for effective civil-society programmes. Civil-society organizations agreed with other stakeholders that much more money was needed for research, control of drug-resistant TB, psychosocial support for patients and the combating of stigma.

Over 45 civil-society organizations had joined to make an Offer of Partnership from Civil Society to the Ministers of the European Region (Annex 2), and the Forum participants accepted it.

Take-home messages

Discussion at the Forum pointed to three strong messages for the WHO European Region.

1. TB is a Region-wide threat. While almost 80% of total cases come from the eastern part of the Region, some western countries with relatively low TB morbidity have seen a reversal of the previous decline. The Region shows several worrying patterns: the world's highest levels of MDR- and XDR-TB, TB as the most prevalent cause of illness and mortality in people living with HIV/AIDS, the danger of disease associated with migration within and between countries, the lack of new diagnostic methods, drugs or vaccines, shortages of human resources for TB control in most countries of the Region and the lack of integration of TB interventions in national health systems. Appropriate measures, tailored to countries' needs and circumstances, are needed to tackle this Region-wide problem.
2. Governments should ensure that they properly address the TB problem. Whether trying to control or to eliminate TB, countries have many useful tools at their disposal, including the worldwide Stop TB Strategy with clear components and guidance, the Plan and strategic recommendations for the Region developed by the WHO Regional Office for Europe, the forthcoming action plan being developed by ECDCand national plans to control TB that follow international recommendations. Countries could also do much, however, to fill significant gaps in the Region's response to TB by such means as:
    - ensuring universal access to the Stop TB Strategy by strengthening the health sector and involving the full spectrum of health care providers, private and public, civilian and penitentiary;
    - ensuring that all vulnerable populations have access to adequate services providing high-quality care for TB and that TB is integrated into HIV treatment and care programmes;
    - developing new diagnostic methods, drugs and vaccines through basic research and product development by, for example, public–private partnerships, private industry and national research institutes;
    - making civil society and affected communities essential partners in all aspects of TB control; and
    - ensuring that the shortfall in funds can be met through increased, properly prioritized, sustained and targeted local, national and international funding.
3. Region-wide partnership is needed to control the public health problem of TB. Greater partnership and coordination across different sectors in countries – health, penitentiary, social services, etc. – should be promoted and supported, as well as more intercountry and regional collaboration. This partnership should embrace not only the governments of Member States but also technical partners and agencies such as WHO, the EU, the Global Fund, the Bill and Melinda Gates Foundation, and other donor agencies and countries.

TB as a public health problem and mechanisms to control or eliminate it: ministers' views

Health ministers, a justice minister and other high-level officials in European countries formed two panels to discuss the public health problem of TB in their national health systems and mechanisms for both controlling or eliminating it and securing the necessary resources for the task.

Public health problem

The impact of TB and health systems' responses varied with incidence and resources in countries. In Bulgaria, for example, incidence had doubled between 1990 and 1998, reaching 49.9 cases per 100 000 population, although it had fallen to 39 cases per 100 000 in 2006. In response, the country started to implement DOTS in 2003, and set national targets based on the MDGs: to reduce TB incidence to 20 cases per 100 000 population by 2015, to increase the rate of successful treatment to 77% and to ensure high-quality implementation of DOTS. The fifth national programme on TB (2007–2011) included an action plan, based on DOTS and the Global Plan, to reduce the burden of TB. The Ministry of Health allocated substantial funds for the tasks, but there were gaps filled by external donors. For the next five years, the country and the Global Fund would devote €27 million and €14 million, respectively, to fight TB in five areas:

- data collection, surveillance, diagnosis and treatment
- developing a laboratory network
- giving doctors additional training in TB, including MDR-TB
- establishing a network of TB centres
- working with vulnerable groups.

It was important for Bulgaria to fight TB in cooperation with international organizations and to plan specific local action with civil society.

Kyrgyzstan had not only a high TB incidence but also a particular problem with TB in prisons: over a third of the population of 12 000 prisoners had the disease. This was a danger to the health of both prisoners and the general population. To deal with this and reach international standards for prisons, the country had adopted a plan for penitentiary reform until 2015. The old-fashioned prisons crowded inmates together, which encouraged the spread of disease. Kyrgyzstan had asked international organizations for help in reforming its prison system, and particularly in reducing the concentration of inmates. IFRC had analysed and evaluated the situation; with help from the Global Fund, Médecins Sans Frontières and other organizations, Kyrgyzstan had taken the first steps towards reform through a package of action including: reducing the number of prison sentences, sharing its problems with partners and working to improve nutrition in prisons to benefit sick prisoners (which Germany had supported with €300 000). In addition, agreements had been signed to improve social support for convicts, with the help of the Ministry of Health, and to prevent the further spread of disease after prisoners were released. The country welcomed cooperation in tackling some other problems, such as improving TB diagnosis and treatment services to reach international standards.

In Ukraine, TB was a major problem. The epidemic started in 1995; morbidity had tripled in the last 15 years and HIV/TB coinfection was a serious problem. The country had adopted DOTS in 2005 and a TB strategy in 2007, fighting TB as a threat to security. To tackle the problem,

Ukraine was devoting resources to improving living standards and TB services; it had worked to improve its laboratories and provide standard treatment, and TB morbidity and mortality had stabilized and slightly decreased. The new national programme for 2007–2011 aimed to improve laboratory diagnosis, treatment methods, training for service providers and the information given to the population.

Croatia had intermediate TB incidence (26 cases per 100 000 population, with pulmonary cases comprising 90% of the total), which had consistently fallen over the previous five years. Drug resistance was not a significant problem. The strongest element of Croatia's TB control programme was its laboratory network. The national reference laboratory had been proposed to become a supranational reference laboratory. In 2009, Croatia would host the conference of the International Union Against Tuberculosis and Lung Disease, European Region.

TB incidence in Italy was low: 7.48 cases per 100 000 population. The Ministry of Health had established a committee to update national priorities and guidelines – on such topics as contact tracing, the evidence-based management of HIV coinfection and of TB in migrants from high-incidence countries, and a system to collect information on MDR-TB. A plan was needed for surveillance in each region, to ensure early detection. The plan to Stop TB in Italy included strategic interventions and 10 planned actions to control the disease. Italy needed to work on social determinants to prevent TB; it would fight the diseases of poverty and establish a national centre for this purpose and for migrants' health. The country recognized the value of the Plan to Stop TB in the Region and the forthcoming EU action plan. It would continue to fight TB through international cooperation and work with civil society.

TB incidence had fallen steadily in Malta from 1920 to 1977 (except during the Second World War), but pulmonary TB had recently increased and irregular immigrants were an important vulnerable group. They comprised 0.5% of the population; most came from sub-Saharan African countries with high TB and HIV incidence. Malta had two cases of MDR-TB in 2006. The Government's attack on TB focused on this vulnerable group, using a strategy for containment, early detection, treatment and information for irregular immigrants. On arrival, all irregular immigrants were examined for TB and other infections; DOTS was used with all TB cases, with a 99% treatment success rate in 2002–2005. Malta was applying for EU funds and building a special centre for screening. The Minister of Health, the Elderly and Community Care urged other countries receiving irregular immigrants to tackle the issue so that it could be settled.

While TB incidence in the United Kingdom was low in public health terms, it had increased by 11% in 2005. In addition to a 2004 action plan, the United Kingdom had held a large meeting of stakeholders in 2005. As health care in the country had become more decentralized, a TB toolkit was published for service commissioners in 2007. The priorities for the fight against TB were early diagnosis, rapid treatment and follow-up.

Mechanisms for controlling or eliminating TB and ensuring sufficient resources

Countries with high or intermediate incidence focused on TB control; the others looked towards elimination. Countries worked through projects, programmes or strategies on TB; in general, the resources needed to control the disease included:

- political commitment and leadership in the country
- good diagnosis

- standard treatment and monitoring
- a continuous supply of drugs
- continued monitoring and following of epidemiological trends.

Some countries stressed outreach to vulnerable groups, and the need to integrate TB services into the health care system. Partnerships – with donors, international organizations such as WHO and civil society – were an important tool and source of resources. Important mechanisms to secure the necessary resources included political commitment, which could lead to increased funding from the government, and donors, particularly the Global Fund.

In Belarus, the state programme to fight TB included the use of DOTS, which was adopted in 2005, centralized drug purchasing and outreach to vulnerable groups. TB morbidity had declined by 5% in two years. The Ministry of Health coordinated the work on TB by all medical services and other government ministries and departments. Government funds allocated to the national strategy did not cover all the diagnostic equipment and drugs needed, so the Ministry of Health had secured a grant from the Global Fund to make such purchases. The Ministry supported an integrated and international approach to TB; countries needed to seek new drugs and ways to protect medical staff, and to consider the legal aspects of refusal to complete treatment.

Bosnia and Herzegovina had introduced DOTS in 1995; TB incidence fell to 50 cases per 100 000 population in 2006, and had remained stable with a decreasing trend. Drug-resistant cases and HIV coinfections were low. Family medicine played a crucial role. Experience in the country pointed to a number of conclusions on the fight against TB. For example, the national TB programme should identify bottlenecks and priorities. The health ministry should use information to make a strategy to meet the country's needs; in addition, the government should adopt a programme for human resource development, disease management and community involvement. Planning and training of human resources were critical to enable all planned action to be carried out. As financing was also essential, the health and finance ministries should work together to secure funding and enlarge the public health infrastructure. Partnership was another key factor; for example, public–private partnerships were useful to ensure various types of care, and innovations in diagnosis and care were needed. The role of the community needed more attention, and primary health care teams needed more resources to educate the community. Finally, engaging international partners in action in a country led to better health outcomes.

Serbia aimed to reduce TB incidence to 25 cases per 100 000 population by 2009. It had received US$ 4 million from the Global Fund, in addition to a large allocation from the state budget, for a five-year project to reduce the burden of TB. The Ministry of Health had established a project implementation unit. The country worked to strengthen the provision of care; all personnel (including prison doctors) had been trained in DOTS; laboratory equipment had been renewed and all first-line anti-TB drugs were in use and offered free of charge to patients. The information system had been improved and active case finding was used for vulnerable groups. The priorities were to strengthen DOTS implementation and increase national funding for the fight against TB.

The former Yugoslav Republic of Macedonia was determined to work through increased national and international cooperation to control and then eliminate TB. The country had received most of the funding for its work from the Global Fund since 2002, with great results, and was still implementing a grant. In addition, the treatment of drug-resistant cases had started in 2007. Good mechanisms for cooperation with international partners were the biennial

collaborative agreements negotiated with the WHO Regional Office for Europe, and the South-east Europe Health Network; the Network's members could work together through FP7. Work at the national level focused on the national strategy for TB control, and strengthening the health system, particularly human resources. Other important tasks included strengthening the structure for disease management, ensuring the rational use of funds and fighting stigma in the community. Close cooperation with government and political leadership were needed to get results, and coordination was needed between the efforts of government, professionals, NGOs, patients and others.

France focused on several key mechanisms for success in the struggle against TB.

1. Free care needed to be available to all patients. TB services needed to be properly integrated into health systems, and programmes on TB and AIDS needed to be integrated. Two new challenges were the loss of expertise and demographic disparities in TB. Health care providers needed better training and to work in the community.
2. Policy needed regular updating to adjust to changed circumstances, and a new strategy for early detection and treatment, particularly including support for and close observation of patients.
3. Partnership was important for campaigns and monitoring; patients had an important role. Cooperation on monitoring was needed with the WHO Regional Office for Europe and other partners.
4. At the international level, France supported the Global Fund.

The Netherlands highlighted three issues. First, the interaction of HIV and TB necessitated an integrated approach to tackle them. The draft declaration proposed to the Forum stressed this, and the Netherlands had taken this approach in its control of TB and HIV. Second, civil society was an essential partner in TB control; in the Netherlands, for example, NGOs had assisted in the task for over 100 years. Civil-society organizations were essential for outreach; they facilitated innovation and its acceptance by high-risk groups. Among vulnerable groups, women needed special attention, as trafficking and sexual abuse increased risks to them. Third, governments and donors were collectively responsible for sustaining funding; unfortunately, many donors were pulling out of central and eastern European countries hard hit by TB. The G8 and EU could be challenged to provide more resources.

Poland had a long history of TB control, having reduced the very high incidence after the Second World War to 22 cases per 100 000 population in 2006. MDR-TB was not a significant problem; all cases had been found in non-compliant TB patients. The national programme was established by legislation. Quality assurance of laboratory services was always important. While the country's situation had greatly improved, much remained to be done, particularly in view of immigration. TB incidence in Poland was still twice that in the EU, so control efforts needed to continue. The country was concerned about the re-emergence of the disease, and took part in all WHO initiatives and other international efforts against it.

As TB incidence in Slovenia had been falling for the previous 10 years, reaching 10 cases per 100 000 population, the country was working towards eliminating the disease. Slovenia used both passive and active case finding and public health insurance covered all services. Drug-resistant TB was not a problem in the country. It needed a modern health infrastructure, the introduction of TB control nurses and better monitoring of high-risk groups. Few countries had achieved the WHO goals of a high level of success in case detection and treatment; this required

more consistent implementation of strategies. Among the stakeholders, those at the national level should provide sufficient funds to tackle TB and those at the European and international levels should promote partnership to coordinate action.

Conclusions

1. The question facing the WHO European Region is how to move forward against TB. What to do is well known: ensuring political commitment, integrating TB services into the health system and with primary health care, ensuring funding from national and international sources and making fighting TB a real national priority.
2. The development of new tools to fight TB has stagnated. Much is being done, but more money and more partnership are needed to create new diagnostic methods, vaccines and drugs for treatment.
3. Ways of working need to be re-examined; services need to be integrated and horizontal. In particular, much closer work with activities against AIDS is needed. In addition, TB patients need to be empowered in the same way as HIV/AIDS patients. The struggle needs to move more effectively towards intersectoral work.
4. Partnership is crucial; now is the time to create European mechanisms for monitoring.
5. Communication needs to be more effective in conveying the threat posed by TB, particularly drug-resistant strains, and combating misconceptions and stigma.
6. The Global Fund plays a crucial role, although the possibility that economic indicators might prevent high-burden European countries from getting funding is worrying.
7. Action against drug-resistant TB strains needs to be considerably scaled up, and requires much more funding.

Berlin Declaration on Tuberculosis

The participants adopted the Berlin Declaration on Tuberculosis. Their presence at the Forum was a step forward in the fight against TB in Europe and globally. It was hoped that the Forum would become a wake-up call to take action to control TB in the WHO European Region.

Annex 1

SESSIONS AND PRESENTATIONS

Opening session

Chair: Ms Ulla Schmidt, Federal Minister of Health, Germany

Welcome – Ms Ulla Schmidt, Minister of Health of Germany, and Dr Marc Danzon, WHO Regional Director for Europe

Keynote speech – Mr Jorge Sampaio, United Nations Special Envoy to Stop TB

Tuberculosis: the threat is real!

Co-chairs: Professor Antonio Correia de Campos, Minister of Health, Portugal, and Professor Oktay Shiraliyev, Minister of Health Azerbaijan

Europe and the white plague: far from elimination in the west, but close to disaster in the east – Dr Mario Raviglione, Director, Stop TB Department, World Health Organization

Republic of Moldova: is TB a public health threat? – Dr Ion Ababii, Minister of Health of the Republic of Moldova

"Nothing about us, without us": what this means for TB control – Mr Paul Thorn, Project Director, TB Survival Project (representative of affected communities)

The European Region's response to the TB threat

Co-chairs: Mr Dmytro Volodymyrovych Tabachnyk, Vice Prime Minister of Ukraine, and Professor Aydin, Turkey

How to Stop TB in the 18 high-priority countries in the WHO European Region – Dr Nata Menabde, Deputy Regional Director, WHO Regional Office for Europe

Main action areas on TB in the European Union – Ms Zsuzsana Jakab, Director, European Centre for Disease Prevention and Control

Kyrgyzstan: TB control in the country-specific context – Mr Tuygunaly Abdraimov, Minister of Health, Kyrgyzstan

Filling the gaps

Co-chairs: Mr Erich Stather, State Secretary, Federal Ministry for Economic Cooperation and Development of Germany, and Dr Ranohon F. Abdurahmanova, Minister of Health of Tajikistan

Russian Federation: do we have gaps in TB control? – Ms Galina Makhakova, Director, Department of Health Care Development, Ministry of Health and Social Development, Russian Federation

Current and future tools – Dr Tadataka Yamada, President, Global Health Programme, Bill and Melinda Gates Foundation

Tuberculosis Research in the EU Framework Programmes – Dr Hannu Laang, Directorate-General for Research, European Commission

Financing TB control interventions – Dr Michel Kazatchkine, Executive Director, Global Fund to fight AIDS, Tuberculosis and Malaria

Can we contribute to better TB control: civil society's and communities' perspective – Mr Markku Niskala, Secretary-General, International Federation of Red Cross and Red Crescent Societies

Our offer of partnership: will you accept? – Mrs Zemfira Kondur, Vice-President, Roma Women Fund "Chiricli", Ukraine

Take-home messages – Mr Eugen Nicolaescu, Minister of Health of Romania

Ministerial panel

Panel 1. What is the place and importance of tuberculosis as a public health problem within national health systems?
Chair: Dr David Ross Harper, Director General, Department of Health, United Kingdom

Panel: Dr Valeri Tzekov, Deputy Minister of Health, Bulgaria; Dr Neven Ljubicic, Minister of Health, Croatia; Mr Serafino Zucchelli, Deputy Minister of Health, Italy; Mr Akylbek Japarov, Minister of Justice, Kyrgyzstan; Dr Louis Charles Deguara, Minister of Health, Malta; Dr Yuriy Gaidaev, Minister of Health, Ukraine

Panel 2. What mechanisms are needed to ensure proper resources for TB control/elimination?
Chair: Dr Tomica Milosavljevic, Minister of Health, Serbia

Panel: Dr Vasilli Ivanovich Zharko, Minister of Health, Belarus; Dr Ranko Skrbic, Minister of Health and Social Welfare, Republic of Srpska, Bosnia and Herzegovina; Dr Imer Seljmani, Minister of Health, The former Yugoslav Republic of Macedonia; Mr Paul Bekkers, HIV/AIDS Ambassador, the Netherlands; Dr Jaroslaw Pinkas, Undersecretary of State, Poland; Ms Zofija Mazej Kukovič, Minister of Health, Slovenia

How do we move forward? – Dr Gudjón Magnússon, Director, Division of Health Programmes, WHO Regional Office for Europe

The Berlin Declaration: adoption

Co-chairs: Ms Anna Cataldi, Stop TB Partnership Ambassador; Mrs Sandra Elisabeth Roelofs, First Lady of Georgia, Stop TB Partnership Ambassador

Closing session

Closure of the Forum – Dr Klaus Theo Schröder, State Secretary, Federal Ministry of Health, Germany

Annex 2

AN OFFER OF PARTNERSHIP FROM CIVIL SOCIETY TO THE MINISTERS OF THE EUROPEAN REGION[6]

Our vision of "All against TB" is the creation of a new relationship among TB patients and affected communities, health and welfare service providers, and governments, that is built on genuine partnership.

We note that...

- All countries – whether low or high burden – need to address TB as a serious public health threat. Although tuberculosis (TB) is a preventable and a curable disease, in 2005, 65 700 people in the European Region died from it. TB is a disease of poverty and inequity that thrives when individuals or communities experience discrimination, economic or social exclusion. The burden of TB is greatest among the most marginalized.
- There are trends of increasing co-infection of TB and HIV, a development of concern given the high rates of HIV infections in some parts of Europe and because TB is harder to diagnose and can be more complicated to treat for people who are HIV-positive.
- Weak public health infrastructure, poor TB treatment practices and the challenges of economic transition in some countries have contributed towards levels of multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) in Europe that are among the highest in the world.
- TB treatment and services are not just about providing medicines but involve addressing the emotional and psychological needs of patients, their families and communities.

We recognize that...

- The WHO Regional Office for Europe and other partners are strengthening the capacity of health authorities to respond to TB.
- Governments in the Region are prioritizing TB control efforts and scaling up their interventions.
- National authorities and donors are committing new financial resources to TB control, but more needs to be done to strengthen the capacity of health systems to respond adequately to the complex challenges of TB.
- Civil society – in all its diversity – can play a critical role in efforts to prevent and treat TB if constructive partnerships are developed that address the social and economic conditions that allow TB to flourish.
- Stronger linkages between TB and HIV programmes and organizations (governmental and nongovernmental [NGOs]) at all levels are needed for the effective control and treatment of both diseases.

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[6] Originally published on All against tuberculosis in Europe [web site] (http://www.tbnetwork.eu; accessed 23 October 2007).

- There is an urgent need for shorter and more effective drug regimens with fewer side effects, more accurate and faster diagnostic tools, and effective vaccines against TB in order to reverse the epidemic in Europe and elsewhere.

Effective TB control requires …

- Civil society and patient involvement and engagement at all levels of TB policies and programmes.
- Sustained investment in improving quality standards of service provision and care by implementing best practice such as the International Standards for TB Care.
- Increased and sustainable financial support for basic research and product development for diagnostics, drugs and vaccines for TB.
- Engagement in global efforts to combat TB. International travel and migration mean that failure to control TB in high burden countries results in TB in Europe.
- Addressing the underlying social determinants that fuel the TB epidemic, such as poverty and the isolation and criminalization of marginalized groups.

We offer...

- Our engagement in the efforts to combat TB at personal, community, national and international levels.
- Our commitment to dialogue and partnership building with governments and health providers. Specifically, our commitment to working together with national health authorities in developing multi-faceted approaches to TB control, including continuum of care.
- Our engagement in mobilizing communities to get involved in TB control and to mobilize resources from other sectors, including social services, other ministries, private sector and donors.
- Our experiences of TB, MDR-TB and XDR-TB service delivery, the patient perspective of the disease, and addressing obstacles on the road to recovery.
- Our ability to reach out to and understand the culture and environment of the communities most affected by TB. Our access to these networks and our experience in improving access to TB care for hard-to-reach, marginalized, and isolated individuals and communities.
- Our creativity to develop innovative and inclusive tools to prevent, diagnose and treat TB that are accepted by groups at highest risk.

We seek from governments …

- Political commitment to a new and equitable relationship with civil society organizations that will lead to access and opportunities for meaningful participation in TB programme planning and implementation together with the financial resources to enable such participation.
- Political commitment to the principle of free, accessible, equitable, acceptable, reliable and effective diagnosis and treatment of TB regardless of legal or socioeconomic status.

- Political commitment backed up by concrete measures to address the social determinants of TB including decent housing, legal status for migrants, access to social and health services, integrated social and welfare services.
- Public commitment leading to action to address the psycho-social environment of people affected by TB and specifically to combat stigma and discrimination.
- Political commitment to create country mechanisms to engage all stakeholders and particularly community based organizations in the development or modification of national and local TB response strategies.

This Offer of Partnership was developed through a transparent and collaborative online drafting and review process that was open to all interested civil society organizations and advocates. It was formally presented on 22 October 2007 to the WHO European Ministerial Forum – All against Tuberculosis by Ms Zemfira Kondur, Vice-President of the NGO Roma Women's Fund "Chiricli". The following European-based individuals and organizations contributed to the preparation of the drafting of the document:

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Annex 3

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