World Health Organization

SIXTY-SECOND WORLD HEALTH ASSEMBLY **A62/20 Add.1**
Agenda item 12.15 **19 May 2009**

Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis

Ministerial meeting of countries with a high burden of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis and Beijing "Call for Action" on tuberculosis control and patient care

Report by the Secretariat

1. Health ministers from countries most affected by multidrug-resistant tuberculosis[1] and extensively drug-resistant tuberculosis and others with relevant experience[2] met in Beijing from 1 to 3 April, 2009, at a meeting organized by WHO, the Ministry of Health of China and the Bill & Melinda Gates Foundation. The aims were to build consensus and political commitment globally and in countries with a high burden of multidrug-resistant and extensively drug-resistant tuberculosis, with countries with emerging economies taking the lead; and to stimulate immediate action to expand the prevention and management of those diseases and start developing five-year national strategic plans to control them within national tuberculosis and health-sector plans.

2. The Member States represented at the meeting issued the Beijing "Call for Action" on tuberculosis control and patient care (at Annex).

3. Particularly relevant was the acknowledgement by all the governments represented that full control and care of multidrug-resistant and extensively drug-resistant tuberculosis do not depend solely on the actions of national tuberculosis programmes, but on policies that span the health sector and engage other sectors as well and which require action at the ministerial level.

4. The first such policy is commitment to moving towards universal access to high-quality care that ensures removal of financial barriers. Other necessary elements of ministerial-level policy featured in the Call for Action include:

- redressing the lack of appropriately trained health workers

[1] Armenia, *Azerbaijan*, *Bangladesh*, *Belarus*, *Bulgaria*, *China*, *Democratic Republic of the Congo*, Estonia, *Ethiopia*, Georgia, India, Indonesia, *Kazakhstan*, *Kyrgyzstan*, Latvia, Lithuania, Myanmar, Nigeria, Pakistan, *Philippines*, Republic of Moldova, Russian Federation, *South Africa*, *Tajikistan*, Ukraine, Uzbekistan, *Viet Nam* (the use of italics denotes that the minister or vice/deputy minister was present).

[2] Lesotho, Peru, Thailand (in all cases the minister or vice/deputy minister was present).

- establishing an adequate laboratory network with modern diagnostics for care and surveillance, using technologies that can be extended to other priority conditions

- assuring quality of all anti-tuberculosis medicines, including all first-line and second-line anti-tuberculosis medicines

- ensuring rational use of all anti-tuberculosis medicines, particularly the second-line, last-resort medicines for multidrug-resistant disease, making them available on prescription only and limiting their prescription to accredited providers

- elaborating and implementing policies for airborne infection control in all health-care facilities and high-risk settings.

5. Failure to address these and other policy reforms properly will simply allow multidrug-resistant and extensively drug-resistant tuberculosis to continue to spread.

ACTION BY THE HEALTH ASSEMBLY

6. The Health Assembly is invited to note this report.

ANNEX[1]

THE BEIJING CALL FOR ACTION ON TUBERCULOSIS CONTROL AND PATIENT CARE: TOGETHER ADDRESSING THE GLOBAL M/XDR-TB EPIDEMIC

1. We, Member States of the World Health Organization (WHO) and others represented here today, and especially those affected by M/XDR-TB*, are meeting in Beijing, China, on 1–3 April 2009, to address the alarming threat of M/XDR-TB. While there have been major achievements over the past decade in TB control, we **note with grave concern** that M/XDR-TB poses a threat to global public health security and severely undermines our efforts to implement the Stop TB Strategy and dramatically reduce the global burden of TB.

(a) More than half a million new MDR-TB cases are estimated to emerge annually as a result of inadequate treatment and subsequent transmission. The 37% of incident cases who are not reached globally by the Stop TB Strategy are especially affected. XDR-TB, a sub-set of MDR-TB caused by highly drug-resistant strains, with significantly worse outcomes, is now reported by more than 50 countries. Yet only some 3% of cases of MDR-TB are being treated according to WHO standards. Furthermore, people living with HIV/AIDS are at particular risk of dying if affected by M/XDR-TB.

(b) M/XDR-TB represents a tragedy for patients, their families and communities, compounded by stigma, and by the catastrophic expenditures often required today for effective diagnosis and treatment.

(c) The global threat of M/XDR-TB can be halted if we respond urgently, reconfirming a system-based approach, involving partners across the health system and beyond. If we fail to do so, we are aware our countries will face the prospect of a bigger M/XDR-TB epidemic requiring significantly heavier investment.

2. **We recognize that countries have not yet fully addressed the possible causes of M/XDR-TB:**

Causes related to inadequate treatment: too few trained and motivated health-care providers to offer proper treatment and support for patients; insufficient coordination among ministries involved in provision of care; public and private facilities which do not follow national policies; unregulated sale and use of first and second-line anti-TB medicines; manufacturers not complying with stringent standards applied by drug regulatory authorities and by the WHO Prequalification Programme; insufficient use of fixed-dose combination medicines, or co-blistered drugs in single doses under direct observation; and insufficient attention to advocacy, communication and social mobilization around TB issues.

[1] M/XDR-TB: multidrug-resistant and extensively drug-resistant tuberculosis.

* Armenia, Azerbaijan, Bangladesh, Belarus, Bulgaria, China, Democratic Republic of the Congo, Estonia, Ethiopia, Georgia, India, Indonesia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Myanmar, Nigeria, Pakistan, Philippines, Republic of Moldova, Russian Federation, South Africa, Tajikistan, Ukraine, Uzbekistan, and Viet Nam.

Causes related to transmission: insufficient and late case detection; insufficient infection control in health facilities and other high-risk settings.

Causes related to the underlying social determinants, which influence the risk of drug-resistance. Poverty, poor living conditions, and social vulnerability put people at higher risk of infection, developing active disease, having poor access to quality care and difficulties to adhere to treatment.

3. **We recognize the key barriers to effective management of M/XDR-TB lie throughout the health system and beyond:** not all countries have comprehensive, adequately funded, and M/XDR-TB control policies and plans that respect human rights; access to diagnosis and treatment remains difficult and costly for patients; community-based M/XDR-TB treatment is not sufficiently emphasized; health workers often lack the necessary training and resources to diagnose and treat patients with M/XDR-TB; many national laboratory networks have insufficient capacity and unsafe infrastructure with no access to the new rapid tests to detect M/XDR-TB; people living with HIV/AIDS too often pick up the infection in health facilities, while the diagnosis of M/XDR-TB arrives too late; and other vulnerable groups, such as migrant workers and prisoners, often do not benefit from adequate preventive measures and care.

4. We there **commit ourselves** to accelerate efforts to prevent M/XDR-TB through effective TB care and control, and to scale-up the diagnosis and treatment of M/XDR-TB. This will be done by developing and implementing strategic M/XDR-TB policies and plans that respect human rights, as part of national TB control plans, in line with the Millennium Development Goals relevant to TB control**, the Global Plan to Stop TB, 2006–2015, and overall health system strengthening efforts, and must include the following actions:

(a) Moving urgently towards universal access to diagnosis and treatment of M/XDR-TB by 2015 as part of the transition to universal health coverage[1] and supporting the global target of enrolling 1.6 million M/XDR-TB patients on treatment by 2015, thereby saving lives and protecting communities;

(b) Ensuring the removal of financial barriers to allow all TB patients equitable access to TB care,[2] that their rights are protected, and that they are treated with respect and dignity;

(c) Ensuring a comprehensive framework for management and care of M/XDR-TB is developed, including community-based care, and identifying the groups most vulnerable to, and at risk of, drug-resistant TB and its impact, including people living with HIV, prisoners, mine workers, mobile populations, drug users, alcohol dependents, the poor and other vulnerable groups; and ensuring that services to prevent and treat drug-resistant TB are targeted to their needs;

(d) Ensuring sufficiently trained and motivated staff are available to implement both TB and M/XDR-TB diagnosis, treatment and care, as part of overall health workforce development efforts;

[1] Resolution WHA58.33 on Sustainable health financing, universal coverage and social health insurance.

[2] WHO Stop TB Strategy endorsed by the Health Assembly in resolution WHA60.19 and WHO Expert Committee on Tuberculosis – Ninth Report 1974.

** Millennium Development Goals
Goal 6: Combat HIV/AIDS malaria and other diseases.

(e) Strengthening laboratory systems, through increasing capacity and adequate human resources, and accelerating access to faster and quality-assured diagnostic tests;

(f) Ensuring that all ministries involved in provision of TB care collaborate, and ensure that public and private health-care providers are properly managing TB and M/XDR-TB patients according to national policies, and the primary health-care network is effective in supporting patients;

(g) Ensuring that national airborne infection control policies are developed (as part of general infection prevention and control programmes) and implemented in every health-care facility and other high-risk settings[1] and that there is sufficient TB infection control awareness in the community;

(h) Ensuring a sufficient supply of first- and second-line medicines for TB treatment, which meet WHO prequalification or strict regulatory authority standards, and fixed-dose combination medicines are used within a system that promotes treatment adherence,[2] or that co-blistered medicines in single doses are used under direct observation by a DOT provider;

(i) For achieving the Millennium Development Goals, supporting developing countries to establish manufacturing plants to produce combined preparations of anti-TB medicines to the standards of the WHO Prequalification Programme to ensure adequate drug supply for the prevention and control of M/XDR-TB;

(j) Strengthening mechanisms to ensure that TB medicines are made available on prescription only[3] and that they are prescribed and dispensed by public and accredited private providers;

(k) Strengthening harmonized surveillance, monitoring and evaluation systems to ensure cases of M/XDR-TB are identified and notified to the fullest extent possible;

(l) Identifying and addressing the underlying social determinants of TB and M/XDR-TB. This needs action both within and outside the health system, and should linked to broader national initiatives to ensure “health in all policies”; and

(m) Ensuring effective advocacy, communication, and social mobilization initiatives are an essential component of M/XDR-TB policies and plans.

5. As part of our efforts to promote sustained financing for health in this time of economic crisis, and to protect the most vulnerable, we **further commit** to help mobilize the estimated US$ 2 billion needed over the next two years to adequately finance TB and M/XDR-TB control and care, using all available financing mechanisms and specially the Global Fund and UNITAID, harmonized with national health strategies and budgets. We call upon funding agencies to help implement the necessary actions to stop TB and M/XDR-TB, reflecting the needs of each country.

[1] Resolution WHA60.19 – referring to prompt implementation of infection control precautions.

[2] WHO Stop TB Strategy endorsed by the Health Assembly in resolution WHA60.19.

[3] Resolution WHA51.44 – referring to prohibiting the dispensing of antimicrobials without the prescription of a qualified health-care professional.

6. We **call** for substantially increased investment by Governments and all partners in research and development of new diagnostics, medicines and vaccines to prevent and manage TB and M/XDR-TB. This requires coordinated action at the global level.

7. We **urge WHO**, together with technical agencies in the Stop TB Partnership, to:

- provide technical support for the development and implementation of M/XDR-TB response plans;
- assist national regulatory agencies in adopting international standards and enabling pharmaceutical manufacturers to produce products of sufficiently high quality to be sold in international markets;
- systematically evaluate newer and faster diagnostic technology and made the results widely available;
- strengthen the Green Light Committee mechanism to help expand access to concessionally-priced and quality assured second-line medicines; and
- monitor and evaluate the implementation of the measures outlined in this Call for Action by governments, civil society, communities and the private sector, among others.

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