We, the participants of the International Conference on Integrated Tuberculosis Control,

Acknowledging that

1. Notwithstanding the significant progress achieved by the Central Asian countries in reducing tuberculosis morbidity and mortality rates among the population of this region, challenges remain and there are certain factors hampering the scale-up of prevention and treatment of tuberculosis, including M/XDR-TB.
2. Recognizing the importance of having strong health systems in the region, there is a clear need for an integrated approach with introduction of reforms in the system of provision of TB care is required for effective tuberculosis control and to achieve sustainable impact;

Being mindful that

To achieve goals and objectives of the WHO “End TB” Strategy and the Tuberculosis Action Plan for WHO European Region 2016-2020 in line with the Global Plan to END TB 2016-2020, it is necessary to eliminate structural limitations in the area of TB control, including constraints in implementation of the patient-centered approach and application of rapid TB diagnostic methods, with new drugs for the treatment of DR-TB and shorter M/XDR-TB treatment regimens;

Also noting

The need to further improve intersectoral and interagency interaction, expanded engagement of civil society resources to provide social assistance to patients undergoing outpatient treatment, and proper infection control in medical facilities;

And being convinced that

Implementation of the “End TB” Strategy and a comprehensive integrated TB control combined with enhancement of the healthcare systems are the key tools in the current situation;

adopt the following Resolution:
1. To improve treatment outcomes through implementation of integrated TB models of care favoring more ambulatory-based care and a patient-centered approach at all levels of medical care with engagement of civil society and addressing social determinants to support patients’ adherence to treatment.

   • Include in the national documents (appendixes to the Order on TB Control in the Central Asian countries) recommendations on outpatient treatment of TB patients with description of outpatient care models and criteria (adherent to current WHO recommendations and international standards of care) for patient selection into these models
   • Amend the existing regulatory framework on epidemiological surveillance based on the adopted outpatient care models and patient selection criteria
   • National tuberculosis control programs shall scale up the best civil society practices in implementation of TB control measures with a special focus on vulnerable populations, including migrants

2. To strengthen the diagnostic and laboratory network and introduce modern methods of laboratory diagnostics of tuberculosis and to ensure proper quality of laboratory tests using the most efficient diagnostic and treatment algorithms in the context of coordination between tuberculosis and general medical laboratory services.

   • Develop a legal framework enabling effective interactions between specialized and general healthcare networks for efficient distribution of responsibilities and prevention of research overlap as well as for procurement of reagents and equipment maintenance
   • Establish in the Appendix to the national orders on public healthcare services an adequate level of laboratory testing for tuberculosis diagnostics and treatment supervision at specialized and general healthcare facilities
   • Scale-up implementation of a quality management system in laboratories of all levels and conduct certification of the countries’ reference laboratories by supra-national laboratories to ensure quality of laboratory services
   • Strengthen effective specimen transportation systems to the appropriate level of the laboratory network
   • Ensure access for all patients to modern rapid molecular based methods of TB detection and drug susceptibility testing, including those for second-line anti-TB drugs

3. To progressively foster providing better access to new drugs and shorter treatment regimens for DR-TB cases, while ensuring proper pharmacological surveillance and introduction of combination treatment methods, including surgical interventions.

   • Given that the region has a disproportionately highest rates of the global DR-TB cases, a rapid and an effective and sustainable scale up of the introduction of new and repurposed drugs and shorter treatment regimens for DR-TB cases, should be implemented
   • A strong system of drug forecasting and procurement, adverse drug reactions, quality treatment monitoring should be developed along with other essential program components for quality Programmatic Management of Drug Resistant TB (PMDT), and all to be aligned with the principle that “all patients are to be guaranteed a full scope of tuberculosis care based on standards and clinical protocols, including access to new drugs and regimens,” and a general assessment of drug resistance in the country to prevent development of resistance to new drugs
   • Introduce new TB treatment protocols based on the latest WHO treatment recommendations, and ensure continuous monitoring of the rational use of anti-TB drugs in outpatient settings
Revise practical recommendations and regimens on TB treatment with consideration of the use of new drugs and regimens for DR-TB

A combination TB treatment approach, including surgical interventions, can be relevant when the crucial principle -- “benefits for a patient should prevail over the risks (including the risks for medical staff)” -- is respected

4. To ensure effective TB and M/XDR-TB control, the current system of tuberculosis care for the population must be reformed by integrating it with the general healthcare system based on substantive changes in the legal framework, financing mechanisms and the skilled personnel training system leading to enhanced patient access to comprehensive and high-quality treatment.

Within 3 months of signing of this Resolution, National TB Program managers shall develop a “roadmap” listing the practical steps to be taken in the next 24 months for reforming TB care in accordance with the WHO “End TB” Strategy and in addition to the existing National Plans

Ministries of Health of the countries shall hold working sessions to adopt country-level documents – “roadmaps”¹

Twelve months following the signing of this Resolution, a regional working meeting for the National TB Program managers and stakeholders is to be organized to exchange experience and best practices

Two years following the signing of this Resolution, hold the Second Conference on Integrated Tuberculosis Control to summarize outcomes of TB service reforms

Regulatory documents governing access to diagnostics and treatment of vulnerable groups shall be developed/revised and shall provide for monitoring of their implementation

Interaction between the penitentiary and civil sectors shall be improved specifically with respect to sharing of information on TB patients who transition from one system to another and on social rehabilitation of tuberculosis patients released from penitentiary facilities

Countries shall develop a package of social services for TB patients and specify a list and cost of such services

Establish the scope of TB control services that may be provided by NGOs, and enable NGOs to apply for funding

Develop criteria for participation of NGOs in directly observed treatment interventions

<Signatures...>

Almaty, 27 September, 2016

¹ Implementation of the National TB programs at the regional level requires harmonization of the adopted documents.
Appendix 1

Recommendations of the Working Groups

1. There is a need to establish a new and clear model of tuberculosis care with clear distribution of duties and services in the outpatient and inpatient treatment settings (TB REP Project materials can be used as a basis).
   1.1. Primary healthcare system is ready to take responsibility for a portion of TB services (prevention, treatment and care), provided that:
       1.1.1. Mechanisms of TB service funding will be changed to scale-up outpatient treatment with a focus on treatment effectiveness and economic feasibility;
       1.1.2. Services will be specified in job descriptions of healthcare providers; job responsibilities of TB specialists and primary healthcare providers (physicians, nurses) will be clearly divided and appropriately compensated;
       1.1.3. Primary healthcare personnel will be trained;
       1.1.4. Appropriate resources will be available for provision of medical services:
           • models of cost reimbursement to facilities and organizations providing services will be clearly defined
           • these services will be included in the package of guaranteed services used by primary healthcare facilities
           • capitation standard rate for tuberculosis services at the primary healthcare level will be calculated
           • Cost per treated case and payment methods based on diagnosis-related groups will be determined
   1.2. Tuberculosis dispensaries are ready to delegate some of their duties to primary healthcare while retaining treatment monitoring, coordination and inpatient treatment;
   1.3. Human resources should be distributed and redistributed in accordance with the new treatment models, and training of new staff – with due consideration of patients’ needs in treatment and care; and
   1.4. Bring existing sanitary-epidemiological requirements (SanPin) in compliance with the potential inpatient and outpatient models of tuberculosis care.

2. For scale-up of tuberculosis control activities with a focus on vulnerable population groups it is necessary:
   2.1. To develop/review regulatory documents governing access to diagnostics and treatment of vulnerable groups, and to ensure monitoring of their implementation;
   2.2. To improve interaction between penitentiary and civil sectors;
   2.3. To develop a standard package of social services for tuberculosis patients listing the cost of each service;
   2.4. To identify a list of services from this package that may be provided by NGOs/CSOs;
   2.5. To provide for NGOs/CSOs the right and access to apply for governmental funding for implementation of these services in accordance with the established criteria, including such services as distribution to patients of drugs prescribed by doctors and monitoring of drug administration to patients.

3. Use of new drugs and treatment regimens for DR-TB cases
   3.1. Access to new drugs and regimens:
3.1.1. Shall be considered in the program context (availability and accessibility of the drug-susceptibility testing, access to the second-line tuberculosis drugs, active clinical monitoring, availability and operation of an early warning system, etc.);

3.1.2. Shall be aligned with the principle “all patients are to be guaranteed a full scope of care based on standards and clinical protocols, including access to new drugs and regimens,” and based on general assessment of tuberculosis drug resistance in the country;

3.1.3. Shall be designed to prevent development of resistance to the new and repurposed drugs.

3.2. Programs providing access to new drugs/treatment regimens shall be scaled up effectively and as rapidly as possible, whilst maintaining the highest levels of quality of care:

1 - Revise guidelines and protocols on the use of new anti-TB drugs and shorter regimens for DR-TB patients;
2 - Endorse the guidelines at the Ministry of Health level;
3 - Promote the procurement of quality-assured TB medicines in countries graduating from the GF support through registration of the new anti-TB drugs and inclusion in the national list of essential medicines;
4 - Revise national essential medicines lists to include all second-line anti-TB drugs, repurposed drugs for TB, and the new anti-TB drugs;
5 - Calculate demand and develop drug procurement and supply plans including phase-in phase-out plans for new drugs and regimens;
6 - Train healthcare workers responsible for treatment prescription and monitoring;
7 - Implement directly observed treatment during outpatient treatment stage;
8 - Use a system of consilia when any changes to treatment regimens are made collectively;
9 - Access to quality services shall be ensured for all including migrant population.

4. Additional recommendation:

4.1. Initiate establishment of the WHO Cooperation Center on tuberculosis and other infectious diseases in the Republic of Kazakhstan.
Appendix 2

Outpatient Models of TB Treatment and Care

**GOAL:** To standardize outpatient treatment and the system of psychosocial support of patients with tuberculosis and drug resistant tuberculosis (DR-TB) at the TB service and primary healthcare levels

**Outpatient treatment enables:**

- To eliminate the risk of hospital-acquired cross infection and nosocomial transmission of drug-resistant TB strains
- To develop a patient-centered tuberculosis treatment regimen and, as a result, reduce treatment dropout and interruptions, and improve treatment efficacy
- To reduce treatment costs for the government through reorganization of hospital beds and redistribution of savings to development of various hospitalization replacement technologies; establishment of a sustainable patient treatment retention system (social and psychological support, legal assistance, etc.); improvement of hospital living conditions for patients who are in a real need of hospitalization; and introduction of infection control measures in accordance with the standards
- To reduce financial burden on a patient’s family

**Full outpatient treatment of patients with tuberculosis requires:**

- Enrollment in a complete course of specific treatment from the very first day of treatment in outpatient settings (at TB outpatient clinics, day patient facilities, directly observed therapy at home, primary healthcare facilities, and at pre-school facilities and regional education institutions), or short-term hospitalization course (1-1.5 months) followed by outpatient treatment
- Psychological and social-economic support of patients based on their individual needs to ensure patient retention to full completion of treatment
- Redistribution of funds saved as a result of the reduction in the number of hospital beds at TB inpatient facilities to pay the salaries of day patient facilities’ staff, conduct home-based treatment, provide social support of patients, and introduce additional positions for social workers and psychologists

**Hospitalization replacement models for treatment of TB patients**

1. Day Patient Facility
2. DOT Rooms
3. TB Dispensary Visiting Nurse Care
4. “Home Care”
5. “Sputnik” Program
6. TB Drug Administration Observed by Volunteers of the Red Cross and Red Crescent Societies (RC) or Non-governmental Organization (NGO)
7. TB/HIV Patient Support by NGOs
1. Day Patient Facility

Day patient facility can be established under the auspices of a tuberculosis service separately from a 24-hour inpatient facility.

Day patient facility has bed space corresponding to the number of patients undergoing treatment. A patient shall spend at least 6 hours in the day patient facility.

This mode of treatment shall be indicated for patients:

- with associated diseases, who require supervision by medical staff and treatment of co-morbidities
- with adverse reaction to TB drugs, who need to take drugs to suppress side-effects or who need to take fractional dosage tuberculosis drugs 2-3 times a day
- who require consultations with a psychologist or other health specialists (otolaryngologist, endocrinologist, neurologist, etc.).

After verification of the diagnosis, the following patients shall be referred to the day patient facility:

- TB/DR-TB sputum smear negative patients who do not pose epidemiological threat and whose condition does not require round-the-clock monitoring;
- TB/DR-TB sputum smear positive patients whose living conditions enable them to stay at home in isolation
- Children and adolescents who, irrespective of their sputum smear status, had been hospitalized for at least 1 month and who were prescribed an adequate treatment regimen

2. DOT Rooms

DOT room is a treatment model designed for patients with limited forms of TB not requiring hospitalization. The DOT room can be located at a TB service dispensary department or at a PHC family doctor office. A patient arrives at the DOT room at a time that is convenient for him/her and receives treatment under the supervision of a healthcare provider.

After verification of the diagnosis, the following patients shall be referred to DOT rooms:

- TB/DR-TB sputum smear negative patients whose condition does not require round-the-clock monitoring and who live in the vicinity of a DOT room;
- TB/DR-TB sputum smear negative patients who had been hospitalized for at least one month, who have been prescribed an adequate treatment regimen and who live in the vicinity of a DOT room.

3. TB Dispensary Visiting Nurse Care

TB dispensary visiting nurse care also performs the directly observed treatment of TB patients at home during any treatment phase. The treatment is administered based on an agreement with a patient at his/her place of residence or work. After seeing patients who are examined in the TB doctor’s office, nurses visit the patients during their work hours. A nurse visits patients who reside in an area covered by one or several TB doctors.

After the confirmation of the diagnosis, patients are referred to treatment under the supervision of a visiting nurse provided they are:

- TB/DR-TB sputum smear and/or culture positive patients whose condition does not require 24-hour monitoring and whose living conditions allow them to remain isolated in a home environment

4. “Home Care”

“Home care” team provides directly observed therapy for those TB patients whose health condition does not require 24-hour monitoring but who live in remote urban or rural areas, are disabled, have small children or are employed, or for other patients who are otherwise unable to receive treatment.

- TB/DR-TB sputum smear negative patients who do not pose epidemiological threat and whose condition does not require 24-hour monitoring
• TB/DR-TB sputum smear positive patients whose living conditions allow them to remain isolated in a home environment
• Children and adolescents irrespective of their sputum smear status who have been treated in an in-hospital setting for at least one month and who have been enrolled in an appropriate treatment regimen

(Additional note – this treatment model requires a mandatory provision of a motor vehicle, two nurses and a skilled driver).

5. “Sputnik” Program

The “Sputnik” team provides observed treatment by delivering drugs to every patient at a location and time that are convenient for the patient.

In addition to TB drugs, “Sputnik” patients receive social support (including daily food packages), assistance in handling everyday problems, comprehensive information about the disease and duration of treatment, and if required, doctor consultations and drugs for management of side effects.

The most difficult cases, which failed to adhere to treatment in spite of all other measures taken, are referred to the “Sputnik” program. Decisions to refer patients to the “Sputnik” program are made collectively by regional TB service staff at a meeting of the Centralized Medical Advisory Commission.

(Additional note – this treatment model requires a mandatory provision of a motor vehicle, two nurses and a skilled driver).

6. TB Drug Administration Observed by Volunteers of the Red Cross and Red Crescent Societies (RC) or Non-governmental Organization (NGO)

A RC/NGO volunteer works with several TB patients throughout the entire treatment course. In addition to observed therapy, the volunteer counsels patients and their family about the need for treatment. He/she locates patients if they miss treatment. If any patient receiving TB drugs has side effects, the volunteer arranges a visit to a TB doctor.

7. TB/HIV Patient Support by NGOs

Combined dual therapy for TB/HIV patients is a big burden. On the one hand, it represents a chemical stress on a human body, and on the other hand, it represents stigma from the immediate social environment.

TB/HIV cases can be effectively managed by non-governmental organizations engaged in social integration of TB/HIV patients and facilitating TB drug and ART treatment. The interaction of NGOs with three systems – primary health care, TB service and AIDS Center – is a prerequisite for achievement of positive treatment results.

After verification of the diagnosis, the following patients shall be referred to DOT rooms:
• TB/HIV and drug-resistant TB/HIV sputum smear negative patients whose health condition does not require 24-hour monitoring.