FSS Sláinte Phoiblí: Chosaint Sláinte

HSE Public Health: Health Protection

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Striving to End Tuberculosis: A Strategy for Ireland 2024 – 2030

Year 2 Implementation Report


HSE Public Health: National Health Protection Office
FSS Sláinte Poiblí: An Oifig Náisiúnta um Chosaint Sláinte

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Abbreviations

CIR	Crude incidence rate
DOT	Directly -Observed Therapy
HSE	Health Service Executive
HPSC	Health Protection Surveillance Centre
IMRL	Irish Mycobacterium Reference Laboratory
NHPO	National Health Protection Office
HPAC-ID	Health Protection Advisory Committee-Infectious Diseases
NTBAC	National Tuberculosis Advisory Committee
MDR –TB	Multi Drug Resistant Tuberculosis
OCIMS	Outbreak Case Incident Management and Surveillance System
SJH	St James' Hospital
TB	Tuberculosis
TBI	Tuberculosis Infection
UK	United Kingdom
USPs	Under-served populations
VOT	Video- Observed Therapy
XDR –TB	Extremely Drug-Resistant Tuberculosis
WGS	Whole-Genome Sequencing

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Foreword

Two years after the introduction of *Striving to End Tuberculosis – A Strategy for Ireland 2024–2030*, this report summarises the achievements during the second year of its implementation. Created by the HSE National Health Protection Office (NHPO) along with the National Tuberculosis Advisory Committee (NTBAC), the strategy aims to provide a unified national approach to preventing, diagnosing, treating, and monitoring TB—aligning with WHO End TB goals of reducing incidence by 80% and TB-related deaths by 90% by 2030. The context in which this work continues is a challenging one. TB incidence in Ireland has risen since the end of the COVID-19 pandemic and remains above the trajectory required to meet international targets. Against this backdrop, this report documents the progress that has been achieved, identifies challenges in, and sets out the priority actions for the immediate future.

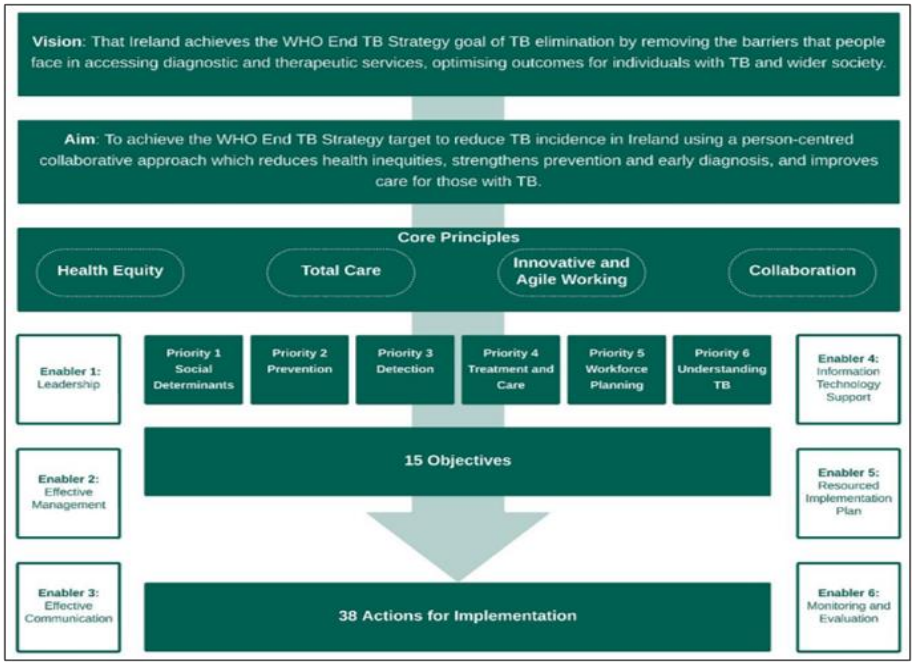

Figure 1 Graphic summary of Striving to End Tuberculosis – A Strategy for Ireland 2024 – 2030

Epidemiology

In Ireland, while TB rates per 100,000 population increased by 32% between 2023 (4.3) and 2024 (5.6), they remained stable (5.5) in 2025, with 285 people notified. TB Rates obsverved in 2024 and 2025 are comparable to levels observed prior to 2019 (Figure 2).

The lower rates seeing during the peak of the COVID-19 pandemic are likely to represent issues regarding access to diagnostic services at that time while escalating rates since represent a truer picture of the burden of disease with rising levels driven by movement of people associated with international conflict as well as wider migration patterns into the State from countries with higher levels of infection than Ireland as well as and other factors affecting the social determinants of health among people in Ireland generally. If this increase is sustained Ireland may lose its status as a low TB incidence country, which is defined as a Crude Incldence Rate (CIR) ≤10 per 100,000 population.

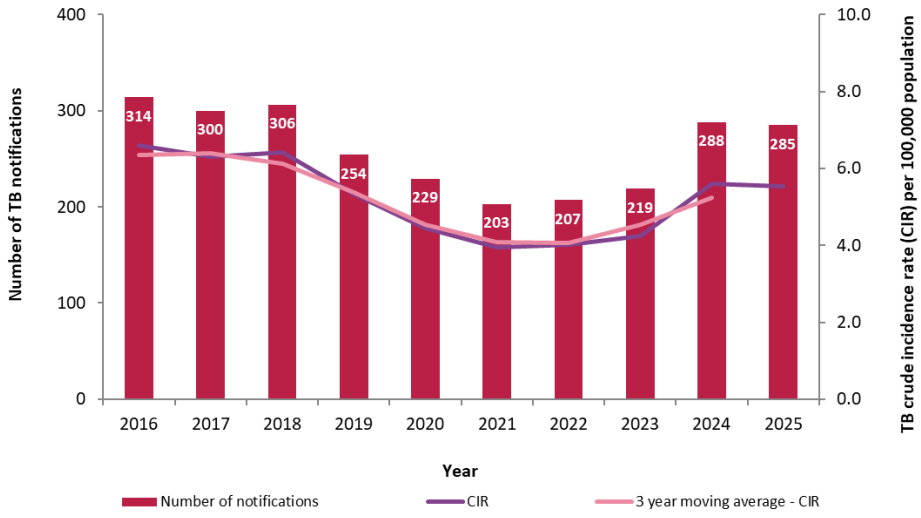

Figure 2 Number of TB notifications, crude incidence rate and 3-year moving average of the crude incidence rate by year, Ireland

The following graph outlines the growing gap between the number of TB cases that have been notified each year in Ireland and the number required to archive the End TB target (Figure 3). Unfortunately, this gap is growing with the number of cases notified in 2025 (285) being more than double that projected to achieve the target.

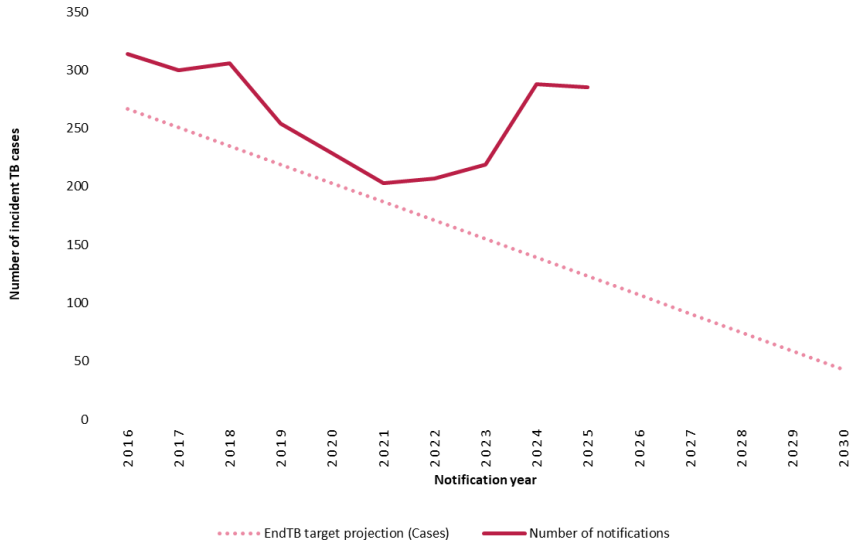

Figure 3 Annual TB notifications Ireland,and required trend to achieve the End TB Strategy target by 2030

Paediatric TB notifications have steadily increased since the Covid-19 pandemic ended as a Public Health Emergency of International Concern in May 2023 (Figure 4). The number of notifications among those aged under 15 years old increased sharply in 2024 (13 cases) and the upward trend was sustained in 2025 (14 cases). These were the highest levels of paediatric TB reported since 2016 (17 cases), with three cases were reported in those aged less than one year old, including one case of congenital TB reported in this age group.

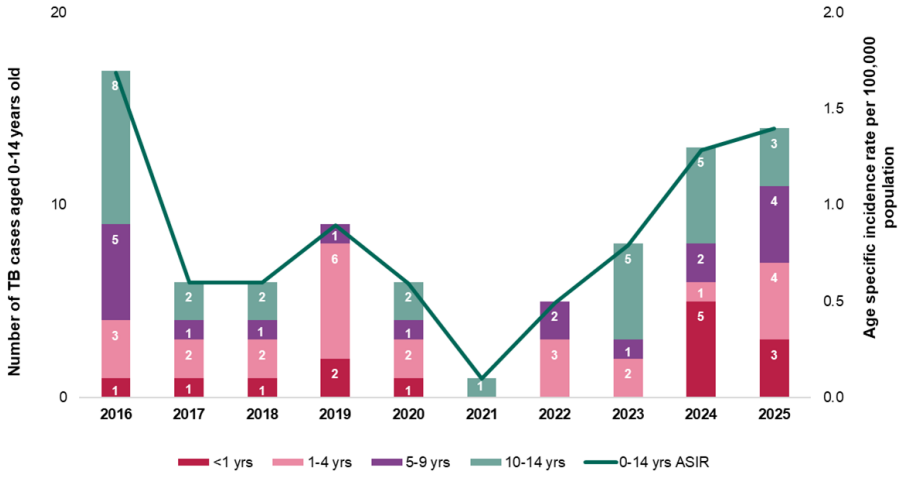

Figure 4 Number of paediatric TB notifications and age specific incidence rate (ASIR) by year, Ireland

Sixty-five percent of TB cases notified in 2025 were born outside of Ireland (Figure 5). The CIR in those born outside of Ireland is 20.3 per100,000 population, which compares to a CIR of 1.7 per 100,000 in the Irish born population.

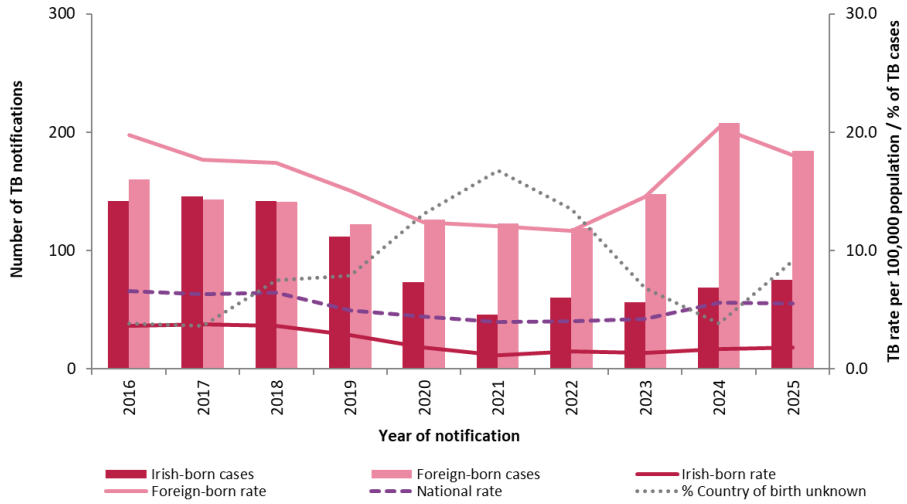

Figure 5 Number of TB notifications and crude incidence rate by geographic origin and year, Ireland

Five cases of at least rifampicin resistance were notified during 2025, all of whom were diagnosed with either multidrug resistant or pre-extremely drug resistant TB. This represents a decrease compared to 2024.

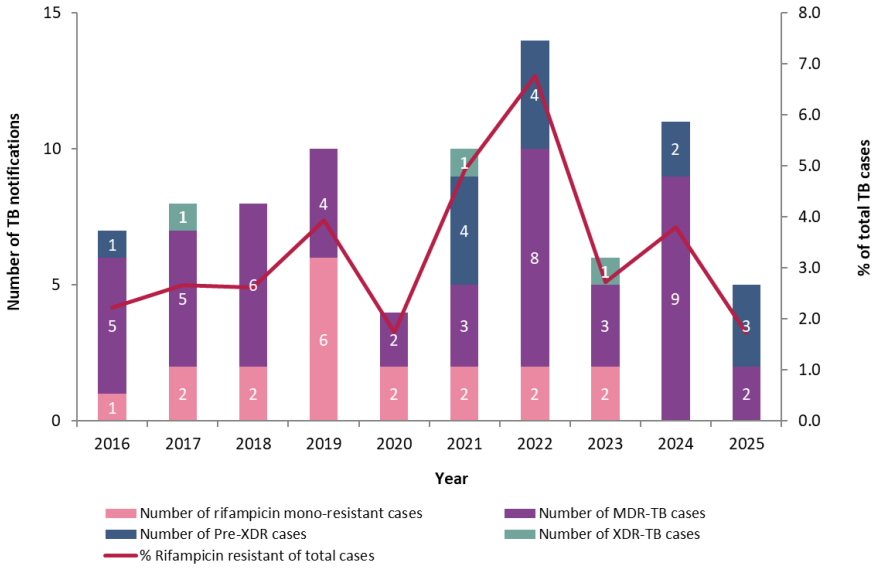

Figure 6 Number of TB notifications with rifampicin resistance detected and proportion of total notifications with rifampicin resistance by year, Ireland

Treatment outcome data provision has decreased since the early 2000s and was adversely affected by resource re-allocation from within public health during the acute phase of the emergency response to the COVID -19 Pandemic. Concerted efforts are underway among Departments of Public Health to improve systems and processes required to collect these data.

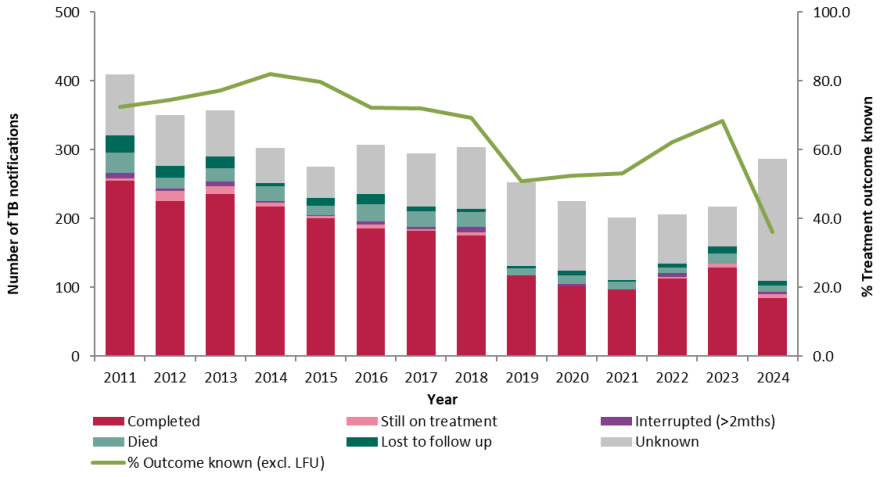

Figure 7 Number of TB notifications by treatment outcome and year, Ireland

(Note: Figures for recent years are based on incomplete data submissions and should be interpreted with caution)

Implementation

Following the launch of the National TB Strategy, the NTBAC undertook a prioritisation exercise to support the development of an implementation plan. This exercise considered the actions set out in the strategy, their interdependencies and relative prioritisation. The outputs of this process were described in detail in the **Year 1 Strategy Implementation Report**. It was agreed that pre-existing work to address TB that aligned with strategic actions would be continued, while high priority actions related to models of care, staffing and resources would be progressed, subsequently enabling implementation of the highest priority programmatic actions (Figure 8).

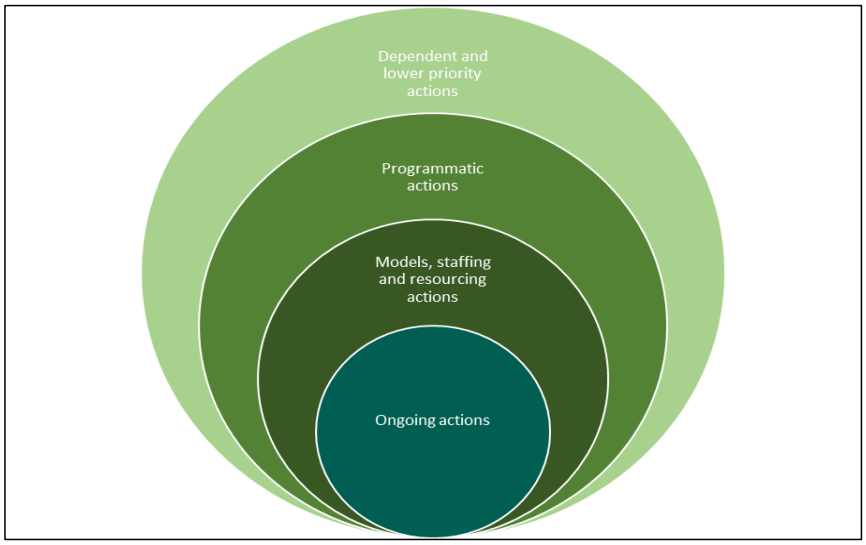

Figure 8 Strategy implementation approach

The implementation approach recognised that several enabling actions relating to models of care, staffing and resourcing would need to be progressed before many of the programmatic actions of the strategy could be delivered. In practice, implementation has therefore focused on maintaining and strengthening existing TB control activities while progressing those strategic actions that could be advanced **within available resources**. However, a number of the enabling actions identified in the strategy **require additional funding and system-level support** in order to be implemented fully. As a result, **progress on some actions has been constrained in the**

absence of the additional resources required. *The proposed timeline for implementing this approach across the lifetime of the strategy is outlined in* ***Figure 9***.

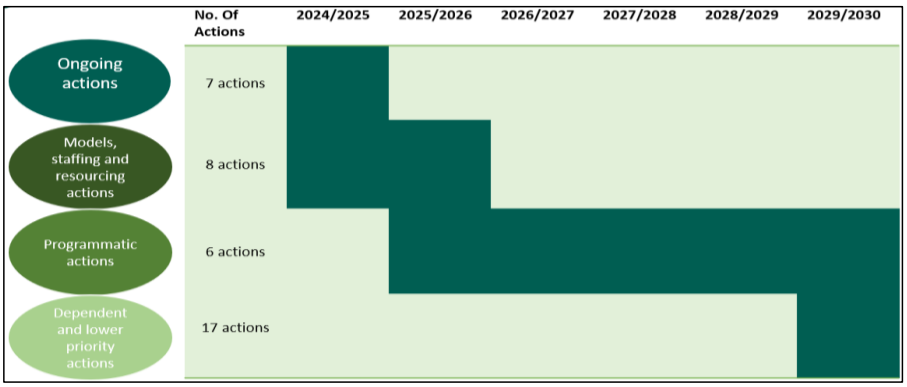

Figure 9 Proposed implementation timeline

Despite these challenges, work aligned with several strategic objectives has continued as part of routine TB prevention and control activities across public health departments, clinical services and national programmes. Progress across the strategic actions is summarised in the following section of this report.

Progress on Strategic Actions

Progress against the strategic actions of *Striving to End Tuberculosis – A Strategy for Ireland 2024–2030* is summarised in **Tables 1 and 2**. Actions are assigned a Red–Amber–Green (RAG) status to reflect progress to date, where green indicates substantial delivery or implementation on track, amber indicates partial progress or activity underway, and red indicates that no progress has been made.

Year One Actions

Of the 15 actions ranked as high priority for implementation during the first year of the strategy, two actions in Table 1 have now progressed from amber to green since the year 1 implementation report

The update of the **National TB Guidelines** (Action 13) has advanced substantially, with eight of nine chapters now published under the NTBAC; the final Laboratory has recently been approved by the Health Protection Advisory Committee – Infectious Diseases (HPAC-ID) and will be published imminently. Given the progress made to date, this action is considered substantively delivered.

Participation in European and international whole-genome sequencing (WGS) surveillance (Action 5) is also assessed as green. Ireland is uploading sequences once or twice annually and actively engaging with EpiPulse cluster analyses coordinated through the European Centre for Disease Prevention and Control. This represents a meaningful and sustained contribution to international TB genomic surveillance.

Six Year 1 actions are rated amber, reflecting partial progress, three of which progressed from red to amber since the year 1 implementation report. The HSE Outbreak, Case, Incident Management and Surveillance (OCIMS) system (Action 15) will provide a standardised national approach to contact tracing once fully delivered. TB medication supply challenges persist

(Action 27), including rifampicin shortages, though newer agents under development offer a medium-term prospect of improvement. Partial work on the 2016 resources report has been undertaken in the HSE South West Region (Action 2) but has not been consolidated nationally. Multidisciplinary team accessibility (Action 22) and TBI feasibility work (Action 7) are both held at amber pending agreement on the national model of care and the OCIMS TBI dataset going live, respectively. Stakeholder engagement on social determinants (Action 1) is ongoing but has not produced specific new actions in this period.

Seven Year 1 actions remain red. Several are interdependent, with delays in one area affecting progress across others. The National TB Lead post is currently vacant (Action 23) but has been advertised as part of a larger brief and not as a stand along post as recommended in various reports, reflecting resources available to HSE National Health Protection Office and consideration of other priority areas of work, including pandemic preparation and winter pressure responses. A number of other actions, including the cohort review process (Action 14), the workforce skills mix assessment (Action 29), and the national model of care (Action 30) require this post to be in place before they can progress. Related to this, a national model of service and care delivery for TB control has not yet been agreed (Action 30); this is a prerequisite for workforce planning actions to advance. National standardisation of contact tracing has similarly not been achieved (Action 6), with partial progress via the OCIMS tool development reflected under Action 15. No progress has been recorded in this period on either the Directly Observed Therapy (DOT) programme (Action 24) or Video Observed Therapy (VOT) and adherence support (Action 25). The development of Regional Health Areas and related governance and resources is a key interdependence for progressing some of these objectives as originally conceived at the publication of the Strategy. Further work with the evolving Regional structures will continue in 2026 to clarify roles and responsibilities as well as resources for these actions.

Table 1: Action Status – Year 1

Group	Action	2024/2025	2025/2026
Ongoing	13. The National TB Advisory Committee will update the National Guidelines for the Prevention and Control of TB by the end of the 2024.		
	6. Standardise the approach to all contact tracing nationally.		
	25. Implement a national VOT programme.		
	24. Strengthen the provision of interventions that support patient adherence such as DOT.		
	15. Invest in digital technology-based contact tracing systems for TB treatment and prevention, building on capabilities that were developed in response to COVID-19.		
	27. Provide patients with shorter more tolerable treatment regimens (e.g. Bedaquiline, Pretomanid, and Linezolid) and ensure nationally there is adequate access to paediatric formulations of TB drugs.		
	5. Participate in European and international whole-genome sequencing surveillance.		
Staffing, resources, models	2. Update the 2016 Report on the Resources Required for TB Control to account for the resources and associated funding needed to meet the strategic objectives.		
	29. Determine skills mix and capabilities required to provide TB services, undertake a gap analysis and develop a workforce implementation plan.		
	22. Improve the accessibility of multidisciplinary TB teams.		
	30. Agree, nationally, a model of service and care delivery for TB Control to be implemented regionally (from prevention to post care delivery).		
	23. A national TB network to support TB care across Ireland will be established by the National TB Lead.		
	14. A cohort review process for the systematic review of cases and contact investigations will be established by the National TB Lead.		

Table 1: Action Status – Year 1

Group	Action	2024/2025	2025/2026
Staffing, Resources, Models	7. To conduct a feasibility study of programmatic management of TBI including its surveillance.		
	1. Engage with key stakeholders to advocate and implement policies and actions that address the social determinants which increase the risk of TB.		

Year Two Actions

The Year 2 action set covers a broad range of 14 programmatic, clinical, and enabling actions assessed across two reporting periods, noting that the implementation timeline for some of these actions will run until the end of the strategy. Progress is mixed: one action has reached green, the majority sit at amber, and a small number remain red.

WGS for surveillance and outbreak investigation (Action 4) is the standout advance for year 2. A retrospective upload of WGS cluster identifiers was completed to provide a fully integrated view of all cases clustered by WGS from 2011 to present day within CIDR. Health Protection Surveillance Centre (HPSC) and Irish Mycobacteria Reference Laboratory (IMRL) also continue to actively respond to ECDC EpiPulse cluster alerts. Among the amber-rated actions, **the selective BCG programme** (Action 11) is being delivered through an NHPO Task & Finish Group led by the National Immunisation Office (NIO) and Phase One (targeting higher-risk infants aged 12 months or less) is expected to be implemented during 2026. Screening for high-risk groups including those in prisons, those living with HIV, and workers in occupationally exposed settings continues on a business-as-usual basis (Action 9), though this reflects existing practice rather than new programmatic development. Peer-delivered patient

support (Action 26) is amber on the basis of a Red Cross prison peer-support programme, though a national model has not yet been implemented. Universal rapid diagnostics are now recommended as first line tests in updated guidance (Action 18), and direct notification of positive laboratory results to TB teams is progressing on the basis of communications from St James's Hospital and planned NTBAC Chair follow-up with the HPSC (Action 20). A broader group of actions remaining at amber include those relating to TB awareness and stigma reduction, One Health engagement, educational materials, universal health care access, quality improvement, the national TB conference, and clinician education on diagnostics reflects activity that is ongoing but not yet consolidated into fully resourced programmes. RAG status for training and for information resources for underserved populations (Actions 31, 32) is currently at red while those relating to education, and workforce development actions are amber (33, 34).

No progress has been recorded on the new entrant immigrant TBI management programme (Action 8), the test-and-treat programme for underserved populations including people in prison (Action 16), pre-employment screening for high-risk occupations (Action 10), or the review of Section 38 of the 1947 Health Act (Action 28).

Workforce development

A number of initiatives and outputs were achieved during Year 2 to strengthen the TB multidisciplinary workforce, with a particular focus on health protection nurses. These are summarised below:

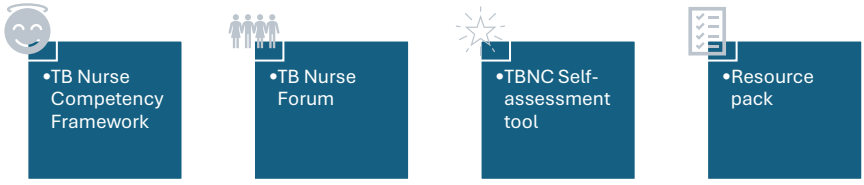

Figure 10 Development of MDT TB-workforce: Tuberculosis nurse competence framework

- Establishment of **Health Protection Nursing TB Nurse Network (TNN)**, to develop TB nurse workforce capability
- Developed Irish health protection **TB Nurse Competency Framework**. https://www.hpsc.ie/healthprotection/nursing/Health%20Protection%20TB%20Nurse%20Competency%20Framework_V1.1.pdf
- Developed a **Self-assessment tool** linking with the TB Nurse Competency Framework, to enable self-assessment to plan professional development
- Collated a **Resource pack** to support nurses on their professional development, working towards achieving TB Nurse competencies
- The TB nurse competency framework and supporting resources contribute to implementation of the TB Strategy, in particular actions 6, 22, 23, 31, 34, 35 and 38.

Research and Innovation Enabler

Although Action 37 (scoping exercise on research needs) is formally rated as red for 2025-2026, important enabling work has taken place at national level. The NHPO has initiated a broader research development process, including two national workshops facilitated by the Research and Guideline Development Unit (RGDU) to operationalise the Health Protection Research Framework. This framework includes TB among its published priorities and provides a foundation to accelerate TB-specific research from 2026 onward.[1] This activity represents meaningful progress toward future implementation even if the formal action remains incomplete.

Table 2: Action Status – Year 2

Group	Action	2024/2025	2025/2026
Programmatic actions	8. Agree a comprehensive, adequately funded and resourced, inter-stakeholder implementation plan for the new entrant immigrant TBI management programme.		
	9. Improve screening among those at-risk of TB due to social risk factors (e.g., people in prisons), medical risk factors (e.g., people living with human immunodeficiency virus (HIV)), and occupational exposures (e.g., abattoir workers).		
	16. Establish a test and treat programme for USPs for both TB and TBI that will involve outreach models and the use of rapid diagnostics as part of a multi-pathogen and non-communicable disease health screening programme.		
	10. Improve the targeted pre-employment screening for those entering high-risk occupations e.g., health care workers, prison officers.		
	11. Agree and implement a comprehensive, adequately funded and resourced, inter-stakeholder selective BCG programme.		
	26. Develop peer-delivered patient support programmes as part of TB care.		
Dependent and lower priority actions	18. Provide health care providers with access to universal rapid diagnostics for TB.		
	20. Ensure all positive microbiology and histology specimens are notified directly to TB teams (which should comprise a public health and clinical specialist in TB).		
	4. Fully utilise whole-genome sequencing as an aid for surveillance and outbreak investigation locally, nationally and internationally.		
	28. Revisit Section 38 of the 1947 Health Act to ensure it effectively allows for TB control measures to be taken including the detention of non-adherent patients.		
	3. Improve the completeness, relevancy and use of surveillance and epidemiological data to inform local and national programmatic activities.		

Group	Action	2024/2025	2025/2026
	32. Develop a comprehensive information resource to support working with TB in under-served populations.		
	17. Raise awareness of TB and address stigma and misinformation.		
	12. To engage with stakeholders to determine how a One Health approach could be integrated into TB prevention and control.		
	35. Develop, disseminate and deliver educational materials for the public, patients and health care providers.		
	21. Advocate for universal health care access.		
	38. To consolidate a quality improvement approach throughout all TB prevention and control activities.		
	35. To support an annual national TB conference.		
	37. Conduct a scoping exercise to establish research needs and priorities that are aligned with the strategic objectives.		
	19. Strengthen education for clinicians and health care professionals in the use and performance of modern diagnostics for TB.		
	34. Identify the training needs and employee development initiatives of the multidisciplinary team.		
	31. Undertake an education and training needs analysis and develop a multidisciplinary education plan for health service staff.		
	33. Review the need for formal education to support career pathways and specialist roles in TB control in Ireland.		

Commented [TT1]: Considering HPN Competency frame work, and related outputs suggest Amber

Successes in 2025-2026

Progress to date has been encouraging in a number of areas. WGS continues to be used to support both domestic outbreak investigation and Ireland's contribution to international genomic surveillance and cluster investigation through EpiPulse, coordinated by the ECDC. The updating of the National TB Guidelines has advanced substantially, with eight of nine chapters now published under the NTBAC. The selective BCG programme is under way and expected to reach green status once fully operational, representing a significant step forward in paediatric TB prevention. Effective TB outbreak investigation and case detection have been demonstrated at both regional and national levels, and Irish authors continue to contribute meaningfully to European and international TB literature. Building workforce capability, developing TB Nurse competency framework and supporting tools is expected to advance specialist career pathway.

Conclusion

The second year of strategy implementation reflects both the progress that is possible within existing structures and the extent to which further advancement depends on resolving key enabling conditions. In addition to the actions presented in Tables 1 and 2, a further 17 actions are scheduled for implementation in future years of the strategy. Progress on a cluster of interdependent actions, including cohort review process for the systematic review of cases and contact investigations, workforce planning, and the development of a national model of care, has been constrained by the absence of key enabling structures. Advancing the selective BCG programme, utilisation of WGS, and guideline development demonstrates what can be achieved when resources and clinical leadership are aligned. Sustaining and building on these gains will require targeted investment and system-level commitment. The NTBAC remains committed to the ambition of the strategy and to working across HSE clinical, laboratory and Public Health functions to ensure Ireland's TB control efforts continue to move in the right direction.

References

1. Gilbourne C, Parlour R, Boland M, O'Moore É, Williams MA, Kiersey R. Determining health protection research priorities for Ireland. Glob Public Health. 2025;20(1):2546629. doi: 10.1080/17441692.2025.2546629