GLOBAL TUBERCULOSIS CONTROL WHO REPORT 1998

Warning: This report is out-of-date. In particular, entire time-series of TB disease burden estimates are updated every year. For the latest data and analysis, please see the most recent edition of the global TB report.



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List of abbreviations

- AFR African Region
- AMR American Region
- CDR Case Detection Rate
- DOTS WHO TB control strategy
- EMR Eastern Mediterranean Region
- EUR European Region
- GLRA German Leprosy Relief Association
- GTB Global Tuberculosis Programme
- IUATLD International Union against Tuberculosis and Lung Disease
- JATA Japan Anti- Tuberculosis Association
- KNCV Royal Netherlands Tuberculosis Association
- NTP National Tuberculosis Control Programme
- SEAR South-East Asia Region
- TB Tuberculosis
- WPR Western Pacific Region

Summary

This is the second annual compilation of data by the World Health Organization's (WHO) tuberculosis surveillance and monitoring project.

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In May 1997, two hundred and twelve countries, territories and areas were asked to provide information about TB control policy, case notifications for 1996 and treatment outcomes for 1995. One hundred and eighty-one of 212 countries (85%) submitted data to WHO in 1997, covering 97% of the global population. They reported 3.81 million cases of tuberculosis, of which 1.29 million were smear-positive. Compared with estimated annual global incidence, these figures represent case detection rates of 39% and 51%, respectively.

Between 1995 and 1996, case notifications increased in four out of six WHO regions. The marked rise in Africa is almost certainly linked to HIV. Declines seen in the Eastern Mediterranean and American Regions probably reflect real falls in incidence, but it is unclear how much of the decline is due directly to TB control programmes.

Globally, DOTS programmes reported 67% of new pulmonary cases to be smearpositive (65% expected), as compared with 30% in other control programmes. They evaluated a higher fraction of registered cases (94% vs 55%), achieved higher treatment success rates (78% vs 45%), and a higher fraction of patients was shown to be cured by smear conversion (72% vs 23%). Collecting together data from all programmes (DOTS and non-DOTS), 57% of approximately one million registered cases were reported to have been treated successfully.

Despite the advantages of DOTS, only one third (32%) of the world's population had access to such programmes by the end of 1996, as judged by population coverage. True access was undoubtedly lower because fewer than a quarter (23%) of all cases were reported from DOTS areas. These reported cases represent only 12% of all estimated cases, and only 15% of smear-positive cases. This is true even though 96 (63%) countries used DOTS (30 for the first time in 1996) and, in 63 countries, DOTS programmes were said to reach more than 90% of the population.

A subset of 25 industrialized countries and Gulf States distinguished between cases among nationals and non-nationals. The incidence rates among non-nationals were 14 times higher in industrialized countries, and three times higher in the Gulf States. In 11 of the 25 countries, cases among non-nationals outnumbered indigenous cases.

In 1996, only 26 out of 96 DOTS countries had case detection and cure rates which approach WHO targets. Those 26 countries carry just 6% of the estimated global incidence. Many of the high-burden countries were not among the 26. Of greatest concern are India, Indonesia, Nigeria and Pakistan. Bangladesh and China are continuing to advance towards the targets, but slowly. Progress in these and other high-incidence countries is the key to global tuberculosis control.

In the high-burden countries Viet Nam, Peru and Tanzania, the DOTS control programmes are exemplary; they must be sustained, and held up as models for other national programmes.

Introduction

Tuberculosis (TB) has been neglected as a public health issue for many years by many countries.¹ TB remains the major cause of death from a single infectious agent among adults in developing countries. There has been a resurgence of TB in the industrialised world.² Several factors, most notably a lack of resources and government commitment, have prevented adequate implementation of control measures. In many countries of Africa and South-East Asia, infection with the human immunodeficiency virus (HIV) has further increased TB morbidity and mortality.^{3,4,5} In several of the former socialist countries, TB morbidity and mortality continue to rise because of the deterioration of public health systems.⁶ In many industrialised countries, the recent increase in TB is due largely to cases among immigrants from other countries,^{7,8,9} a further consequence of global neglect.

The key to controlling TB now is the rapid detection and cure of infectious cases by TB programmes. In 1991, the World Health Assembly (WHA)¹⁰ recommended that each National Tuberculosis Control Programme (NTP) should work towards two objectives by the year 2000: (1) to treat successfully 85% of detected smear-positive cases, and (2) to detect 70% of all such cases by the introduction of an effective framework for TB control.¹¹

In 1993, the World Health Organization (WHO) declared TB to be a global emergency.² The exact burden of disease, however, was not known, and the worldwide achievements of NTPs, in terms of diagnostic coverage and treatment results had never been analysed.

To assess the magnitude of the global tuberculosis problem, and to measure the achievements of TB control, WHO set up a worldwide surveillance and monitoring project in 1995. In 1997, the global status of TB control and the progress towards achiev-

² Raviglione MC, Snider DE Jr, Kochi A. Global epidemiology of tuberculosis: morbidity and mortality of a

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¹ In this document we use the term "countries" to mean countries, territories and areas.