Summary

Background and aims

1. This is the 7th WHO annual report on global TB control. It includes data on case notifications and treatment outcomes from all national control programmes that have reported to WHO, together with an analysis of plans, finances, and constraints on DOTS expansion for 22 high-burden countries (HBCs). Eight consecutive years of data are now available to assess progress towards the 2005 global targets for case detection (70%) and treatment success (85%).

Methods

2. During 2002, a standard form for reporting surveillance data was sent to 210 countries via WHO regional offices. The form requests information about policy and practice in TB control, the number and types of TB cases notified in 2001, and the outcomes of treatment and retreatment for smear-positive cases registered in 2000.

3. National programme managers in the 22 HBCs were asked to identify the major constraints to DOTS expansion, and to present plans to overcome these constraints as they move towards target case detection and cure rates.

4. A new standard form for financial monitoring of TB control programmes was sent to the 22 HBCs during 2002. The form requests information on NTP budgets, available funding and funding sources, and general health infrastructure resources used for TB control.

Main findings

5. The global incidence rate of TB is growing at approximately 0.4%/year, but much faster in sub-Saharan Africa and in countries of the former Soviet Union.

6. The number of countries implementing the DOTS strategy increased by seven during 2001, bringing the total to 155 (out of 210). By the end of year 2001, 61% of the world's population lived in parts of countries providing DOTS. DOTS programmes notified 2.4 million new TB cases, of which 1.2 million were smear-positive. Over 10 million patients have been diagnosed and treated in DOTS programmes since 1995.

7. However, the 1.2 million smear-positive cases notified by DOTS programmes in 2001 represent only 32% of the estimated incidence, and the rate of progress in case finding between 2000 and 2001 was not significantly faster than the average since 1995, a mean annual increment of 137 000 cases. Globally, DOTS programmes would have to treat an extra 360 000 smear-positive patients each year to reach 70% case detection by the end of 2005.

8. Two thirds (67%) of the additional smear-positive cases reported under DOTS in 2001 (as compared with 2000) were found in India alone. There were smaller but marked improvements in case detection in Myanmar, the Philippines and Thailand. Other HBCs made minor gains in case detection, though Pakistan and Brazil reported significant increases in the geographic coverage of DOTS.

9. As DOTS programmes have expanded geographically, the proportion of estimated cases found within DOTS areas has remained constant at 40–50%. Overall, DOTS programmes in the 22 HBCs are not increasing case detection towards the 70% target within designated DOTS areas.

10. Treatment success under DOTS for the 2000 cohort was 82% on average, and has moved closer to the 85% target as the patient population has grown in size. Treatment success was substantially below average in the African Region (72%).

11. Sixteen countries had reached targets for case detection and cure by the end of 2001, but Viet Nam was the only HBC among them.

12. Twenty of the 22 HBCs are known to have adequate plans for DOTS expansion; implementation of many of these plans began in 2001 or 2002, and will be scaled up only in 2003.

13. The constraints on DOTS expansion most commonly identified were: lack of qualified staff; insufficient preparation for decentralization; non-compliance of the private sector with DOTS; inadequate health infrastructure; and weak political commitment.

14. A total of US$ 211 million in new funding for NTPs was committed during 2002, to cover the five-year planning period 2001–2005. This reduces the total funding gap anticipated by NTPs for this period to only US$ 0.2 billion. However, there may be an additional shortfall of at least US$ 0.9 billion due to deficiencies in staff and infrastructure.

15. For 2003, the total budget requirement specifically for TB control in the 22 HBCs is US$ 481 million, of which US$ 52 million (11%) is not yet available. The anticipated funding gap for 2003 is lower than that reported for 2002.

Conclusions

16. If the current rate of DOTS expansion in maintained, the 70% detection target will not be reached by

2005. If that target is ever to be reached, DOTS programmes must improve case finding within designated DOTS areas, and must expand to new areas. To reach the 85% target for treatment success, cure rates must be improved under DOTS in some countries, especially those in sub-Saharan Africa.

17. Although funding for TB programmes, and planning for DOTS expansion, both improved during 2002, deficiencies in staff and health infrastructure are likely to hinder progress towards both of the global targets. At present, NTPs are significantly underestimating the cost of rectifying these deficiencies.

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On January 31st, as this report was going to press, the GFATM announced the approval of 27 applications for funding for TB control (with no or minor adjustments or clarifications), for a total of US$ 122 million over 2 years.

Applications from the following HBCs were approved:

Afghanistan (for TB, AIDS, and malaria), Cambodia, DR Congo, India, Kenya, Myanmar, Mozambique, Nigeria, Pakistan, the Phillipines, and Uganda.

Except in the case of the Philippines (where more funding is required), acceptance of the above proposals will close or significantly reduce the estimated funding gap for TB control in 2003 in these HBCs.