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Book Review

Global tuberculosis control 2008: Surveillance, planning, financing (World Health Organization, Geneva) 2008. 304 pages. Price: CHF/US$ 40.00; in developing countries: CHF/US$ 28.00
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This annual publication of WHO is the 12th Report on Global Tuberculosis Control situation in 2008 and has focus on surveillance, planning and financing. This is based on the data reported to the WHO by 202 of 212 countries of the world in 2007. It has three chapters including The global TB epidemic and progress in control, Implementing the Stop TB Strategy, Financing TB Control, Conclusions and four annexures.

Using these data, the publication presents the latest assessment of the epidemiological burden of TB and the progress made towards targets for global control in the context of the Millennium Development Goals (MDG) and by the World Health Assembly and Stop TB Partnership.

There were an estimated 9.2 million new cases of TB in 2006 (139 per 100,000 population), including 4.1 million new smear-positive cases of (44% of the total) and 0.7 million HIV-positive cases (8% of the total). There is an increase from 9.1 million cases in 2005 which could be explained due to population growth. India, China, Indonesia, South Africa and Nigeria rank first to fifth respectively in terms of absolute numbers of cases. The African Region has the highest incidence rate per capita (363 per 100,000 population).

There were an estimated 14.4 million prevalent cases of TB in 2006, and an estimated 0.5 million cases of multi-drug-resistant TB (MDR-TB) in 2006. In 2006, there were an estimated 1.5 million deaths from TB in HIV-negative people and 0.2 million among the people infected with HIV. In 2007, a total of 202 (out of 212) countries and territories reported TB notification data for 2006 to WHO. A total of 5.1 million new cases (out of the estimated 9.2 million new cases) were notified for 2006, of which 2.5 million (50%) were new smear-positive cases. The African, South-East Asia and Western Pacific regions accounted for 83 per cent of total cases notifications.

Data presented revealed that TB is a major cause of illness and death worldwide, especially in Asia and Africa. Globally, 9.2 million new cases and 1.7 million deaths from TB occurred in 2006; of these, 0.7 million cases and 0.2 million deaths were in HIV-positive people. More positively, and reinforcing a finding first report in 2007, the number of new cases per capita appears to have been falling globally since 2003, and in all six WHO regions except for European Region where rates are approximately stable. If this trend is sustained, MDG 6, to have halted and begun to reverse the incidence of TB, will be achieved well before the target date of 2015. Four Regions are also on track to halve prevalence of death rates by 2015 compared with 1990 levels, in line with targets, following large increases in the incidence of TB during the 1990s. At current rates of progress these Regions will prevent the targets being achieved globally.

The Stop TB Strategy is WHO's recommended approach to reduce the burden of TB in line with global targets. The Global Plan of the Stop TB Partnership details the scale at which the six components of the strategy should be implanted if the global targets are to be achieved. To date, progress has been mixed. The first component of the strategy – the detection and treatment of new cases in DOTS programmes – fares best. Globally, the rate of case detection for new smear-positive cases reached 61 per cent in 2006 (compared with the target of at least 70%) and the treatment success rate improved to 84.7 per cent in 2005, just below the target of 85 per

cent. Progress in the implementation and planning of other parts of the strategy includes provision of TB/HIV interventions for TB patients in the African Region, monitor with a need for improved guidance on advocacy, communication and social mobilization (ASCM) activities, and more ambitious planning for treatment of patients with MDR-TB, in the European, South-East Asia and Western Pacific regions.

Available funding for TB control in 2008 peaked at US$3.3 billion across 90 countries (with 91% of global cases) that reported data, up form less that US$1 billion in 2002. Nonetheless, these same countries reported funding gaps totaling US$385 million in 2008; only five of the 22 high-burden countries reported no funding gap. The gap between the funding reported to be available by countries and the funding requirements estimated to be needed for the same countries in the Global Plan is still large- US$1 billion. This is mainly due to the higher funding requirements for collaborative TB/HIV activities, management of DMR-TB and ACSM in the Global Plan, compared with country reports.

Progress in case detection slowed globally in 2006 and began to stall in China and India. The detection rate in the African Region remains low in absolute terms. Budgets stagnated between 2007 and 2008 in all but five of the 22 high-burden countries. Incidence rates are falling slowly compared with the 5-10 per cent decline annually that is theoretically feasible. Renewed effort to accelerate progress in global TB control in line with the expectations of the Global Plan, supported by intensified resource mobilization from domestic and donor sources, is needed.

The publication has further highlighted the global efforts for DOTS expansion and enhancement, TB/HIV, MDR- TB and other challenges, health system strengthening by engaging all care providers, involvement of the patients and community, enabling and promoting research, *etc*. The report also has highlighted the financial aspects, TB control in the world and the funding position of TB control. The gaps and the available funding of such activities have also been discussed.

The book has given in detail the country profile in the world in an alphabetical manner and also the WHO Regions. It has also given a summary of surveys of TB control infection and disease by the country and year.

According to surveillance and epidemiology 2006, with a population of 1,151,751,000 in India, the estimated incidence of tuberculosis (all cases) is 168/100,000 population /yr with smear positive cases to be 75/100,000 population /yr. The prevalence of the disease (all cases) is 299/100,000 population and a mortality of 28/100,000/yr of new cases of TB, 1.2 per cent are HIV +ve and 2.8 per cent are MDR-TB cases, 17 per cent are MDR amongst previously treated cases. DOTS expansion in the country has increased progressively, while +ve coverage was only 1.5 per cent in 1995, it is 100 per cent in 2006.

The Report gives an account of the Revised National Tuberculosis Control Programme (RNTCP, hereafter NTP) of India that has begun to operate in parts of the country that are particularly challenging. It remains to be seen if the Stop TB Strategy can be implemented as successfully in these districts as it has been in the rest of India. The introduction of MDR-TB treatment as part of routine programme activities will succeed only if the planned sub-national reference laboratories function properly, and if a reliable supply of high-quality second-line drugs is available. Plans to expand collaborative TB/HIV activities nationally will need to reflect the local variations in HIV epidemiology. Assessing the impact of TB control in India will require careful analysis of the extensive and detailed data that are routinely collected by the NTP, in addition to recent and planned surveys on the prevalence of infection of disease.

This book must be read/consulted by all TB workers and planners involved in TB control activities.

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