Conclusions

This concluding section of the report highlights key findings from **Chapters 1, 2 and 3**, as well as common themes across all chapters.

The data and analysis presented in **Chapter 1** show that TB remains a major cause of illness and death worldwide, especially in Asia and Africa. Globally, there were an estimated 9.2 million new cases and 1.7 million deaths from TB in 2006, including 0.7 million cases and 0.2 million deaths in HIV-positive people. Population growth means that these numbers are higher than in 2005. More positively, and confirming a finding first reported in 2007, the data also show that the number of new cases per capita appears to have been falling globally since 2003, and in all six WHO regions except the European Region where rates are approximately stable. If this trend is sustained, MDG 6 Target 6.C, to halt and reverse the incidence of TB, will be achieved well before the target date of 2015. Four regions are also on track to halve prevalence and death rates by 2015 compared with a baseline of 1990, in line with targets set by the Stop TB Partnership. Africa and Europe are not on track to reach these targets, following large increases in the incidence of TB during the 1990s. At current rates of progress, these regions could prevent the targets being achieved globally.

The Stop TB Strategy is WHO's recommended approach to reducing the burden of TB in line with global targets, and the Stop TB Partnership's Global Plan has set out the scale at which the strategy needs to be implemented to achieve global targets. To date, **Chapter 2** shows that progress with implementation of the six components of the strategy is mixed.

- *DOTS expansion and enhancement.* This is the component for which progress is best. Globally, the percentage of estimated new cases of smear-positive TB that were detected in DOTS programmes reached 61% in 2006, compared with the global target of at least 70%. The rate of treatment success for smear-positive cases detected in DOTS programmes improved to 84.7% in 2005, just below the target of 85%.
- *Addressing TB/HIV, MDR-TB and other challenges.* There has been considerable progress in the African Region with the provision of TB/HIV interventions such as HIV testing for all TB patients and co-trimoxazole preventive therapy (CPT) and antiretroviral therapy (ART) for HIV-positive TB patients. However, planning for treatment of patients with MDR-TB falls far short of Global Plan targets in the European, South-East Asia and Western Pacific regions.
- *Contributing to health system strengthening.* Diagnosis of TB and treatment of patients are fully integrated into general health services in most countries. Links with general health sector or development planning frameworks are variable, but consistency with sector-wide approaches was comparatively good among reporting countries. The Practical Approach to Lung Health is being piloted or expanded nationwide in 15 countries, and is included in the plans of 72 countries. Many countries lack comprehensive plans for human resource development or a recent assessment of staffing needs.
- *Engaging all care providers.* Among the 22 HBCs that collectively account for 80% of TB cases globally, 14 are scaling up public–private and public–public mix approaches to involve the full range of care providers in TB control, and seven have used the International Standards for Tuberculosis Care to facilitate this process.
- *Empowering TB patients, and communities.* Several HBCs are implementing ACSM activities, and 13 have conducted KAP surveys. Nonetheless, many countries state that they need much more guidance and technical assistance in this area.
- *Promoting research.* Operational research activities were reported by 49 countries including 19 HBCs.

The data and analysis presented in **Chapter 3**, on financing for TB control, show that the funding available for TB control in 2008 reached US$ 3.3 billion across 90 countries (with 91% of global cases) that reported data. This is up from less than US$ 1 billion in 2002. Nonetheless, funding gaps totalling US$ 385 million in 2008 were reported by the 90 reporting countries, and only five of the 22 HBCs 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 larger still: US$ 1 billion. This is mainly due to the higher funding requirements for collaborative TB/HIV activities, management of MDR-TB and ACSM in the Global Plan, compared with country reports. This finding is in line with the implementation and planning deficits described in **Chapter 2**.

Most of the funding deficit is for collaborative TB/HIV activities, management of MDR-TB and ACSM. Another example of consistency between the data included in **Chapter 2** and **Chapter 3** is the diagnosis and treatment of MDR-TB in the Russian Federation and South Africa. These two countries account for a large share of the patients with MDR-TB who are projected to be started on treatment in 2008, in line with fact that these two countries account for 93% of the total budgets for management of MDR-TB reported by HBCs.

Overall, there are several signs that global progress in TB control is slowing and that there are parts of the world where much more needs to be done to achieve the global targets that have been set. Progress in case detection decelerated globally in 2006 and began to stall in China and India. The percentage of estimated cases being detected in DOTS programmes in the African region remains low, at 46%. Incidence rates are falling slowly compared with the decline of 5–10% per year that is theoretically feasible. Budgets stagnated between 2007 and 2008 in all but five of the 22 HBCs. Renewed effort to increase the rate of progress in global TB control in line with the expectations of the Global Plan, backed up by intensified resource mobilization from domestic and international donors, is required.