1.1 Summary

In 2005, 426,717 cases of tuberculosis (TB) were notified in the WHO European Region. The overall notification rate averaged 48 cases per 100,000, with large variability between countries and an incremental west-to-east gradient in recent years. In general, TB mortality rates in recent years mirrored notification rates in their geographical gradient across the Region (median overall rate: 0.8/100,000, country range: 0.2-22.8).

European Union (EU) and West (34 countries)
The 27 countries of the EU, and Andorra, Iceland, Israel, Norway and Switzerland (West, no data from Monaco and San Marino), reported 93,129 TB cases in 2005. TB notification rates (18/100,000 overall) were highest in Romania (135) and Bulgaria (43) – which joined the EU in 2007 – and in the Baltic States (39-75). Between 2001 and 2005, overall notification rates decreased by 2.5% yearly, reflecting a decline in numbers of previously untreated TB cases. However, substantial increases were observed in Greece (+6%, improved reporting), and in Sweden and United Kingdom (+8 and +5% respectively, mostly in foreign-born cases). In 2005, 20% of cases (country range: 0-82%) were of foreign origin, two-thirds of whom were from Asia or Africa and 9% from the former Soviet Union (FSU). HIV prevalence among TB cases in recent years was 1% or less in 11/23 countries, 15% in Portugal but stable, while it increased since 2000 to 4-6% in 2005 in Estonia and Latvia and doubled between 2000 and 2003 in the United Kingdom (8% in 2003). Multi-drug resistance (MDR) remained more frequent in the Baltic States (combined MDR: 18%) than in the other countries (2%; range: 0-6%), where it was generally more common in cases of foreign origin, and highest (18%) among cases from the FSU. In 24 countries with complete outcome data (2004), success was reported in 78% of new definite pulmonary cases. Loss to follow up was more frequent among foreign cases than nationals (21% vs 15% respectively, all pulmonary cases) while death was less frequently reported (4% vs 8%). Success ratios diminished with increasing age. TB mortality rates were 0.2-9.6/100,000 (29 countries, latest available data 2001-2004).

Balkans (7 countries)
The Balkan countries notified 27,573 cases in 2005, of which 74% by Turkey alone. The overall TB notification rate in 2005 was 29/100,000, and higher in Bosnia & Herzegovina (55) than in Albania, Croatia, F.Y.R. of Macedonia, Montenegro, Serbia and Turkey (17 to 32). Notification rates have increased slightly in Turkey in recent years, as a result of improved case detection, but they decreased in other countries since 2001 by -2% to -7% yearly. HIV prevalence among TB cases was <1% in the 4 countries with data. Combined MDR was 1-2% in the 3 countries with representative data and 5% in Turkey. Success ratios among new pulmonary definite cases (2004) were 85% or higher in three countries, but lower in three other countries (43-84%). TB mortality rates ranged between 3.3 and 3.8/100,000 (4 countries, latest available complete data 2002-2004).

East (12 FSU countries)
In 2005, 306,015 TB cases were reported in the East, 51% of them by the Russian Federation. TB notification rates in 2005 (110/100,000 overall) were highest in Kazakhstan (210), Rep. of Moldova (149), Georgia (144) and Kyrgyzstan (129), and lower in Armenia, Azerbaijan, Belarus, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan (65-110). The mean annual increase in 2001-2005 was lower than that observed in 1995-2000 (+4% vs +10%). HIV prevalence among TB cases was 1% or lower in 5 countries in recent years, but was 2% in Armenia in 2005. No HIV prevalence data were available for Ukraine, but 2,243 AIDS cases with TB were reported in 2005 (5% of TB cases reported in the country). Nationwide and regional drug resistance data from a number of countries suggest a widespread, high prevalence of MDR (eg, 15% combined MDR in Georgia in 2005-2006). In countries reporting outcomes for complete cohorts of new smear-positive pulmonary cases (2004), 85% success was achieved in Kyrgyzstan but not in the other six countries (56-74%). Low success associated with high failures (4-12%) may reflect the frequency of 1^{ary} MDR. TB mortality rates ranged from 10.4 to 22.8/100,000 (6 countries, latest available complete data 2003-2004).

In the European Region, FSU countries have high TB notification and mortality rates, as well as a high burden of TB cases and MDR-TB. The FSU remains the regional priority for TB control, which is often complicated by inadequate information and resources necessary to mount the best-suited response. Further west, recent political changes have influenced the diversity of TB patterns in today's European Union. In industrialized countries anticipating TB elimination, control should prioritize immigrants and vulnerable sub-groups. The Baltic States should target MDR, as well as HIV which increasingly contributes to their TB case-load. Central European countries, several bordering the FSU, should be vigilant to a possible re-emergence of TB as the one in Western Europe in the early 1990s. EU-candidate states should continue efforts to achieve effective TB surveillance throughout their territories.