

1.1 Summary

In 2006, 422,830 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 distribution across the Region (median overall rate: 0.8/100,000, country range: 0.0-25.4).

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 89,032 TB cases in 2006. TB notification rates (17/100,000 overall) were highest in Romania (127) and Bulgaria (42) – which joined the EU in 2007 – and in the Baltic States (34-75). Between 2002 and 2006, overall notification rates decreased by 4% yearly, reflecting a decline in previously untreated TB cases. However, substantial increases were observed in Greece (+5%, improved reporting), and in Sweden and United Kingdom (+5% and +4% respectively, mostly in foreign-born cases). In 2006, 20% of cases (country range: 0-100%) were of foreign origin, two-thirds of whom were from Asia or Africa and 7% from the former Soviet Union (FSU). HIV prevalence among TB cases increased in 2000-2006 in Estonia and Latvia (from <1 to 9% and 3% respectively) and doubled in the United Kingdom in 2000-2003 (from 4% to 8%). In the rest of the countries, it was 1% or less in 9 countries, 2-7% in 9 others, 15% in Iceland (2 cases), and 14% in Portugal. Multi-drug resistance (MDR) remained more frequent in the Baltic States (combined MDR: 15-19%) than in the other countries (0-2%; 7% in Israel, 14% in Malta – 2 cases), in which it was generally more common in cases of foreign origin. In 25 countries with complete outcome data (2005), success was reported in 79% of new culture-positive pulmonary cases. Loss to follow up was more frequent among foreign pulmonary cases than nationals (19% vs. 12% respectively) while death was less frequently reported (5% vs. 7%). TB mortality rates ranged from 0.0-9.6/100,000 (29 countries, latest available data 2001-2005).

Balkans (7 countries)

The Balkan countries notified 26,911 cases in 2006, of which 76% by Turkey alone (an additional 1,122 cases were reported by Kosovo). The overall TB notification rate in 2006 was 28/100,000, and higher in Bosnia & Herzegovina (46) than in Albania, Croatia, F.Y.R. of Macedonia, Montenegro, Serbia and Turkey (16 to 31). Notification rates have stabilised in Turkey in recent years, as a result of improved case detection, but they decreased in other countries since 2002 by 4% to 11% yearly. HIV prevalence among TB cases was 0.0-0.6% in the four countries with data. Combined MDR was 0.4-1.9% in the 3 countries with representative data. Success ratios among new definite pulmonary cases in 2005 were 85-97% in three countries, and lower in three others (46-84%; excluding Montenegro pilot programme). TB mortality rates ranged between 2.5 and 3.8/100,000 (4 countries, latest available complete data 2002-2005).

East (12 FSU countries)

In 2006, 306,887 TB cases were reported in the East, 50% of them by the Russian Federation. TB notification rates in 2006 (110/100,000 overall) were highest in Kazakhstan (282), Moldova (160), Georgia (142) and Kyrgyzstan (127), and lower in Armenia, Azerbaijan, Belarus, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan (62-106). The mean annual increase in 2002-2006 was lower than that observed in 1998-2002 (+3% vs +6%). The number of new cases decreased between 2005 and 2006 in 9 countries. HIV prevalence among TB cases was 1% or lower in 7 countries in recent years, but was higher in the Russian Federation and Ukraine (1.7% and 5.1% respectively among new cases in 2006). Nationwide and regional drug resistance data from a number of countries attest to a widespread, high prevalence of MDR (e.g. 7-16% primary MDR in surveys in Georgia, Russian Federation and Ukraine in 2005-2006). In countries reporting outcomes of new smear-positive pulmonary cases (2005), 85% success was reported by two countries but was less in another nine countries (59-82%). Low success associated with high failures (4-14%) may reflect the frequency of 1st MDR. TB mortality rates ranged from 10.4 to 25.4/100,000 (5 countries with complete data, latest available 2003-2006).

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. Industrialized countries anticipating TB elimination, should prioritize control in vulnerable sub-groups. The Baltic States should target MDR, as well as HIV which increasingly contributes to their TB case-load. Central European countries 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.