At a meeting of stakeholders and donors to the Global TB Programme held in Oslo in September 1995, a key discussion point related to the need to monitor progress towards global targets set in 1991 by the World Health Assembly. The targets – the popular 70% case detection rate and 85% cure rate for new cases of smear-positive pulmonary TB – were to be reached by 2000.

At the time of the meeting, no standardized global monitoring system existed. While clear definitions of TB cases and treatment outcomes were key components of WHO’s then-new global TB strategy – DOTS – the only data available to assess trends in the disease came from the epidemiological bulletins of better-off countries and occasional ad-hoc reports from low-income countries following reviews and monitoring missions.

Since TB is primarily a disease of poor countries, this was not good enough for the influential people meeting in Oslo. Their request came loud and clear: WHO should start immediately to develop a system that would request all Member States to report essential information on TB notifications and treatment outcomes, so that progress – or lack of progress – could be monitored and discussed at their next meeting.

Though global targets had been set in 1991, it nevertheless took four years before such a system was recognized as a necessity: this was not yet the era of precision, accountability, and evidence-based evaluation. Since only a couple of other programmes had developed such systems by then, the field of TB was among the pioneers in this endeavour.

As a result of the discussions in Oslo, Dr Arata Kochi, then the Director of the Global TB Programme, asked me to move quickly to create a global monitoring and evaluation system that would satisfy the request.

Exactly 20 years ago, in October 1995, I started setting up a team composed of a handful of people charged with globalizing the local recording and reporting system recommended within the DOTS strategy. That strategy was based on the model programmes that Dr Karel Styblo had developed in several countries where the KNCV Tuberculosis Foundation and the Union were implementing modern TB control efforts.

During several months of intensive work, we created a database and a standard data collection form (in paper and electronic formats) that was distributed to all Member States. By the summer of 1996, most countries had provided information to WHO Headquarters using standardized definitions so that data from one country could be compared easily with data from another. For the first time, we could assess global progress toward the 2000 targets. The results were presented at the September 1996 meeting of donors and other stakeholders. They showed that fewer than 20% of all cases estimated worldwide were being detected and that the global cure rate was less than 80%.

In the following years, our global monitoring and evaluation system for TB evolved further, with the inclusion of additional information and more sophisticated analyses. For example, our team – led first by Dr Christopher Dye and later by Dr Katherine Floyd
began to monitor the financing of TB control to assess whether Member States were investing as required. Later, we integrated data from the drug resistance surveillance system to enable us to assess comprehensively all the key indicators needed to monitor progress and to identify and correct problems. Our team, under the guidance of Dr Philippe Glaziou, developed more precise estimates of the burden of TB, improving the methodology to measure incidence, prevalence and mortality. In particular, since 2006, concerted efforts have been guided by the WHO Global Task Force on TB Impact Measurement, resulting in substantially increased data from national TB prevalence surveys and much greater use of mortality data from vital registration systems.

As a result of these efforts, 20 years later, we are able to judge fairly precisely the status of the epidemic and the response of Member States. We can assess where people with TB are missing from notification systems; where cure rates remain low and failure rates are high; where multidrug-resistant TB is a serious issue; and where domestic funding must be complemented by international financing. None of this was possible in 1995.

We are now entering the era of the Sustainable Development Goals, in which paradigm shifts are expected in all sectors, including health. TB is an infectious disease that, despite all progress, claims a number of deaths paralleled only by those from HIV/AIDS. To end the epidemic (defined as an incidence of fewer than 100 cases per million people) by 2035 will require a rapid upgrade of care and managerial standards.

During the next 20 years, we will need to change our mentality and adopt all effective innovations, including those exploiting digital technology, especially in the realm of information management. Novel ways of diagnosing and reporting already exist and their adoption will help us evolve further towards interventions that are more user-friendly, cheaper and more sustainable. If fully adopted, these technologies will not only transform the way we handle care and surveillance, but will increase the effectiveness of managerial and training efforts for the benefit of those who suffer from TB.

On the occasion of the publication of this 20th WHO global TB report, which coincides with the assessment of the 2015 global TB targets set as part of the Millennium Development Goals, I am humbled by the progress in terms of impact and operations that we have witnessed in many countries over two decades. The Global Report is a testimony to the tireless efforts of many people worldwide, from National TB Programme staff to community members, from clinicians and nurses to those working for non-governmental organizations who have devoted themselves to the noble fight against a classic example of a disease of poverty.

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