

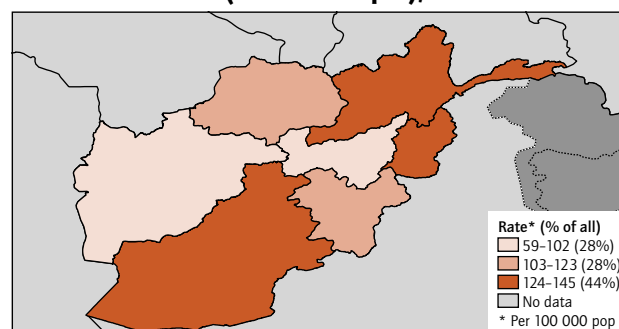
Afghanistan

Despite a difficult situation on the ground, Afghanistan achieved a case detection rate of over 60% in 2007. The treatment success rate fell below 85% for the 2006 cohort after four years above the target. TB control services are an integral part of the package of services delivered through the primary health-care system at district and provincial levels. This package is implemented largely by NGOs; a network of partners has been developed at national and international levels to provide coordinated support to the NTP. The sustainability of activities is unclear, given the unstable security situation in many areas, particularly in the southern and south-eastern regions. The involvement of private practitioners has begun but needs to be expanded beyond pilot projects. Furthermore, several components of TB control have not yet been addressed, including the management of MDR-TB, the development of collaborative TB/HIV activities and the implementation of contact investigation.

SURVEILLANCE AND EPIDEMIOLOGY

Population (thousands) ^a	27 145	
Estimates of epidemiological burden, 2007^b	ALL	IN HIV+ PEOPLE
Incidence		
All forms of TB (thousands of new cases per year)	46	0
All forms of TB (new cases per 100 000 pop/year)	168	0
Rate of change in incidence rate (%), 2006-2007	0	—
New ss+ cases (thousands of new cases per year)	21	0
New ss+ cases (per 100 000 pop/year)	76	0
HIV+ incident TB cases (% of all TB cases)	0	—
Prevalence		
All forms of TB (thousands of cases)	65	0
All forms of TB (cases per 100 000 pop)	238	0
2015 target for prevalence (cases per 100 000 pop)	218	—
Mortality		
All forms of TB (thousands of deaths per year)	8.2	0
All forms of TB (deaths per 100 000 pop/year)	30	0
2015 target for mortality (deaths per 100 000 pop/year)	25	—
Multidrug-resistant TB (MDR-TB)		
MDR-TB among all new TB cases (%)	3.3	—
MDR-TB among previously treated TB cases (%)	36	—

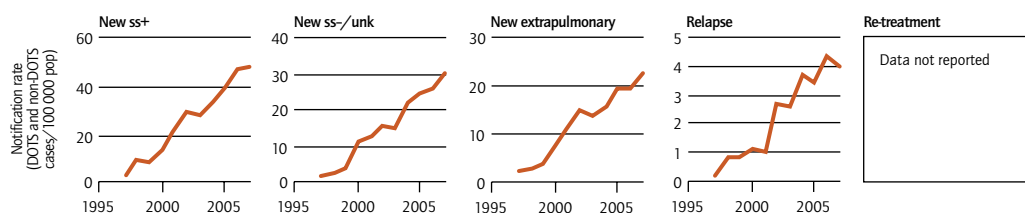
TB notification rate (new and relapse), 2007



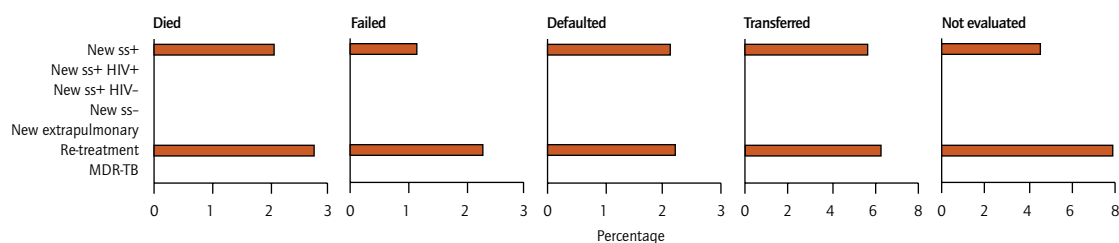
Total notifications, 2007

Notified new and relapse cases (thousands)	29
Notified new and relapse cases (per 100 000 pop/year)	106
Notified new ss+ cases (thousands)	13
Notified new ss+ cases (per 100 000 pop/year)	49
as % of new pulmonary cases	62
sex ratio (male/female)	0.5
DOTS case detection rate (% of estimated new ss+)	64
Notified new extrapulmonary cases (thousands)	6.2
as % of notified new cases	22
Notified new ss+ cases in children (<15 years) (thousands)	0.7
as % of notified new ss+ cases	5.0

Case notifications



Unfavourable treatment outcomes, 2006 cohorts



	2000	2001	2002	2003	2004	2005	2006	2007
DOTS coverage (%)	15	12	38	53	68	81	97	97
Notification rate (new & relapse cases/100 000 pop)	34	47	62	60	76	87	98	106
% notified new & relapse cases reported under DOTS	100	100	100	100	100	100	100	100
Notification rate (new ss+ cases/100 000 pop)	14	22	29	28	34	40	48	49
% notified new ss+ cases reported under DOTS	100	100	100	100	100	100	100	100
Case detection rate (all new cases, %)	20	28	35	34	43	50	55	61
Case detection rate (new ss+ cases, %)	18	29	39	37	45	52	63	64
Treatment success (new ss+ patients, %)	85	84	87	86	89	90	84	—
Re-treatment success (ss+ patients, %)	78	—	—	—	—	89	79	—

Note: notification, case detection and treatment success rates are for the whole country (i.e. DOTS and non-DOTS cases combined).

DOTS EXPANSION AND ENHANCEMENT

Overview of services for diagnosis of TB and treatment of patients

Description of basic management unit	Regional hospital, provincial hospital, district hospital, comprehensive health centre, basic health centre
Number of units (DOTS/total), 2007	991/991
Location of NTP services	
Rural	District hospital, comprehensive health centre, basic health centre
Urban	Regional hospital, provincial hospital, professional hospital
NTP services part of general primary health-care network?	Yes
Location where TB diagnosed	
Rural	District hospital, comprehensive health centre, basic health centre
Urban	Regional hospital, provincial hospital, professional hospital
Diagnosis free of charge?	Yes (all suspects)
Treatment supervised?	All patients in all units
Intensive phase	Health-care worker, community member, family member
Continuation phase	Health-care worker, community member, family member
Category I regimen	2(HR)ZE/6(HE)
Treatment free of charge?	All patients in all units
External review missions	last: 2007 next: 2009

Political commitment

National strategic plan?	Yes (2009-2013)
Mechanism for national interagency coordination?	Yes (established 2003)
National Stop TB Partnership?	Yes (established 2008)

Financial indicators, 2009

(see final page for detailed presentation)	%
Government contribution to NTP budget (incl loans)	1.7
Government contribution to total cost TB control (incl loans)	12
Government health spending used for TB control	11
NTP budget funded	97

Per capita health financial indicators, 2009

	US\$
NTP budget per capita	0.3
Total costs for TB control per capita	0.4
Funding gap per capita	0.01
Government health expenditure per capita (2005)	4.0
Total health expenditure per capita (2005)	20

Quality-assured bacteriology

National reference laboratory?	Yes
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All TB laboratories performing EQA of smear microscopy or DST under the supervision of the National Reference Laboratory

	Smear				Culture		DST			
	Number	per 100 000	EQA	% adeq perf	Number	per 5 000 000	Number	per 10 000 000	EQA	% adeq perf
2007	500	1.8	360	86%	1	0.2	–	–	–	–
2008	545	1.9	545	71%	1	0.2	–	–	–	–

Note: for routine diagnosis, there should be at least one laboratory providing smear microscopy per 100 000 population. To provide culture for diagnosis of paediatric, extra-pulmonary and ss-/HIV+ TB, as well as DST of re-treatment and failure cases, most countries will need one culture facility per 5 million population and one DST facility per 10 million population. EQA column shows number of laboratories for which EQA was done. Adeq perf; adequate performance for microscopy based on results of EQA.

System for managing drug supplies and laboratory equipment

	Central level			Peripheral level		
	2005	2006	2007	2005	2006	2007
Stock-outs of laboratory supplies?	–	No	No	–	No	No
Stock-outs of first-line anti-TB drugs?	No	No	Yes	No	No	No

Monitoring and evaluation system, and impact measurement

NTP publishes annual report?	Yes (since 2005)	Burden and impact assessment		last	next
% of BMUs reporting to next level in 2007		In-depth analysis of routine surveillance data	No	–	–
Case-finding	100%	Prevalence of disease survey	No	–	–
Treatment outcomes	100%	Prevalence of infection survey	No	–	–
		Drug resistance survey	Yes, national	–	2010
		Mortality survey	No	–	–
		Analysis of vital registration data	No	–	–

MDR-TB, TB/HIV AND OTHER CHALLENGES

Multidrug-resistant TB (MDR-TB)	2005	2006	2007
	Number (% of estimated ss+ MDR-TB)		
Estimated incidence of ss+ MDR cases	1 266	1 318	1 371
Diagnosed and notified	– (–%)	– (–%)	– (–%)
Registered for treatment	– (–%)	– (–%)	– (–%)
GLC	0	0	0
non-GLC	–	–	–

MDR-TB, TB/HIV AND OTHER CHALLENGES (continued)**Detection and treatment of HIV in TB patients, 2007**

TB patients for whom the HIV test result was known	–
as % of all notified TB patients	0
TB patients with positive HIV test	0
as % of all estimated HIV+ TB cases	–
HIV+ TB patients started or continued on CPT	–
as % of HIV+ TB patients notified	–
HIV+ TB patients started or continued on ART	–
as % of HIV+ TB patients notified	–

Screening for TB in HIV-positive patients, 2007

HIV+ patients in HIV care or ART register	0
Screened for TB	–
as % of HIV+ patients in HIV care or ART register	–
Started on TB treatment	–
as % of HIV+ patients in HIV care or ART register	–
Started on IPT	–
as % of HIV+ patients without TB in HIV care or ART register	–

High-risk groups, 2007

Number of close contacts of ss+ TB patients screened	–
Number of TB cases identified among contacts	–
% of contacts with TB	–
Contacts started on IPT	–
% of contacts without TB on IPT	–

HIV testing for TB patients

Data not reported

CPT and ART for HIV-positive TB patients

Data not reported

CONTRIBUTING TO HEALTH SYSTEM STRENGTHENING

Lack of basic infrastructure, scarce human resources and security problems are formidable challenges to strengthening health systems that also affect TB control. The NTP is addressing these challenges jointly with other stakeholders by aligning its planning and implementation processes with other planning processes, including the national plan for human resources for health and the general health-sector development plan. The NTP, which is implemented mostly through contracted NGOs as part of an integrated package of primary health care, is also developing approaches to use the private sector to implement public health interventions.

Practical Approach to Lung Health (PAL), 2007

Number of health-care facilities providing PAL services	0	As % of total number of health-care facilities	0
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ENGAGING ALL CARE PROVIDERS**Public-public and public-private approaches (PPM), 2007**

Number of providers collaborating with the NTP ^a	Number collaborating (total number of providers)	% total notified TB	
		Diagnosed	Treated
Public sector	3 (–)	0.8	0.8
Private sector	2 (–)	2.7	2.7

International Standards for Tuberculosis Care (ISTC)

ISTC endorsed by professional organizations?	No
ISTC included in medical curriculum?	–

EMPOWERING PEOPLE WITH TB, AND COMMUNITIES**Advocacy, communication and social mobilization (ACSM)**

The NTP has integrated ACSM into the National Strategic Plan for TB Control. In 2007–2008, primary and secondary research was used to conduct a national situation analysis and the first National ACSM Strategy 2009–2013 was developed. Funding for ACSM activities, outlined in the national ACSM strategy, was secured through round 8 of the Global Fund. Developing national implementation capacity and social mobilization capacity in remote areas in a complex security situation are the major challenges to ACSM faced by the NTP.

Community participation in TB care and Patients' Charter

The NTP has involved Afghan communities in TB control through NGOs, community organizations and public sector community health workers who are involved in case detection, treatment support, counselling, follow-up and management of suspect TB cases in hard-to-access rural areas of the country. The NTP has also involved religious leaders in its awareness campaigns. Affected communities and TB patients participate in decision-making forums such as the country coordination mechanism and the Board of the national Stop TB Partnership. No data on use of the Patients' Charter were reported.

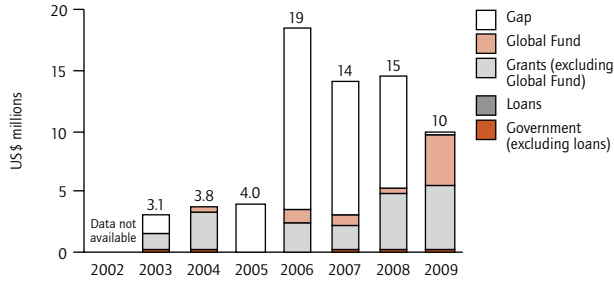
ENABLING AND PROMOTING RESEARCH**Programme-based operational research, 2007**

Operational research budget (% of NTP budget)	14%
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FINANCING

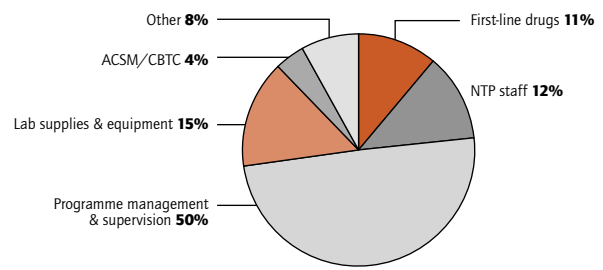
a. NTP budget by source of funding

Decreased budget requirement in 2009 is in line with revised strategic plan 2009–2013; greatly increased funding from Global Fund and other donors in 2009



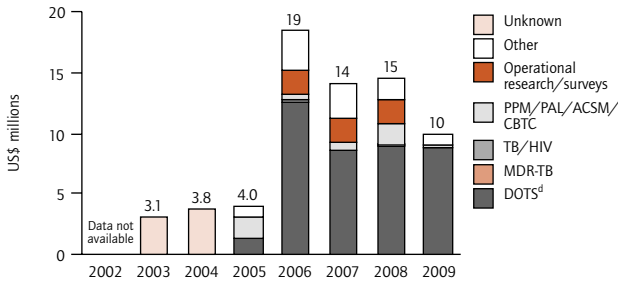
b. NTP budget line items in 2009

DOTS implementation accounts for 88% of the budget, with considerable investment in programme management and supervision



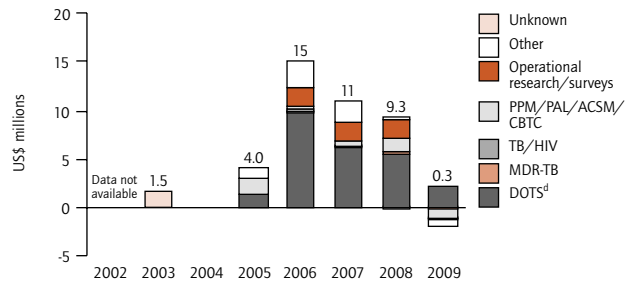
c. NTP budget by line item

Budget for operational research and community TB care reduced in 2009 following revision of strategic plan



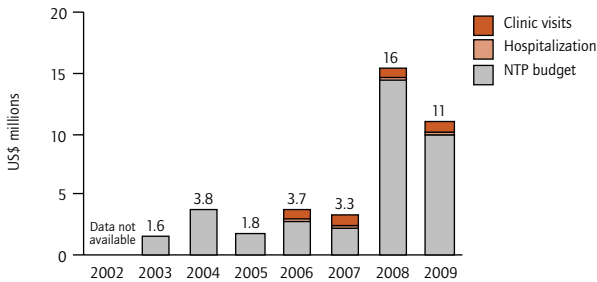
d. NTP funding gap by line item

Funding gaps within DOTS mainly for routine programme management, first-line drugs and laboratory supplies and equipment



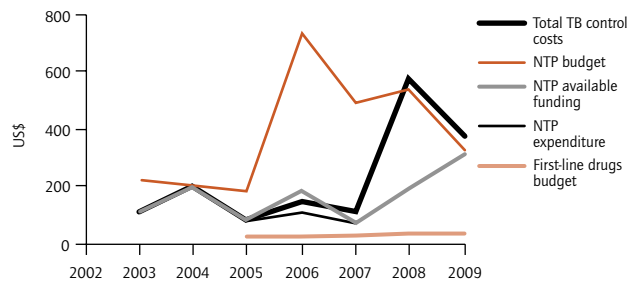
e. Total TB control costs by line item¹

Hospitalization costs are for 200 TB beds; outpatient costs based on 71 visits per new ss+ TB patient during treatment and 68 visits per new ss- and extrapulmonary patients



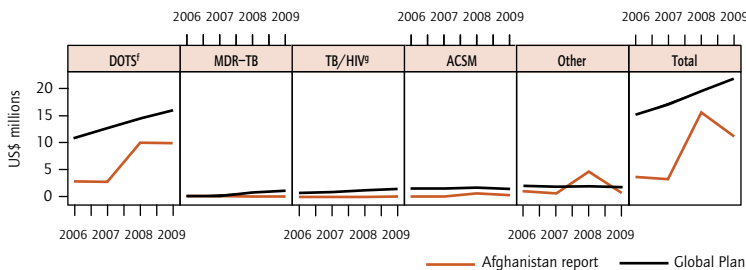
f. Per patient costs, budgets and expenditures²

Considerable fluctuation in all indicators but available funding per patient has risen since 2007



g. Global Plan compared with country reports³

Global Plan estimates of funding requirements are higher than country expenditures and projected funding requirements, mainly due to a higher forecast of patients to be treated in the Global Plan



h. NTP budget and funding gap by Stop TB Strategy component (US\$ millions)

Component	2009 BUDGET	GAP
DOTS expansion and enhancement	8.8	2.2
TB/HIV, MDR-TB and other challenges	0	-0.1
Health system strengthening	0	0
Engage all care providers	0	-0.1
People with TB, and communities	0.4	-0.8
Research and surveys	0	-0.1
Other	0.8	-0.8

SOURCES, METHODS AND ABBREVIATIONS

^{a-g} Please see footnotes page 169.

¹ Total TB control costs for 2003–2004 are based on available funding, whereas those for 2005–2007 are based on expenditure, and those for 2008–2009 are based on budgets. Estimates of the costs of clinic visits and hospitalization are WHO estimates based on data provided by the NTP and from other sources. See Methods for further details.

² NTP available funding for 2005–2007 is based on the amount of funding actually received, using retrospective data; available funding for 2003–2004 and 2008–2009 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

– indicates not available or not applicable; pop, population; ss+, sputum smear-positive; ss-, sputum smear-negative pulmonary; unk, pulmonary – sputum smear not done or result unknown.