

# Afghanistan

## Overview of TB control system

Twenty-three years of war has resulted in the steady collapse of the public health system and in low coverage of primary health care. This has led to poor access to TB treatment, and to frequent treatment failure. The huge influx of returnees from neighbouring countries could increase the prevalence of TB, but reliable data are not available to assess the scale of the problem. Political uncertainty and a lack of security continue to make TB control precarious. In the absence of a fully-functioning NTP, minimal TB control activities are carried out, mainly by WHO and NGOs. The DOTS strategy is an essential component of Afghanistan's redeveloping health services, and is included in the Basic Package of Health Services (BPHS), a group of interventions designed to reduce childhood and maternal mortality.

## Surveillance, planning, operations

Thirty-eight percent of the Afghan population was reported to have access to DOTS by the end of 2002, and an estimated 19% of all new smear-positive cases were detected. The increase in population coverage between 2001 and 2002 was considerably greater than the increase in case detection, perhaps because of the delay between establishing DOTS in a new area and finding cases. Like Iran, Afghanistan reports more women with TB than men, and the difference is greatest between young women and men. One possible explanation, yet to be tested, is that men seek treatment from non-DOTS private practitioners whereas women use DOTS public health facilities that report to the NTP. It is also possible that there really is more TB among

women. No TB cases were reported from outside the DOTS programme in 2002. Eighty-four percent of patients registered during 2001 were successfully treated, though only 53% were confirmed to be smear-negative at the end of treatment.

The draft strategic plan for TB control was finalized in 2003, and an operational plan for DOTS expansion was developed and partially implemented. The National Guidelines for TB Control were revised in October 2003, and will be introduced in 2004. Microscopes and reagents were procured in October 2003, but the development of a reference laboratory has been delayed until the NTP is further rehabilitated, and until a needs assessment can be undertaken with WHO's support in 2004.

Staff shortages remain at all levels. A staff training plan will be implemented in 2004, to include

training of master trainers in TB and fellowships in other countries. Regional centres that integrate training for TB, malaria, and other communicable diseases are part of the strategy to augment staff qualifications. Support from WHO human resource experts will be required to achieve these goals.

NGOs play a growing role in DOTS delivery. A MoU was signed in March 2003 between NGOs and the MoH for the provision of food rations to TB patients. The expansion of DOTS into the most difficult areas of the country will be facilitated by a massive education campaign, aimed at removing the stigma associated with TB. The successful expansion of DOTS will partly depend on security risks in new districts. Community-based DOTS is being explored to improve TB control activities in remote populations and for other people who

## PROGRESS IN TB CONTROL IN AFGHANISTAN

### Indicators

• Treatment success 2001 cohort	84%
• DOTS detection rate, 2002	19%
• NTP budget available, 2003	46%
• Government contribution to NTP budget, including loans, 2003	0%
• Government contribution to total TB control costs, including loans, 2003	NA
• Government health spending used for TB, 2003	NA

### Constraints to achieving targets

- Weak health sector infrastructure, including insufficient personnel
- Weak NTP capacity due to staff shortages and poor training
- High stigma about TB resulting in unwillingness to seek early treatment
- Increasing private sector involvement in DOTS services
- PHC facilities not always implementing DOTS strategy

### Remedial actions needed

- Construct and rehabilitate physical infrastructure
- Develop plan for staff development that includes recruitment, retention, and training strategies for clinical and management staff
- Identify and implement best IEC practices to reduce stigma and raise TB awareness
- Involve private practitioners in DOTS; encourage use of standard drug regimens in the private sector
- Systematically introduce DOTS into PHC facilities, including community-based DOTS in the most inaccessible and under-served areas

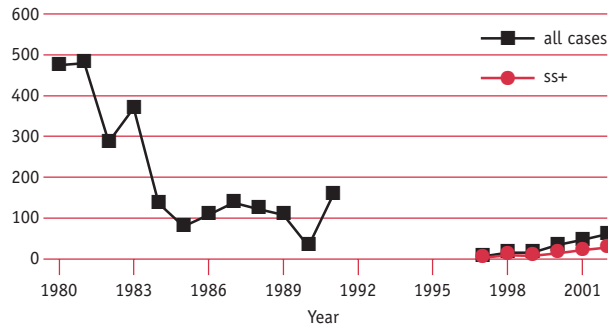
NA indicates not available

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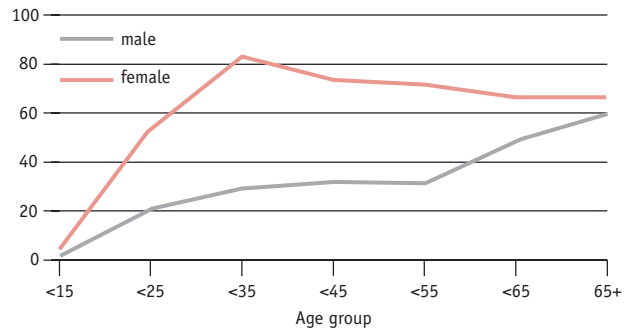
LATEST ESTIMATES <sup>a</sup>		TRENDS	1999	2000	2001	2002
<b>Population</b>	<b>22 930 036</b>	DOTS population coverage (%)	14	15	12	38
Global rank (by est. number of cases)	20	Notification rate (all cases/100 000 pop)	16	33	46	60
Incidence (all cases/100 000 pop)	333	Notification rate (new ss+/100 000 pop)	8	14	21	28
Incidence (new ss+/100 000 pop)	150	Detection of all cases (%)	4.8	10	14	18
Prevalence (ss+/100 000 pop)	302	Detection of new ss+ cases (%)	5.3	9.0	14	19
TB mortality per 100 000 pop	92	DOTS detection of new ss+ (%)	5.3	9.0	14	19
% of adult (15-49y) TB cases HIV+	0.0	DOTS detection of new ss+/coverage(%)	39	60	117	50
% of new cases multi-drug resistant	7.3	DOTS treatment success (new ss+, %)	87	86	84	—

## Notification rate (per 100 000 pop)

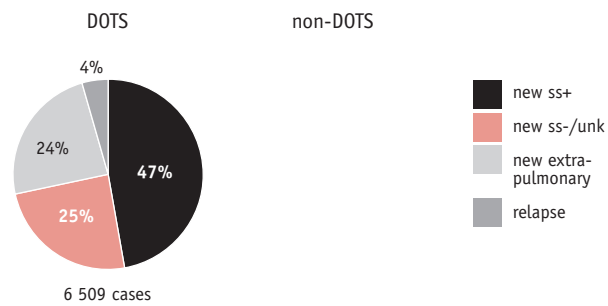
Notification (all cases) = 13 794 in 2002



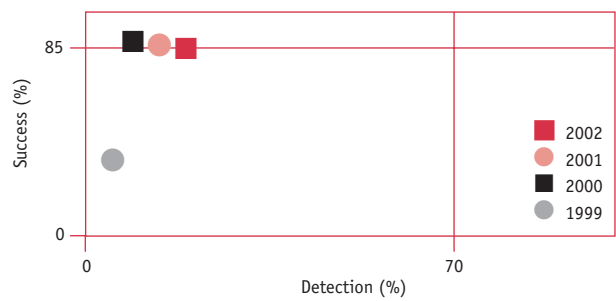
## Notification rate by age and sex (new ss+)<sup>b</sup>



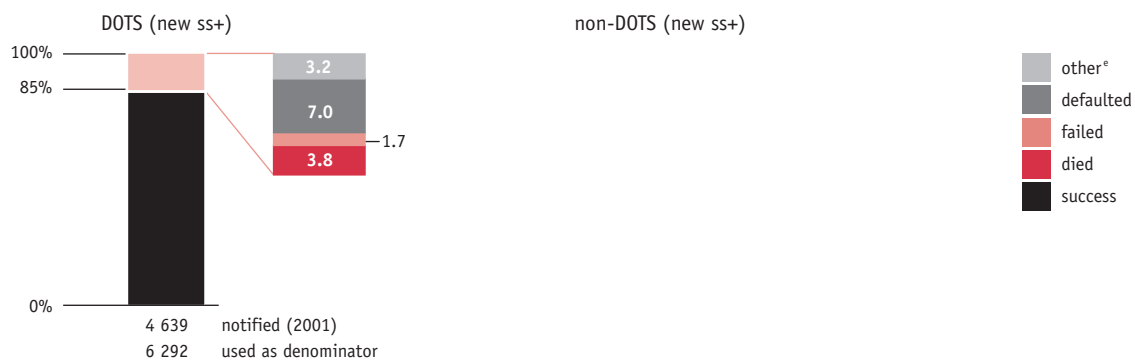
## Case types notified<sup>c</sup>



## DOTS progress towards targets<sup>d</sup>



## Treatment outcomes<sup>e</sup>



## Notes

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

<sup>a</sup> See Methods for data sources.

<sup>b</sup> The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

<sup>c</sup> Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

<sup>d</sup> DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

<sup>e</sup> "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

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### Budget estimates, existing funding, and budget gaps for fiscal year 2003, US\$ millions

	REQUIRED FUNDING	EXPECTED FUNDING				FUNDING GAP
		GOVERNMENT	LOANS	GRANTS	OTHER	
<b>NTP budget</b>						
Drugs	NA	—	—	NA	—	—
Dedicated staff working exclusively for TB control	NA	—	—	NA	—	—
New activities to raise case detection and cure rates	NA	—	—	NA	—	—
Buildings, equipment, vehicles	NA	—	—	NA	—	—
All other line items	NA	—	—	NA	—	—
<b>TOTAL NTP BUDGET</b>	<b>2.8</b>	<b>—</b>	<b>—</b>	<b>1.3</b>	<b>—</b>	<b>1.5</b>
<b>Costs not covered by NTP budget <sup>a</sup></b>						
Hospital stay	NA	NA	—	—	—	—
Clinic visits for DOT and monitoring	NA	NA	—	—	—	—
<b>TOTAL COSTS NOT COVERED BY NTP BUDGET</b>	<b>NA</b>	<b>NA</b>	<b>—</b>	<b>—</b>	<b>—</b>	<b>—</b>
<b>TOTAL TB CONTROL COSTS</b>	<b>NA</b>	<b>NA</b>	<b>—</b>	<b>1.3</b>	<b>—</b>	<b>1.5</b>

— Indicates zero; NA, not available

<sup>a</sup> WHO estimates, data not provided by the NTP

do not have access to health services.

Programme monitoring and supervision have been strengthened through the recruitment of 18 national programme officers, and through the purchase of vehicles for supervision missions. However, half of the planned supervision missions did not take place either because the volatile security situation made travel unsafe, or because funds were not disbursed from the administratively weak NTP. As NTP capacity improves, so should monitoring and supervision.

There is no good national estimate of HIV prevalence among TB patients, in part because no system for HIV testing within the NTP has yet been established (the figure in the accompanying table is the estimated HIV infection rate in adults with TB). There are no TB/HIV collaborative activities at present, and no plan,

so far, to involve the NTP in ART delivery.

Anti-TB drugs were available throughout 2003, and an application for 2004 has been submitted to the GDF. Non-standard regimens are being used in private facilities which, together with the failure to observe patients throughout treatment, could lead to poor treatment outcomes and to the development of drug resistance. EMRO is planning to fund operational research aimed at fostering better practice in the private sector.

#### Partnerships

WHO provides overall technical and financial assistance with the bulk of financial support coming from CIDA and the Government of Italy. JICA is funding the development of a TB laboratory network. GLRA, MEDAIR, GMS, LEPCO, ACD, and other NGOs provide TB diagnosis and treatment in their catchment areas. An appli-

cation to the GFATM was approved in February 2003. USAID has expressed interest in supporting TB control.

#### Budgets and expenditures

The budget for the fiscal year 2003 (from 21 March) was US\$ 2.8 million. As in the 2002 fiscal year, funding for the NTP depended nearly exclusively on donor contributions. In 2002, the programme received a total of US\$ 2.3 million from CIDA and the Government of Italy. In 2003, a budget gap of US\$ 1.5 million was anticipated. It is currently impossible to make estimates of costs not covered by the NTP budget.

In 2003, Afghanistan was awarded a grant from the GFATM for strengthening communicable disease control, including TB control, at the central level and in 6 sub-regions. The funds have not yet been disbursed but the 2-year award total is US\$ 3.1 million.