NATIONAL STRATEGIC FRAMEWORK ON

HIV/AIDS FOR AFGHANISTAN – II

2011 - 2015

Kabul, June 2011

Acronyms

ADB	Asian Development Bank
AHAPP	Afghanistan HIV/AIDS Prevention Project
AIDS	Acquired Immunodeficiency Syndrome
ANASF	Afghanistan National HIV/AIDS Strategic Framework
ANBSTS	Afghanistan National Blood Services and Transfusion Safety
ANDS	Afghanistan National Development Strategy
ANP	Afghanistan National Police
ART	Anti Retroviral Treatment
ARV	Anti Retroviral
BBD	Blood Borne Diseases
BCC	Behavioral Change Communication
BPHS	Basic Packages of Health Services
CBC	Community Based Care
CBO	Community Based Organization
CCM	Country Coordination Committee
CHC	Comprehensive Health Center
CHW	Community Health Worker
EC	European Commission
EPHS	Essential Package of Health Services
FATA	Federally Administered Tribal Areas
FSW	Female Sex Work
GoA	Government of Afghanistan
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	Gesellschaft für Technische Zusammenarbeit
HACCA	HIV/AIDS Coordination Committee of Afghanistan
HBC	Home Based Care
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HPRO	Health Protection and Research Organization
HSV-2	Herpes Simplex Virus
IBBS	Integrated Bio-Behavioral Surveillance
IDPA	Integrated Drug Prevention in Afghanistan
IDU	Injecting Drug Users
IEC	Information Education Communication
IOM	International Organization on Migration
IPD	Internally Displaced Persons
IPIP	Instances, Police Intervention Project
KPK	Khyber Pakhtunkhwa
LSE	Life Skill Education
MARP	Most at Risk Populations
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MoCN	Ministry of Counter Narcotics

MoHRA	Ministry of Haj and Religious Affairs
MoI	Ministry of Interior
MoIYC	Ministry of Information, Youth and Culture
MoJ	Ministry of Justice
MoPH	Ministry of Public Health
MSM	Men who have sex with men
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NSF	National Strategic Framework on HIV/AIDS
NTCP	National Tuberculosis Control Programme
OST	Opioid Substitution Treatment
PEP	Post Exposure Prophylaxis
PHS	Prison Health Strategy
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
POP	Program Operational Plan
RTI	Reproductive Tract Infection
SGS	Second Generation Surveillance
SPHP	Strengthening Provincial HIV/AIDS Programme
STI	Sexually Transmitted Infections
SWG	Surveillance Working Group
TB	Tuberculosis
TIU	Truckers Implementation Unit
ToT	Training of Trainers
UN	United Nations
UNAIDS	United Nation Joint Programme on HIV/AIDS
UNESCO	Unites Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	Unites Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCCT	Voluntary Confidential Counseling and Testing
VCT	Voluntary Counseling and Testing
WFP	World Food Programme
WHO	World Health Organization

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Part I: Situation and Response Analysis

I. 1. SITUATION ANALYSIS

I.1.1 COUNTRY CONTEXT

Thirty years of protracted war, foreign invasion and civil unrest made Afghanistan, a country of 29 million people, fall to 181 out of 182 countries with regard to the Human Development Indicators and be classified as among the poorest nations in the world.[1] Mass out-migration and displacement due to conflict as well as lack of income-generating opportunities resulted in high mobility of populations, including significant exodus to urban areas and long-term migration to Pakistan, Iran, and the countries of the Arab Gulf.[2] Consequently, Afghanistan faces a variety of political, security, economic, social and human development challenges among which the HIV/AIDS epidemic poses an emerging threat. For the most part, this is associated with the increasing dependency of a growing segment of the population on regular use of a wide range of opiates, including opium and heroin, coupled with high prevalence of Tuberculosis (TB) and Sexually Transmitted Infections (STIs) in the context of severe deterioration of access to basic social, education and health services. Among other underlying factors, poor HIV knowledge and limited access to sex and reproductive education, low literacy level (85 percent), and high stigma and discrimination of people living with HIV (PLHIV), as well as most-at-risk-populations (MARPs), including - *injecting drug users (IDUs), female sex workers (FSWs), men who have sex with men (MSM),* and *prisoners,* are most apparent.

DRUG USE : Afghanistan is the world's largest producer of opium and a host to almost 1 million drug users or 8 percent of the adult population (15-64 years old), including 740,000 males, 120,000 females and 60,000 children estimated in 2005.[3] According to the *World Drug Reports* 2009 and 2010, and the United Nations Office on Drugs and Crime (UNODC)/Ministry of Counter Narcotics (MoCN) 2009 *Drug Survey*, Afghanistan remains among the countries with the highest rates of opiate consumption similar to Russia and Iran, with a prevalence of 2.7 percent of the adult population or 290,000 to 360,000 persons. It is believed that the social and economic costs as well as tremendous physical and psychological distress associated with the war and conflict resulted in increased drug dependency among both men and women (single and poly-drug use), initially reported among refugees, returnees and discharged soldiers.[4] Alarmingly, since 2005 the number of regular opium users grew from 150,000 to 230,000 persons indicating an increase of 53 percent while the number of heroin users grew even more so from 50,000 to 120,000 users with a much higher leap of 140 percent.[5] Most of the opium produced in the country is consumed externally, however easily available at a relatively low-cost for local consumption in

[1] Afghanistan at A Glance, World Bank, 2009; WHO, 2010; Human Development Report, 2009; Human Development Index (HDI) ranks countries based on income, life expectancy and literacy rates. In 2007, the Afghanistan National Human Development Report placed the country at 174 out of 178 countries.
[2] UNHCR, Afghanistan Operational Update, 2007
[3] Afghanistan Drug Use Survey, 2005, UNODC and Ministry of Counter Narcotics (MoCN) of the Islamic Republic of Afghanistan
[4] UNODC, MoCN, 2005, *Ibid* and GTZ-IS, Integrated Drug Prevention and Rehabilitation Project in Afghanistan, 2006
[5] UNODC, MoCN 2009 Drug Survey Executive Summary

urban settings and geographic areas where the drugs are produced (Northern and Southern regions), as well as the Central region, mainly Kabul.[6]

INJECTING DRUG USE: Injecting drug use in Afghanistan is associated with intravenous injection of: (a) heroin, (b) pharmaceutical drugs and (c) tranquilizers and painkillers that are often supplemented with other forms of substance abuse. While the exact number of IDUs has not be published yet from the 2009 UNODC/MoCN *Drug Survey*, in 2005 UNODC estimated between 19,000 and 25,000 IDUs, including 7,000 of those who inject heroin and 12,000 of those who inject pharmaceutical drugs.[7] The best available data point at distinct differences with regard to the patterns of injecting drug use by type of drugs, gender, age, and geographic location with **three Western provinces of Herat, Farah and Nimrooz emerging as 'hotspots',** in addition **to Kabul City** that is thought to the a home to the largest number of opium users, heroin users and IDUs. According to UNODC, while the majority of IDUs are males, women IDUs are more likely to be widowed or divorced, with less education and more than twice as likely not to have a job.[8] Available information suggest a profile of a drug user having the following social and demographic characteristics as being from any ethnic group, a poor male under 30 years of age, unemployed, with little or no education, married and living with the extended family; if employed, usually as a farmer or unskilled worker and supplementing his income to meet the costs of his drug use via selling family assets, borrowing money, stealing, begging, or committing other petty crimes.[9] While systematic information is presently unavailable, data suggest a considerable number of adolescents and children among IDUs and drug users at large.[10]

Studies on injecting drug use in Afghanistan clearly specify that while hashish and opium smoking, chewing or inhaling have been, to a certain degree, socially tolerated, injecting of heroin was first reported among the Afghan refugees in Iran and Pakistan and those who returned mainly into the urban areas and frontier provinces. Most recently conducted cohort study among Kabul IDUs reported that over 60 percent of all interviewed IDUs initiated injecting in Iran, including among those living outside in the last 5 years.[11] The 2009 UNODC survey stated that while the average drug user (all opiates) started his/her habit in Afghanistan, almost one-third (28 percent) reported that they began using drugs in Iran, followed by 9 percent in Pakistan while in exile. Up to 40 percent of all opium and heroin users initiated their habit in Iran, including 27 percent of them women heroin users. Nevertheless, there is also an indication of a new generation of IDUs who have started injecting drugs in Afghanistan. The 2010 *Cohort Study* revealed that over 30 percent of IDUs started injecting in the country.[12]

Both 2005 and 2009 drug surveys point to the alarming rates of high risk behavior among IDUs, including sharing of needles and syringes, use of other substances, low condom use, and exchange of sex for money and drugs. In particular, if in 2005 at least half of the heroin IDUs shared needles, in 2009 the majority of interviewed IDUs (87 percent) reported such behavior.[13] Interestingly, the 2010 cohort study, while reporting lower rates of needles and syringe sharing (17 percent), revealed a much higher rate of sharing of injecting works (40 percent). This study also provided important information on

[6] UNODC, MoCN 2009 presented the price of heroin to be at 2.2 USD, followed by opium at 1.6 USD and other opiate at 1.5 USD per day and an overall estimate of 300 million spent by all IDUs annually in the country to maintain their habit.
[7] Data provided by the MoCN, 2006
[8] UNODC, MoCN, 2009, *Ibid*
[9] UNODC, MoCN 2009, Todd C.S, Addul Nasir, Katja Fiekrt, et al, Results of the Intervention and Community Phases of Integration of Needle Exchange & VCT in Kabul, Afghanistan, 2010, IBBS 2009, *Ibid*
[10] Sabawoon A, Samarrudin and G. Sayed, A Rapid HIV Situational Assessment of Herat Province, NACP, The World Bank, 2010
[11] Todd C.S, et al, 2010, *Ibid*
[12] Todd C.S, et al, 2010, *Ibid*
[13] UNODC, MoCN 2005 and 2009 Drug Surveys, *Ibid*

common use of other substances, such as hashish, alcohol (61 percent and 65 percent, respectively) and most disturbingly, transitioning from smoking to injecting of heroin among 98 percent of IDUs.[14]

ROLE OF SOCIO-ECONOMIC, POVERTY AND GENDER FACTORS: In addition to drug production and trafficking and presence of a large number of IDUs and other drug dependant populations, including women and children, poor blood safety and unsafe surgical practices, limited basic physical and health care, high prevalence of TB, STIs, Malaria, Hepatitis A, B, and C, a number of social determinants or amplifiers to HIV have been recently noted.[15] Twenty nine million people suffered over 25 years of war, conflict, displacement, tremendous human loss, and severe impoverishment. Approximately 8 million Afghans spent some time living abroad as refugees, primarily in Pakistan (5 million) and partially in Iran (3 million). Today, about 2 million widows, 2 million orphans, almost 2 million disabled, over 4 million returnees and 500,000 IDPs reside in Afghanistan, while almost 4 million Afghan refugees still live in Pakistan and Iran.[16] As a result, drug dependency, including injecting drug use has become a coping strategy for the physical and physiological trauma faced by a large number of Afghans.[17] At the same time, extreme impoverishment led to higher risk behaviors among some populations, including reliance on *exchanging sex for goods or money*.[18] As for gender-specific concerns, low economic status of women, high illiteracy level among women and girls, gender and age discrimination, including gender segregation and consequent seclusion and low mobility of women, violence against women, labor and sexual exploitation of girls and children, and human trafficking, have been also marked. Social and cultural norms of masculinity and femininity, and taboo about sex and sexual behavior are also considered as risk factors for Afghan women, young men and children. Finally, mobility, including significant rural-urban migration, and reliance of many Afghan households on male seasonal and long-term migrant work (largely illegal and undocumented) to Pakistan, Iran, India, and the Arab Gulf and greater availability of commercial sex - also potentially increase HIV vulnerability and risks for those households.

I.1.2. EPIDEMIOLOGICAL SITUATION, KNOWLEDGE, STIS AND TB

Afghanistan is among the countries of Central Asia and South Asia with evidence of a *concentrated epidemic* that are confronted with growing risk of HIV/AIDS, mainly due to the high incidence of *injecting drug use that partially intersects with sex work.*[19] It is believed that the epidemic that is presently under **0.5 percent among the general population**, has the potential to grow quickly from a small base of injecting drug users (IDUs) to their sexual partners and thus to heterosexual men and women unless effective, vigorous, and sustained action is taken early.[20] In early 2007, the officially

[14] Todd C.S et al, 2010, *Ibid*

[15] Understanding HIV in Afghanistan: The Emerging Epidemic and Opportunity for Prevention, The Islamic Republic of Afghanistan National AIDS Control Program, The John Hopkins University, The Indian Institute of Health Management Research, 2008; S. Rehman et al, 2009, *Ibid;* AIDS in South Asia, 2006, *Ibid*; UNODC, MoCN, 2005, *Ibid;* A Study on Knowledge, Attitude, Behavior and Practice in Most at Risk and Vulnerable Groups in Afghanistan, Action Aid, 2006; Bazgar F.et al, Survey of Groups of High Risk of Contracting Sexually Transmitted Infections and HIV/AIDS in Kabul, 2005; Chase R. et al, Mapping and Situation Assessment of High Risk Populations in Three Cities of Afghanistan, University of Manitoba, 2007

[16] The World Bank, HIV in Afghanistan Data, 2010

[17] Studies on female sex workers (ORA International, 2006), men who have sex with men (Action Aid, 2006), and vulnerable children UNICEF (2009) cumulatively suggest that transactional sex and sexual exploitation of women, girls and children became more prevalent as the result of increased poverty in the last decade. Also, information collected from drop-in-centers (DIC) of MDM (Wilson, John Hopkins, 2010) reveals that young IDU boys, as well female IDUs are sold for sex by some policemen in Kabul.

[18] Andrea Wilson, HIV in Afghanistan: A Review of Literature and Evidence of Disease Burden Among Vulnerable Populations, John Hopkins University, 2010

[19] AIDS in South Asia: Understanding and Responding to a Heterogeneous Epidemic, The World Bank, 2006

[20] UNGASS, 2010; IBBS, 2009; S. Rehman, M. Rasoul, A.Wadak, M.Claeson, J.Freidman, G. Sayed, Responding to HIV Epidemic in Afghanistan, Lancet, Volume 370, December 2009

reported number of HIV cases was 71, including 18 women and 53 men, detected only at three health services in two locations of the country - the Kabul City Central Blood Bank, Kabul and Herat VCT centers - cumulatively between 1989-2007 among 125,800 persons screened or tested for HIV.[21] The UNAIDS and WHO, however, estimated a higher number of people living with HIV ranging from at least 1,000 to 2,000.[22] It was known only that 24 out of the 71 HIV-positive individuals were IDUs, while no information was available about the remaining cases. In August 2007, the government of Afghanistan reported 245 cases.[23] Most recently available data indicated 636 HIV-positive cases reported in 2009, and the number of deaths due to AIDS was estimated under 10 cases.[24]

Despite this low prevalence, high rates are reported among MARPs such as **injecting drug users (IDUs) reporting prevalence rates up to 18 percent in one urban center,** with a soaring regional variation among IDUs while reporting **1.6 percent among prisoners** (mostly IDU prisoners). Although **prevalence rates among female sex workers (FSWs) are presently known to be at 0 percent** and **no data is available for men who have sex with men (MSM),** high risk behavior factors such as unsafe sexual practices (e.g. low condom use, multiple sexual partners), poor knowledge and/or misconceptions about HIV transmission and STIs, drug and alcohol consumption, and, most importantly, close interaction between these populations present the danger of the epidemic spilling over to these populations and potentially to other segments of the wider population.[25]

I.1.3 Most at Risk Populations – IDU, FSW, MSM and Prisoners[26]

INJECTING DRUG USERS (IDUS): According to UNODC, the number of IDUs was estimated at 20,000 in 2009.[27] A 2007 University of Manitoba study estimated 159, 55, and 1,251 IDUs in the three cities of Mazar-i-Sharif, Jalalabad, and Kabul, respectively. The study revealed that injecting drug is largely street based and clustered within urban districts, with Kabul having the largest number of IDUs per cluster (half of all 177 IDU clusters with at least 5 IDUs). While size estimation of rural IDUs is yet to be launched, some sources point at the existence of injecting drug use outside of urban areas.[28] Unsafe Injecting drug use is considered the *key mode of the HIV transmission in Afghanistan* as IDUs report the highest HIV prevalence rates in the country largely due to unsafe injecting practices such as sharing of needles and syringes (47 percent) and unsafe sexual behavior[29]. The 2009 IBBS reported **the prevalence rates among IDUs ranging between 1 percent in Mazar-i-Sharif, 3.7 percent in Kabul to 18.8 percent in Herat** which, overall, corresponds with previously obtained rate of 3 percent among Kabul IDUs.[30] However, Medecins du Monde (MDM) indicated 15% prevalence among Opioid Substitution Therapy (OST) patients in 2010 in Kabul thus demonstrating extremely high rates among IDUs.[31] The 2009 IBBS also reported that IDUs exhibt a range of high-risk behaviors. The majority of sexually active IDUs surveyed in all three cities (up to 64 percent) reported paying for sex with a FSW and up to 25 percent of

[21] NACP data, 2007
[22] Afghanistan Epidemiological Fact Sheets on HIV/AIDS and STIs, UNAIDS, 2006
[23] HIV/AIDS in Afghanistan, World Bank, 2007
[24] UNGASS, 2010, *Ibid*
[25] UNGASS, 2010, *Ibid*
[26] In Afghanistan, MARPs include injecting drug users (IDUs), female sex workers (FSWs), men who have sex with men (MSM), and prisoners.
[27] UNODC, MoCN, 2009, *Ibid*
[28] Andrea Wilson, 2010, *Ibid*
[29] University of Manitoba, 2007, *Ibid*
[30] IBBS, 2009, *Ibid;* and Todd C.S, Abed A.M, Strathdee S.A, et al, Prevalence of HIV, Hepitatis C, Hepatitis B, and Associated Risk Behaviors among Injecting Drug Users in Kabul, Afghanistan. Emerging Infectious Diseases, 2007
[31] Opioid Substitution Therapy: First Results and Way Forward. Presentation to the World Bank, Medicines de Monde (MDM), April 2011

them having sex with a man or a boy.[32] Almost one third of all interviewed IDUs shared needles or syringes and only 32 percent of all IDUs used a condom during their last sexual encounter. In addition, IDUs reported to be highly mobile with 80 percent changing their residence at least one and almost 90 percent of all living outside of the country for the past 10 years, including up to 80 percent of those living in Iran and up to 50 percent in Pakistan.

FEMALE SEX WORKERS (FSWS): According to a mapping exercise, there are an estimated 1,160 FSWs in three major cities of Afghanistan (Kabul, Mazar-e-Sharif and Jalalabad).[33] In spite commercial sex being available in urban areas – in Kabul and primarily in brothels during pre-Soviet era, since the Taliban's criminalization of sex work, today it is believed to be largely home-based and hidden. The best available information indicates an **HIV prevalence among FSWs currently to be at 0 percent.**[34] Although IDUs have the largest potential to introduce HIV into a population, as research indicates, FSWs arguably could have the largest impact on the extent of the spread of HIV through their interactions both with clientele and regular sex partners.[35] A study conducted by ActionAid in 2006 revealed that 84 percent of FSWs had 1-2 clients per day and the rest had 3 clients and more per day.[36]

The University of Manitoba study reported that even with 15 clients per month, 200 FSWs will have 3,000 sexual encounters per month, and more than 35,000 per year[37]. Limited in scale, the ActionAid study nevertheless provided important information about the clients of FSWs indicating that the majority of them were primarily military (33.5 percent) and civil servants (31 percent) followed by police and truck drivers (both at 13 percent of total sex worker clientele in Kabul).[38] The 2009 IBBS revealed that almost half (49 percent) had between 4 - 7 clients per month. It also revealed that 42 percent of FSWs were between 18 and 24 years of age and 81 percent traded sex as the only source of income. Similarly to the ORA International 2003 survey of FSWs in Kabul showing 78 percent of them being married, 65 percent of FSWs interviewed for IBBS were also married[39]. Strikingly, 74 percent could not read or write. The majority of FSWs studied via the IBBS found their clients by telephone (66 percent), pimps and madams (64 percent), as well as taxi drivers (11 percent), at markets (39 percent) and beauty parlors (20 percent). The clients of FSWs were shop keepers (71 percent) and taxi drivers (53 percent), as well as a small number (2 percent) of foreign clients. More than half (58 percent) of FSWs reported using a condom with their most recent client. The IBBS data also indicated that among 70 percent of FSWs who had heard of condoms, 97 percent of them associated them with contraception and only 33 percent had heard of STIs and another 30 percent recognized that sharing a needle was a HIV transmission risk factor. More than half of the interviewed (66 percent) of FSWs reported having STI symptoms while only a third sought care for the STI at a health facility. In addition, 41 percent of them reported having sex with a client while having STI symptoms, 8 percent of FSWs reported being forced into sex and over half (55 percent) reported living outside the country in the last 10 years.

MEN WHO HAVE SEX WITH MEN (MSM): As no robust estimates or behavioral or biological measures are present for MSM, **no data is available on HIV prevalence among MSM**. Although little is known about the extent of MSM behavior or the size of the MSM population in the country due to a tradition of

[32] IBBS, 2009, *Ibid*
[33] University of Manitoba,2007, *Ibid*
[34] UNGASS, 2010, *Ibid*
[35]Andrea Wilson, 2010, *Ibid*
[36] IBBS, 2009, *Ibid;* and Action Aid, 2006, *Ibid*
[37] University of Manitoba, 2007, *Ibid*
[38] Knowledge, Attitude, Behavior and Practice in High Risk and Vulnerable Groups in Afghanistan, Action Aid, 2006
[39] Bazgar, F and Young, A. Survey of Groups of High Risk of Contracting Sexually Transmitted Infections and HIV/AIDS in Kabul, ORA International, 2005; and IBBS, 2009, *Ibid*

sexual relationships of adult men with younger men and boys on one hand, including sexual exploitation of the latter, and high stigma and discrimination and hidden nature of this population on the other hand, sources however suggest that male-to-male sexual contact may play a large role in HIV transmission than previously assumed.[40] The 2006 ActionAid mapping study revealed a close interaction of MSM with female partners (spouses) and young males, and reliance on drugs[41]. In addition, available information indicates that many MSM include those who engage in sex for money and goods, largely unprotected. The mapping study revealed that many of those interviewed in Kabul and Mazar-i-Sharif MSM were actively involved in commercial sex work and had multiple partners.[42] It also demonstrated that in one study location, the MSM had between 12-60 male partners per month from a total network of 100-200 MSM which could total to 86,000 to 144,000 sexual contacts per year for this network. Similarly, the 2009 Naz Foundation International study shed some light on sexual behavior, knowledge and attitudes of MSM in Kabul and Mazar-i-Sharif pointing to alarmingly risky behavior. Over 60 percent of the interviewed MSM reported sexual debut by the age of 19, including 25 percent of those who experienced it by force. Majority (89 percent) of the MSM received goods or money for sex while 26 percent the MSM interviewed in Kabul reported having more than 6 sexual partners in the last month preceding the study, including regular partners, strangers and paid partners of various occupations, and largely police and military.[43] The study also highlighted that MSM had high incidence of having sex with females, especially in Mazar-i-Sharif (both paid and unpaid) and STI symptoms while reporting a low condom use, including during the last sexual encounter with a male. Finally, the study findings suggested that some MSM may include those who perceived male-to-male sex to be somewhat "contextual" given delayed marriage due to its high cost, ban on sexual relationship with women outside marriage, sex with men is considered "safe" (not leading to pregnancy) and less expensive than with FSWs.

PRISONERS: As of November 2009, there were 18,260 prisoners and detainees in the country, including 17,660 male prisoners and 600 female prisoners (as well as 200 children with their mothers among them) in 34 prisons and 203 detention centers in Afghanistan.[44] At the current rate of incarceration, UNODC projects that by 2015 the prison population will rise up to 30,000 persons related to the high level of drug use and readily available drugs in the country. The lack of drug treatment programs and the punitive policies reflected in the Counter Narcotics Law provide requisite conditions for a dramatic increase in country's prison population, with the potential risks of HIV and TB spread. The 2006 study among Kabul IDUs, that included prison IDUs, indicated that over 30 percent of prisoners were injecting heroin.[45] HIV prevalence among prisoners in the country is believed to be growing and is associated with injecting drug use, including regional variation of **0.6 percent of prevalence rate among surveyed prisoners in Kabul and 1.6 percent in Herat in 2009**.[46] However, data obtained in 2008 indicated a prevalence of 11 percent among a small sample of Herat prison IDUs.[47] The 2009 IBBS conducted in Kabul and Herat prisons, a home to the country's largest number of the incarcerated (4,500 prisoners in Kabul and 1,200 prisoners in Herat) - revealed that majority of the interviewed prisoners in Herat (70 percent) were young – between 18-30 years old, married (65 percent), could not write or read (61 percent) and were in prison for more than a year (60 percent). By contrast, only half of Kabul prisoners

[40] Understanding HIV in Afghanistan, National AIDS Control Program, The John Hopkins University, The Indian Institute of Health Management Research, 2008,*Ibid*
[41] Action Aid, 2006, *Ibid*
[42] University of Manitoba, 2007, *Ibid*
[43] Rapid Assessment of Male Vulnerabilities to HIV and Sexual Exploitation, Naz Foundation International, 2009
[44] UNODC 2010 data
[45] Todd, C., Abed A., Strathdee, S., et al. Prevalence of HIV, Viral Hepatitis, Syphilis, and Risk Behaviors Among Injecting Drug Users in Kabul, Afghanistan, 2006
[46] IBBS, 2009, *Ibid*
[47] The World Bank Afghanistan HIV/AIDS Prevention Project Implementation Support Mission Aide-Memoire, June 2008

were between 18-30 years old and 40 percent could not read or write, while the majority (80 percent) spent more than one year in prison. The IBBS 2009 provided first ever information on risk behaviors, including sexual behavior of the prisoners. The majority of the interviewed prisoners (up to 84 percent) reported having sex, including a small number (5 percent) of those who had multiple partners in the last 12 months preceding the study. Over a third of Herat and Kabul prisoners also reported ever buying sex from a FSW, including 12 percent of them doing so in the last 12 months while only 2 percent in Herat and none in Kabul reported condom use with a FSW. When asked if they ever had used a condom, between 12 and 18 percent of prisoners reported using condom. Over 10 percent of all prisoners (in both locations) reported having sex with a male (an adult or a boy) coupled with a significant number of them (75 percent in Herat and 53 percent in Kabul) used drugs, including 25 percent and 10 percent of them using while incarcerated – in Herat and Kabul prisons respectively. Currently, no information is available on sexual behavior of female prisoners, including female IDU prisoners.

POSSIBLE INTERSECTIONS BETWEEN IDU, SEX WORK, AND MSM: Various studies on HIV in Afghanistan point to presence of multiple links or intersections between MARPs, as well as potential links of these populations with otherwise lower risk populations[48]. In the absence of rigorous targeted interventions for all MARPs and comprehensive prevention education among general population taking into consideration high illiteracy levels, high stigma associated with sex, sex work and MARPs, HIV may spread from MARPs to other populations. Research conducted in the country, as well as regionally (South Asia and Central Asia) clearly indicate that the virus can spread from IDUs to FSWs and MSM and their clients and sexual partners, as these populations are in contact with each other. This is also relevant for Afghanistan where MARPs notably exhibit high-risk behaviors. Most IDUs, FSWs and MSM, who are typically under 30 years of age, are married or will be married; some FSWs, MSM and prisoners use drugs, including injecting drugs, while IDUs trade sex for money or drugs. Finally, a considerable number of long distance truck drivers, men in uniform, and male students are clients of FSWs and may engage in male-to-male sex, including with adolescents and children.

Data collected in 2003 and 2006 in Kabul City showed that almost all surveyed IDUs share needles and/or syringes with multiple and concurrent users, almost never use condoms and frequently have sex with FSWs, as well as MSM - primarily young men and boys - either for money or drugs[49]. The findings of IBBS 2009 also confirmed previously obtained information revealing that between 55 and 70 percent of IDUs have ever bought sex from a FSW, while 12 percent of them bought sex in the last six months only 17-32 percent used condom during their last sexual encounter; about 3 percent of IDUs had sex with men[50]. The University of Manitoba 2007 study also indicated high frequency of sexual partners among MSM who were engaged in commercial sex work, i.e. having three clients per day, mostly home-based. The UNODC/MoCN 2009 Survey suggests that a considerable number of IDUs obtain drugs or pay for drugs in exchange for sex and have at least 2 sexual partners in the month prior to the study. There are also indications of a number of female IDUs, particularly among the FSWs, thus pointing to the intersection of drug use and sex work that has serious implications for further spread of HIV/AIDS mainly to the clients of FSWs and sexual partners of the IDUs. The former include long-distance truck drivers, migrant workers, students, police, and military.

[48] Understanding HIV in Afghanistan, 2008, *Ibid*
[49] Community Drug Profile #5, An Assessment of Problem Drug Use in the Kabul City, UNODC, 2003, Prevalence of HIV, Viral Hepatitis, Syphilis, and Risk Behaviour among Injecting Drug Users in Kabul, Afghanistan, University of California, San-Diego (UCSD) 2006
[50] UNGASS,2010, *Ibid*

Women, youth, and children also represent significant segments of the population that are potentially prone to infection as they are in direct contact with MARPs and vulnerable groups (IDUs, FSWs, MSM, truckers, migrant workers, police and the military) and thus are potentially on the "receiving end" of the HIV virus without having knowledge of such risks. Consequently, the possibility of single and multiple intersections within risk groups and further out to the vulnerable populations increases the odds of HIV infection among these populations.

I.1.4. Vulnerable Populations – Long Distance Truck Drivers, Returnees, Refugees and IDPs, Uniformed Services, Youth and Street Children[51]

LONG DISTANCE TRUCK DRIVERS: Existing data (IBBS 2009) report the **HIV prevalence among long distance truck and bus drivers to be presently at zero percent.** However, this group is high mobile including prolonged length of time (up to 30 days at once) and distance travel across the country and to neighboring Iran and Pakistan, countries of higher prevalence rates. Afghanistan relies on road transport routes for international trade over 13 international border crossings and immediate connection to its five neighboring countries (Pakistan, Iran, Turkmenistan, Tajikistan, Uzbekistan, and China).[52] This translates into a large portion of male population engaging in long-distance transport work that is prone to high risk behavior, including exposure to commercial sex, male-to-male sex, and use of alcohol and drug. At the same time, the wives and other sexual partners may also become vulnerable to risk, especially due to their being largely unaware of the sexual behavior of their spouses while absent from home resulting from the taboo around sex as well as cultural expectations that prevent women from discussing or negotiating safe sex. The IBBS noted that long-distance truck drivers estimated at 60,000, including 6,000 of those working in and out of the country, represent a vulnerable group due to their risky sexual behavior. The IBBS results pointed at a number of startling contributing risk factors found among this group such as low literacy level (50 percent), high level of drug use (17 percent) and incarceration (up to 38 percent), high levels of buying sex with FSWs (19 percent) and engaging in sex with men and boys (11 percent) while being married (80 percent) and majority (97 percent) reporting having multiple sex partners

IDPS, RETURNEES AND REFUGEES: There are around 1 million IDPs in the country, of which 865,000 have been re-located to their original places and efforts are being made to re-locate the remaining 135,000 to the places of their origin[53]. In addition to the registered refugees, there are un-registered immigrants (migrant workers or economic immigrants) in Iran and Pakistan.[54] **No data is presently available on HIV prevalence or behavioral data IDPs or refugees and returnees** in Afghanistan. However, evidence from other countries in the region suggest that these groups are potentially vulnerable to HIV as majority had lived a long period of time in Iran and Pakistan and, partially, India – countries with higher prevalence rates, easy availability of drugs and injecting drug, as well as commercial sex.[55] In addition,

[51] In Afghanistan, populations particularly susceptible to HIV include (i) long-distance truck drivers, (ii) refugees, returnees and internally displaced populations (IDPs), (iii) uniformed services (police and military), and (v) youth and street children. However, no systematic data is presently available on HIV prevalence or behavioral data for most of these populations.

[52] Proposed Asian Development Bank Fund Grant for the Islamic Republic of Afghanistan: Road Network Development Project 1, ADB, 2007

[53] Presentation by Ministry of Refugees and Returnees at HACCA meeting, Kabul, 20 April 2010

[54] According to figures provided by the Islamic Republic of Iran and Pakistan, more than one million Afghan economic immigrants who are un-registered live in Iran and more than 300,000 in Pakistan. The Ministry of Refugees and Returnees reported that since 2002 around 6 million people have returned to Afghanistan of which 4.4 have been re-located to their original places. However, there are still 3 million Afghans who live in Iran and Pakistan and elsewhere.

[55] Particular focus is needed on cross-border mobility with Pakistan and Iran, including refugees, those involved in economic activities and Afghan residents in neighboring countries. In the case of Pakistan, for example, a large population of Afghans resides in the main cities of this country, with the majority in the Province of Khyber Pakhtunkhwa (KPK) and the Federally

displacement, mobility, poverty and deprivation can seriously contribute to increasing odds of their HIV risks. At the moment, available information, e.g. the 2006 World Food Program (WFP) study of People Living with HIV (PLHIV) in Afghanistan – indicates that 40 percent of all HIV positive patients surveyed were either not currently living in their place of origin and or just returned from abroad.[56]

UNIFORMED SERVICES: Currently, **there is no data on HIV prevalence among the uniformed services**, including police. However, information available indicates evidence of high risk behavior among this group including drug use, use of commercial sex and sex with men and boys. For instance, a police interventions project (IPIP) under the Integrated Drug Prevention, Treatment and Rehabilitation Project in Afghanistan (IDPA), launched in July-September 2008 revealed that 249 out of the 828 police staff tested were positive for using drugs. Similarly tests carried out from October-November 2008 revealed that out of the 725 police staff tested, 167 were using drugs.[57]

YOUTH AND STREET CHILDREN: Almost 70 percent of Afghanistan's population is below the age of 25, growing up in a challenging and complex environment, marked by poverty and increasing insecurity, lack of access to quality education, and violence.[58] The presence of a large number of street children (estimated at 50,000 persons), including drug users among them, is particularly alarming.[59] While there are no statistics available of how many children in total are living in orphanages in different parts of Afghanistan, UNICEF has estimated that 12 percent of children in Afghanistan are orphans for various reasons.[60] The situation of Afghan girls is of particular concern - under traditional pressures they enter early marriage and early pregnancy, and have limited freedom to escape the norms and traditions that dictate females' lives in many communities around the country. Information on abuse and dependence of children and adolescents on substances indicates that children and adolescents are often involved at a very young age and become familiar with opiate drugs because of drug use at home.[61] Another area of serious concern is related to sexual abuse of male adolescents and children in the country. A 2009 study on male vulnerabilities to HIV and sexual exploitation in Afghanistan highlighted the evidence of sexual exploitation of male adolescents by older males.[62] As the study revealed, almost 61 percent of the interviewed adult males (a purposive sample of 100 persons) had sex with other males, reporting sexual debut by 15 and almost 89 percent of them had been involved in transactional sex. Similarly, women and girls in the country are also prone to violence, including sexual violence in some instances, as well as at detention facilities, or as they become victims of traditional practices to resolve feuds within the family and community, such as forced marriage.[63] In addition, larger numbers of child marriages (43 percent of 20-24 years old women) reported marriage below 18 years of age[64]. Thus, these factors make children, adolescents, and youth particularly prone to HIV-related risks.

Administered Tribal Areas (FATA). In the Province of KPK, and particularly in the provincial capital of Peshawar, Afghans account for a substantial proportion of those seeking health care, including those that cross over the border seeking health care from the bordering districts of Afghanistan. By October 2010, 65 Afghans living with HIV were being followed up by the ART center in Peshawar [source: National and Provincial AIDS Control Program, Pakistan, 2010].

[56] Survey to Determine the Impact of Food Assistance Programmes on PLWHA, World Food Program, MoPH, 2006

[57] GTZ IS, IPIP Internal End of Project Report, 2009

[58] Youth literacy rates are low with 50 percent for boys and 18 percent for girls; secondary school enrolments are respectively 23 percent and 7 percent, and less than 1 percent of the Afghan population obtaining higher education

[59] Best Estimates of Social Indicators for Children in Afghanistan, 2003

[60] A Joint Report of New Orphan Estimates and a Framework for Action, 2004

[61] In some regions of the country, parents provide opium to their children to calm them down to numb their hunger

[62] Rapid Assessment of Male Vulnerabilities to HIV and Sexual Exploitation in Afghanistan, NACP, Naz Foundation International and UNICEF, 2009

[63] Silence is Violence, UNAMA & OHCHR, 2009

[64] Afghanistan National Strategic Framework for HIV/AIDS (2006-2010)

I.1.5 HIV Knowledge

Until recently, no representative evidence existed on knowledge, perceptions and attitudes of MARPs and stakeholder groups, such as policy makers, health professionals and youth, with regard to HIV. Data obtained lately from various studies has made it possible to identify some of the important perceptional trends summarized in this section. One of the first studies conducted among IDUs (2005) determined that 43 percent of **injecting drug users (IDUs)** in Kabul and Herat had heard of HIV/AIDS, 83 percent of whom reported willingness to use condoms to avoid contracting the disease.[65] However, the 2006 mapping study reported that almost 70 percent of IDUs in Mazar-i-Sharif and Jalalabad did not know where to go for an HIV test and 40 percent did not know that sharing needles may lead to HIV infection.[66] The 2009 UNODC,/MoCN *Drug Survey*, the 2009 IBBS, and the 2010 cohort study provided new information among IDUs with some striking differences across findings, although with some indication that contacts with programs were improving knowledge scores. If the UNODC data pointed at relatively low awareness and knowledge about HIV prevention among the surveyed IDUs, both IBBS and the cohort study indicated significantly higher levels of HIV knowledge. The IDUs studied by UNODC reported that many of those IDUs who heard of HIV did not know how it spreads or how its transmission can be prevented. Also, the majority of the studied IDUs never used condoms during sex in the last month of the survey and only a small number mentioned occasionally using condoms. Conversely, most IDUs that participated in the 2010 cohort study (88 percent) were aware of HIV with fairly high accurate knowledge of HIV (63 percent), likely to be associated with the large presence of harm reduction interventions in Kabul compared to other regions. Similarly, the IDUs who participated in IBBS also reported having heard of HIV with 83 percent in Mazar-i-Sharif, 93 percent in Kabul, 96 percent in Herat respectively, including almost all (up to 99 percent in all three cities) identifying needle sharing as a method of transmitting HIV and high condom awareness (between 80- 99 percent) among all surveyed IDUs in all three cities.

Knowledge of HIV among **female sex workers (FSWs)** remains extremely low. Less than 1 percent of FSW in Kabul reported awareness of HIV in 2003, whereas 61 percent of FSWs in Jalalabad and Mazar-i-Sharif had heard of HIV in 2007. The IBBS in 2009 shed some additional light indicating that only 4 percent of FSWs knew their HIV status and that only 2 percent of surveyed FSWs and only 0.7 percent of young FSWs (18-24 years old) were able to correctly identify ways of preventing the sexual transmission of HIV.

Data on knowledge and attitudes of **men who have sex with men (MSM)** made available through the 2009 Naz Foundation International study demonstrated that, in spite of having heard of HIV, poor knowledge prevailed among the studied MSM of Kabul and Mazar-i-Sharif. In both locations, almost half of the respondents failed to provide correct information on the risks of contracting the virus. The IBBS 2009 data revealed that majority of **prisoners** (up to 74 percent in Herat) had heard of STIs and HIV (up to 89 percent in Kabul), while only between 40 percent (in Kabul) and 60 percent (in Herat) had heard of condoms. Likewise, 94 percent of prisoners in Herat and 87 percent of those in Kabul reported knowing of HIV transmission via blood transfusion and mother-to-child (68 percent), however also showing inadequate knowledge – over one-third (37 percent) believing that HIV could be transmitted via a mosquito bite. Only between 26 percent of Kabul and 41 percent of Herat prisoners who have heard of HIV reported correct and consistent condom use as a prevention method.

[65] Study on Knowledge, Attitude, Behavior and Practice in High Risk and Vulnerable Groups in Afghanistan, Action Aid Afghanistan, 2006

[66] University of Manitoba, 2007, *Ibid*

The 2007 mapping study that included a small-scale a survey of truckers on the Uzbekistan border and within Kandaghar trucking routes provided information on knowledge of HIV among **long distance truckers** demonstrating that approximately 34 percent had heard of HIV/AIDS and 7 percent had paid for sex in the previous year, out of which only one quarter had used condoms.[67] Additionally, in a 2005 survey conducted in Kabul by ORA International, none of the truckers reported using a condom during sex with FSWs.[68] The 2009 IBBS revealed that while reporting high level of knowledge about HIV and transmission modes (up to 80 percent) and other STIs (60 percent), only 22 percent reported adequate knowledge about condom use as a preventive measure and only 1 percent knew of HIV prevention services.[69] The 2007 mapping study of **refugees** in Kabul, Herat, Mazar, and Kandahar found that 53 percent of returnees from Iran and 29 percent from Pakistan had heard of HIV/AIDS.[70]

The first ever qualitative study among **policy makers** on HIV knowledge conducted in 2010 revealed that the majority of the interviewed were aware of HIV and AIDS, however lacked correct knowledge of modes of transmission[71]. Stigma and discrimination against MARPs were high among this group, while showing strong respect for the opinions of the country's religious leadership. Another study that also highlighted the perceptions and attitudes of policy makers and health professionals towards the disease and MARPs (i.e. IDUs) demonstrated similar stigma against IDUs and the need of advocacy for involvement of religious leadership, as well as providing awareness to communities and law enforcement.[72] As far as the **general population**, no data on knowledge, behavior, attitudes is available as no household based KABP surveys have been launched in the country.

I.1.6 Prevalence of STI and TB

STI PREVALENCE: Although systematic and rigorous data on STIs is currently unavailable, information collected to-date suggests high prevalence of STIs in certain populations. The IBBS also provided sero-prevalence data on infections other than HIV, such as **hepatitis B (HBV), hepatitis C (HCV), herpes simplex virus (HSV-2),** and **syphilis** among the IDUs, FSWs, prisoners and long distance truckers pointing to potential rapid spread of HCV ad HSV-2 especially among IDUs. Thus, the lowest levels of HCV were reported among the FSW (less than 1 percent) while IDUs reported the highest average rate of 58 percent (across the cities, it ranged from 25.5 percent in Mazari-i-Sharif, 37.5 percent in Kabul to 58 percent in Herat). Surprisingly, truckers, thought to be a sexually active group, demonstrated somewhat lower prevalence rates of 8.2 percent for HBV, 6.6 percent of HCV and 1 percent for Syphilis, and less than 1 percent for HSV-2. Prisoners also reported a relatively lower prevalence across all tested diseases ranging from 1 to 4 percent. The HSV-2 highest rates were also found among IDUs – 20 percent in Mazar-i-Sharif, 16 percent in Kabul and 4.4 percent in Herat, followed by 10 percent among FSWs. For other diseases, the FSWs also reported lower rates of 3.5 percent of HBV and 5.4 percent for Syphilis.

[67] Mapping and Situation Assessment of High Risk Key Populations in Three Cities of Afghanistan, University of Manitoba, 2007, *Ibid*
[68] Bazgar, F and Young, 2005, *Ibid*
[69] IBBS, 2009, *Ibid*
[70] Todd, C., Abed, A., Strathdee S., et al, Association Between Expatriation and HIV Awareness and Knowledge among IDUs in Kabul, Afghanistan: A Cross-Sectional Comparison of Former Refugees to Those Remaining During Conflict, Conflict and Health, 2007
[71] HIV-Related Knowledge, Attitudes and Beliefs of HIV Policy Makers & Persons who Influence HIV Policy in Afghanistan, John Hopkins University, 2010
[72] Todd, C. et al, 2010, *Ibid*

TUBERCULOSIS (TB): Afghanistan has one of the highest TB prevalence rates in Central Asia and it tops the list of 22 high-burden TB countries in the world. According to the World Health Organization (WHO), approximately 46,000 new TB cases occur annually in Afghanistan, and 8,200 people in the country died from TB in 2007.[73] TB cases have been disproportionately high among the female population who are infected more than twice than men: almost 70 percent of the notified cases are women. Current data suggest that there are 70,000 new TB cases per year and the TB Annual Risk of Infection is 2.25 percent. Annual new cases of TB per 100,000 people are 168 and new Sputum Smear (ss+) cases per 100,000 per year are 76. The HIV incidence among TB cases is calculated at 0.02 percent.

[73] World Health Organization's (WHO's) Global Tuberculosis Control Report, 2009

I.2 NATIONAL RESPONSE

I.2.1 INSTITUTIONAL FRAMEWORK

Since 2005-2006, the Government of Afghanistan (GoA) has taken numerous steps towards a comprehensive multi-sectoral HIV response with the financial support of international donors and technical assistance of development partners, involvement of public and private sector stakeholders, and participation of local and international NGOs. In particular, the Afghanistan National Development Strategy (ANDS) had been developed to identify priority policy and program areas for seventeen sectors to achieve the Millennium Development Goals (MDGs), including setting a five-year target to maintain low prevalence (<0.5 percent) of HIV and to reduce mortality and morbidity associated with AIDS by the end of 2010 (Jaddi 1389).[74] Consequently, in October 2006, the GoA approved the Afghanistan National HIV/AIDS Strategic Framework (ANASF) for 2006-2010, and thus to move 'Towards Universal Access for Prevention, Care and Treatment, and Mitigation of the HIV/AIDS epidemic'.[75] Subsequently, within the implementation of ANASF 2006-2010, a number of important achievements have been made by the GoA, namely under the leadership of the Ministry of Public Health (MoPH) and National AIDS Control Program (NACP) that covered areas of: (a) policy, planning, and institutional development; (b) HIV/AIDS programming for most-at-risk populations (MARPs); (c) Information, Education and Communication (IEC) campaigns; (d) provision of STI services; (e) establishing linkages between the National TB Program and Reproductive Health; (f) setting up of Voluntary Confidential Counseling and Testing (VCCT) centers; (g) launching blood safety; and (h) harm reduction programs.[76] The GoA has also encouraged a multi-sector response to HIV translated into commitments made from other relevant ministries, including the Ministry of Counter Narcotics (MoCN), Ministry of Interior (MoI), Ministry of Justice (MoJ), and Ministry of Hajj and Religious Affairs (MoHRA) among others. Efforts have also been made to achieve better coordination of implementation at various levels, including integrating HIV/AIDS into the national health system where relevant and as a part of the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Eight of the 34 provinces have HIV advisors who facilitate coordination and integration at the provincial level. Many provincial governmental directorates, such as those of Women Affairs, Prisons, Culture and Youth Affairs, and Religious Affairs, are involved in the HIV response at national and provincial levels.

POLICY, STRATEGY AND GUIDELINES DEVELOPMENT

As a part of the implementation activities of the ANASF 2006-2010, several policies and guidelines have been developed and approved in the country. One of the important achievements includes adoption of the **Harm Reduction Strategy for IDUs and HIV/AIDS Prevention** in 2005 of the MoCN and MoPH, **National Drug Control Strategy** by the MoCN in 2006 and **National OST Policy** in 2010, developed to provide further policy support for implementing a full package of services for drug-related harm

[74] Afghanistan National Strategic Framework for HIV/AIDS (2006-2010), NACP, MoPH, October 2006; Afghanistan National Development Strategy (ANDS)

[75] The ANASF 2006-2010 put forward 6 objectives, including: (i) **Strengthening Strategic Information** to Guide Policy Formation, Program Planning and Implementation; (ii) **Gaining Political Commitment and Mobilization of Resources** necessary to Implement the National HIV/AIDS Strategy; (iii) **Ensuring Development and Coordination of a Multi-Sectoral HIV/AIDS Response** and Developing Institutional Capacity of All Sectors Involved; (iv) **Raising Public Awareness on HIV/AIDS and STI Prevention and Control**, and **Ensure Universal Access** to Behavior Change Communication on HIV/AIDS, Especially Through Targeting High-Risk Groups and Vulnerable Populations; (v) **Ensuring Access to Prevention, Treatment and Care Services** for High-Risk Groups and Vulnerable Populations; (vi) **Strengthening the Health Sector Capacity** to Implement an Essential Package for HIV/AIDS (EPHA) within the Framework of BPHS and Essential Package of Hospital Services EPHS.

[76] NACP was established in 2003

reduction in Afghanistan. HIV/AIDS concerns were addressed in a number of strategies, including the **National Health Policy 2005-2009** and the **National Health Communications Policy and Strategy 2004-2007** that have an objective on HIV/AIDS. In 2007, a **Communication Strategy for Building an Enabling Environment for Targeted Interventions** was developed. The **National Strategic Plan for TB Control 2006-2010** was formulated in 2005 followed by the **National TB and HIV Policy, Strategy and Guidelines** prepared in 2007**.** In addition, a **National Reproductive Health Strategy** has integrated HIV/AIDS into its programming. A number of other health-related guidelines have been formulated and approved, including the **National Drug Treatment Guidelines** of the MoCN and MoPH in 2006, the **National HIV Testing and Counselling Guidelines** in 2007, the **Basic Package of Health Services** and the **Essential Package of Hospital Services** both developed and became active in 2005 and included an HIV/AIDS component. In 2007, the MoPH also has completed the draft **National Guidelines on VCCT** and, in 2008, it approved the **Blood Transfusion Policy**, which aims to strengthen transfusion safety, including quality testing of blood for HIV and other blood-borne diseases. The MoPH has also developed a comprehensive plan for strengthening access to safe blood formulated through the **Blood Safety Program** currently underway. In 2007, the **National Strategy Plan for the Monitoring and Evaluation** of the MoPH has been developed. In 2007 as well an **HIV Communication Strategy** has been drafted followed by the **Monitoring and Evaluation Plan for HIV Prevention, Treatment, Care and Support in Afghanistan** formulated in 2009.[77] Finally, the **National HIV/AIDS Policy** has been developed in 2010 and is awaiting approval of the MoPH.

COORDINATION MECHANISM

The **HIV/AIDS Coordination Committee of Afghanistan (HACCA**) was established in 2007 to coordinate the multi-sectoral response. HACCA is a body chaired by the Deputy Minister of Public Health and has representatives from several ministries, UN agencies, NGOs, and technical agencies. HACCA has been a platform for high level advocacy, policy engagement and coordination. In November 2009, in order to better organize HACCA activities and avoid possible duplication with the NACP, the 2007 Terms of Reference were revised by a technical group, and an operational guide was developed. Accordingly, the HACCA is currently mandated with (a) providing an advisory role; (b) assisting with the mainstreaming of the HIV in sectors; (c) facilitating the national response; (d) calling upon specific agencies or the NACP to share progress on HIV-related thematic issues; (e) advocating for scaling up of HIV/AIDS interventions as a national priority; and (f) information-sharing through convening regular meetings and by issuing of a newsletter. Accordingly, a number of **working groups were** facilitated by the NACP aimed to facilitate exchange of information, identify issues and recommend solutions for those issues. The working groups cover the areas of (a) harm reduction, (b) prevention; (b) treatment, care and support; (c) surveillance and M&E, (c) advocacy and communication and (d) vulnerable populations. These groups are represented by all relevant participating ministries (MoCN, MoJ) and partners (UN agencies, NGOs) and meet on a regular basis. In order to **coordinate** the development, implementation, monitoring and evaluation and oversight of the **Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)** grants, the **Country Coordinating Mechanism (CCM**) was also established to facilitate the national response for AIDS, TB and Malaria and has been playing a major role in the multi-sectoral agenda. In addition, the **Joint UN Team on AIDS** (Joint Team) was established on March 2009 and is co-chaired by WHO and the Joint UN Program on HIV/AIDS (UNAIDS). Three Joint Team working groups are now operational: Prevention Education and Communications led by the United Nations Educational, Scientific and Cultural Organization (UNESCO), Drug Use led by UNODC, and Strategic Information led by the WHO. In addition, an **HIV/AIDS Task Force** was established with key partners and stakeholders including the GoA, UN family, donor and development partners, and NGOs.

[77] Building an Enabling Environment for Targeted HIV/AIDS Interventions: A Communication Strategy, 2007

Operational Response

In March 2007, a **Program Operational Plan (POP)** was designed as a roadmap to implement the ANASF 2006-2010. Activities proposed within the POP aimed to provide a comprehensive framework for the country to build a solid platform to respond to HIV/AIDS, serve as the main mechanism for achieving the 'Three Ones' and ensure that external sources of financial and technical support are effectively coordinated and aligned around the country systems. In 2007, the CCM led the preparation and submission of the **Round 7 of the Global Fund (GFATM)** also formulated within the scope of the POP and was accepted for financing in 2007. Further funding for the national response was provided through the World Bank supported **Afghanistan HIV/AIDS Prevention Project (AHAPP**) commenced in 2007.

I. 2.2 PROGRAMMATIC RESPONSE: PREVENTION, TREATMENT, CARE AND SUPPORT, STRATEGIC INFORMATION, AND M&E

Interventions in the area of HIV prevention have been reinforced since 2007 and focused on: (a) MARPs, (b) vulnerable populations and (c) the general population, implemented with assistance from 10 international and national NGOs or implementing partners (IPs) and financed through the GFATM Round 7, the World Bank's Afghanistan HIV Prevention Project (AHAPP), and, partially, through UN agencies (UNODC, UNAIDS, WHO, UNICEF, UNFPA, etc.) across eight provinces of the country – Kabul, Herat, Mazar-i-Sharif, Ghazni, Badakhshan, Kunduz, Kandaghar, and Jalalabad.

I.2.2.1. PREVENTION AMONG MOST-AT-RISK POPULATIONS (MARPS)

INJECTING DRUG USERS (IDUS): Interventions targeting IDUs have been provided in line with global recommendations on the comprehensive package of services required for HIV prevention, treatment and care among IDUs and notable achievements have been made in the provision of first ever: (a) harm reduction as well as (b) drug treatment services in the country.[78] ***Harm reduction*** activities for IDUs include the distribution of safe injecting kits, collection of used needles and syringes, syndromic management of STIs, counseling for blood borne diseases including VCCT for HIV, Hepatitis C/B testing, condom promotion, primary health care and abscess management, overdose management, referral for TB services, referral to ARV, as well as social services like hygiene kits and nutrition. In terms of target groups and programmatic area coverage, the World Bank and the GFATM fund most interventions in this area, while UNODC, UNAIDS, and WHO additionally focused on support to: (a) female drug users, (b) drug use among returnees and refugees, (c) advocacy and policy dialogue, particularly on OST, and (d) social and night shelter support to street-based and homeless drug users.

UN agencies and the donors also assist NACP in strengthening of its institutional capacity, as well as that of implementing NGOs. However, some serious challenges are present, including limited geographic coverage to achieve targets for IDUs (Table 1). After several years of policy dialogue and logistical challenges, OST is now available on a pilot basis in a centre run by MDM in Kabul, where by November

[78] WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, WHO Europe, WHO, UNODC, UNAIDS, 2009

2010, 70 persons were receiving methadone maintenance therapy (MMT) while there is need to reach a much large number of the total population of IDUs in the coming years and across the key urban centers. The status of the HIV epidemic among IDUs is also unknown in several urban localities, such as in Jalalabad, as the IBBS 2009 did not cover this city while it is believed to be prone to greater HIV risks than previously assumed.[79]

Table 1: Coverage Gap of Prevention Services among IDUs

	Details	Number
1	Estimated number of IDUs in Afghanistan[80]	20,000
2	Estimated number of IDUs in Kabul[81]	1,261
3	Estimated planned coverage of Needle Syringe Programs (NSP) in the country (2011)[82]	2,400
4	Estimated planned coverage of OST (2011)[83]	200

In terms of ***drug treatment,*** there are a total of 46 treatment centers across 21 provinces supported mainly by the MoCN and the 'Colombo Plan' of the MoPH as well as a range of residential and community based drug treatment centers operated by international and local NGO. Services to the community are free of charge and usually include detoxification treatment, counseling, HIV awareness education, residential rehabilitation, after-care, and/or referral.

Coverage of programmes of harm reduction, in particular of NSP, remains low and insufficient to have impact. UNODC, WHO and UNAIDS Guideline recommend that 60% coverage of NSP (5 of IDUs reached regularly by NSP) is required to prevent the epidemic. Similarly, the coverage of existing programmes is limited in geographical areas and need to be expanded.

FEMALE SEX WORKERS (FSWS): There are currently 2 programs available for FSWs in Kabul and Mazar-i-Sharif with a target of 400 FSWs in total. Services include syndromic case management of STIs, promotion of knowledge and consistent condom use, as well as VCCT are made available. These services need to be reinforced in terms of range of interventions as well as geographic coverage.

MEN WHO HAVE SEX WITH MEN (MSM): Two health centers catering for MSM and others are functional in Kabul and Mazar-i-Sharif. Due to the high stigma associated with MSM, these centers are designed as 'male health clinics'. Services include syndromic case management of STIs, promotion of knowledge and consistent condom use, as well as increasing awareness. In addition, Blood Borne Diseases (BBD) tests, HBs vaccines and general primary health care are made available. Currently, Afghanistan is one of seven country recipients of the **GFATM Round 9 Regional Proposal on Reducing the Impact of HIV on MSM and Transgender Populations in South Asia**, including countries such as Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka. The proposal aims to support a five-year program starting in 2011 that will lead to the development and strengthening of community-based organizations (CBOs) and adapted systems to address risk and vulnerabilities of MSM to HIV by improving the provision of comprehensive HIV prevention, treatment, care and support to them. The program will also help build

[79] UNGASS, 2010
[80] National Drug Use Survey, UNODC, MoCN, 2009
[81] This estimate has been made by the Mapping and Situation Assessment of High Risk Key Populations in Three Cities of Afghanistan, University of Manitoba, 2007
[82] These figures are based on targets and they are expected to increase based on an analysis made in October 2010.
[83] This is the target for the community based OST in Kabul implemented by Medecins du Monde (MDM).

engagement in policy development and advocacy, address stigma and discrimination, as well as undertake operations research on issues related to MSM.[84]

PRISONERS: Harm and risk reduction activities for prisoners target primarily IDU prisoners, including in 8 cities: Herat, Ghazni, Kabul, Kandahar, Balkh, Kunduz, Jalalabad, and Badakshan under the World Bank and GFATM supported nationally implemented projects. In addition, UNODC is supporting interventions in female prisons in Herat, Kabul, Parwan, Balkh, Jalalabad, and Badakshan. However, the harm reduction response in prisons remains limited and condoms, MMT and NSP are not yet permitted in prison settings despite ongoing policy dialogue. Institutionally, while the Ministry of Justice (MoJ) is responsible for the management and operations of provincial prisons and district detention centers, the MoPH is responsible for provision of health services to the prison population formulated through its Prison Health Strategy (PHS) which is expected to be rolled out via BPHS and EPHS financed by the World Bank, the European Committee (EC) and the Government of the USA.[85]

I.2.2.2. PREVENTION AMONG VULNERABLE POPULATIONS

TRUCKERS: Interventions for long-distance truckers and road transport workers include actions in Jalalabad (5,000 truckers), Chamtala (5,000 truckers) and Komany (5,000) via truckers implementation units (TIU). Services include syndromic case management of STIs, promotion of knowledge and consistent condom use, as well as generally increasing awareness.

UNIFORMED SERVICES: Training of Trainers (TOT) curriculum has been developed for the police to provide essential information on HIV and other blood borne diseases, as well as sensitization on substance abuse as well as discrimination against the rights of drug users. Accordingly, most recently a total of 200 police personnel received training in 5 provinces (Ghazni, Nangrahar, Kunduz, Badakshan, Herat and Kabul) in November 2010.[86]

REFUGEES, RETURNEES AND IDPS: Through GFATM Round 7 support as part of 'Strengthening Provincial HIV and AIDS Program' (SPHP), activities are being implemented in four border passage sites in Torkham in Nangarhar, Sherkhan Bandar in Kunduz, Islam Qala in Herat, and Daman district in Kandahar. Basic education on HIV and STI is provided on site and informative leaflets are distributed containing contacts of key personnel in HIV and AIDS centers in the 8 provinces. In terms of regional cooperation, regular tripartite meetings between Afghanistan, host countries and UNHCR are held to address general issues associated with Afghan immigrants and refugees.[87] NGOs have also been selected, in consultation with the NACP, and mobile outreach units have been established in Herat and Nangarhar, and harm reduction services are being provided to Afghan returnee drug users since February 2010. An assessment of the HIV and drug use situation and a mapping of services among returnees/ deportees in

[84] GFATM Round 9 Regional Proposal on Reducing the Impact of HIV on MSM and Transgender Populations in South Asia, 2010
[85] Components of the Prison Health Strategy (PHS) include Prevention, Epidemiological Surveillance, Curative Care, Specialized Medical Care, Communicable Disease Control and Treatment, Mental Health, Drug User Services, Disability, Detention-Specific issues, Antenatal and Postnatal Care, Child Health and Immunization, and Essential Drug Supply.
[86] Information provided by NACP, November 2010
[87] Tripartite agreements with Iran, Pakistan and other countries have been signed. In Kabul Airport, a supervisory unit supported by IOM and the Ministry of Refugees and Returnees operates, where medical services are provided and support is provided in transportation and re-location of returnees. In addition, UNODC and UNHCR are carrying out a joint regional project (2009-11). It involves the Governments of Afghanistan, Iran and Pakistan and provides comprehensive HIV prevention and care services to Afghan refugee drug users in Iran and Pakistan, and returnees in Afghanistan.

Afghanistan is being carried out in Kabul, Parwan, Baghlan, Jawzjan, and Herat. A directory of services for returnees is also being developed. Finally, UNAIDS supported a programmatic and service-providers exchange between NACP Afghanistan and the government and NGO counterparts that provide services to reach Afghans in Pakistan, including on continuum of care, ART, and Prevention of Mother-to-Child Transmission [PMTCT]. Starting in 2011, regular coordination will be established between the NACPs in both countries, including between ART centers given that people living with HIV among the Afghan populations are followed up in health services in cities such as Peshawar in Pakistan as well as in Kabul.

YOUTH: Numerous activities have been initiated jointly by the NACP, HACCA and UNICEF in collaboration with the Youth Department of the Ministry of Information, Youth and Culture (MoIYC), including (a) HIV awareness among youth in Kabul, Herat, Nangrahar, and Mazar-e-Sharif between September 2009 and June 2010 targeting over 30,000 young people (equal number of male and female youth) through 475 sessions in these provinces; (b) delivery of the IEC/Behavioral Change Communication (BCC) materials such as posters, leaflets, magazines, as well as copies of TV and radio skits; and (c) a three-day Training of Trainers (TOT) workshop was held in May 2010 at the Kabul Youth Center. In addition, the HIV/AIDS issues have been included in the national education curriculum for grades 4 to 12. In selected provinces, the MoPH has initiated reproductive health and HIV/AIDS activities specifically for out-of–school youth by establishing youth information centers and youth-friendly services. Since 2007, UNICEF provides technical, financial and material support to the MoIYC to increase opportunities for youth development and participation through the establishment of Youth Information Contact Centers (YICCs). YICCs have conducted training workshops on different areas, including HIV/AIDS, peace-building, child rights, elimination of discrimination against women, drug abuse, dangers of mine and unexploded materials, etc. In 2010, sensitization and awareness workshops were also conducted for 1,471 youth members from these training centers.

I.2.2.3 PREVENTION IN THE GENERAL POPULATION

BLOOD SAFETY: The Afghanistan National Blood Service and Transfusion Safety (ANBSTS) was created in 2008. Among the achievements of the ANBSTS include the nomination in 2010 of the Kabul Regional Blood Bank as a center of excellence. The NACP reported the procurement and distribution of 20,000 HIV test kits through blood banks, while the total number of units of blood collected from all blood banks totaled over 31,000 units in 2008-2009. Another area of progress is related to blood transfusion being incorporated into the BPHS and EPHS resulting in the provision of blood transfusion services at both regional and provincial facility level including screening for Hepatitis B and C, HIV and blood group type. There are also separate health systems for the Afghan National Police (ANP) and the Afghan National Army that also undertake include blood screening. Lastly, a blood assessment is being carried out by the Health Protection and Research Organization (HPRO) aiming to describe the extent and quality of blood donation practices and the safety of the donor blood supply in Afghanistan and to provide meaningful information for blood banks and transfusion policy and programming .

TB/HIV COLLABORATIVE ACTIVITIES: In 1997, Afghanistan's National TB Control Program (NTCP) adopted the DOTS (Directly Observed Therapy Short-Term) - the internationally recommended strategy for TB control - that has resulted in a significant leap in the program's population coverage to 97 percent in 2007 and a case detection of 64 percent. This has been achieved through BHPS and EPHS delivery systems, currently technically supported through WHO and implemented by international and national NGOs, and due to the increased international donor support, improved inter-country coordination, and greater

collaboration between public, private sector providers and communities. TB control services are implemented largely by NGOs. However, the treatment success rate fell below 85 percent after four years of being above this target. Moreover, the management of multi-drug-resistant (MDR) TB, extensively drug-resistant TB and diagnostic capacity are extremely limited in the country.[88] In terms of TB/HIV collaborative activities, some of the key achievements up to September 2010 include the development of the TB/HIV Guidelines and Curriculum. In order to enable coordination at the national and provincial levels, TB/HIV Task Force committees have been established at both levels and a referral system between TB and HIV programs has also been established. So far, around 140 PLHIV have been screened for TB and around 3,177 TB patients have received HIV counseling and testing. So far, 7 persons who are HIV positive and are TB patients have been referred to the ART centre for care and support services during TB treatment.

MANAGEMENT OF STIS: As the NACP has initiated provision of STI services as a prevention strategy for HIV, STI clinical services have been providing an important point of access to MARPs, vulnerable and general populations. The NACP has designed targeted interventions for MARPs through STI diagnostic and treatment facilities and HIV risk minimizing services. The WHO standard STI, Reproductive Tract Infection (RTI) and syndromic management guidelines were adopted, translated, printed and disseminated to service providers. In addition, an STI component has been integrated into the BPHS. STI services are also available at the ART Centers as well as some of the VCCT and harm reduction services for MARPs. However, there is very minimal staff capacity, shortage of medicines and lack of a standard unique treatment protocol.

PMTCT: There is currently no data available on the extent of mother-to-child transmission of HIV though a few cases were reported in 2010. However, there is alarming evidence on Afghan women's vulnerability with respect to their reproductive health. Maternal mortality in Afghanistan is among the highest in the world and stands at 1,600 per 100,000 live births. Nearly one in three pregnant women (32 percent) only is provided care during pregnancy by a skilled health workers and nearly 19 per cent deliver with a skilled attendant. In terms of infant feeding practices, the exclusive breastfeeding rate of children between 0 and 5 months of age is 83 percent. The percentage of children 6 – 9 months of age that received liquid and solid food in addition to mother's breast milk in the last 24 hours is around 28 percent.[89] However, some progress has been noted in this area. A working group on the Prevention of Parent-to-Child Transmission (PPTCT) or Prevention of Mother-to-Child Transmission (PMTCT), has been established and the orientation training of hospital focal points from five regional hospitals has been completed on PPTCT. Operational guidelines, monthly reporting formats and monitoring checklists have been prepared which have been finalized by the PPTCT Working Group in December 2010 with services to be initiated in 2011.

VCCT: By 2007, the MoPH had established 6 voluntary confidential counseling and testing (VCCT) centers, including two in Kabul and one each in Jalalabad, Mazar-i-Sharif, Faizabad, and Herat. In 2008 and 2009, 5 more centers were added. As a result, a total of 19,875 persons were tested for HIV and currently know their status, including 42 percent of women among them. In addition, VCCT has been incorporated at community level via the Community Health Centers (CHCs) under the BPHS.

LIFE SKILLS EDUCATION (LSE): Life-skills education (LSE) program developed by the Ministry of Education (MoE) and MoPH aims at school children and adolescents and is implemented by an NGO (ARSC). As a

[88] USAID, Infectious Diseases, Afghanistan, 2009
[89] Afghanistan Health Survey, MoPH and John Hopkins University, 2006

result, in 2008 and 2009, LSE program coverage reached over 122 schools. In addition, MoPH has launched a number of reproductive health and HIV activities for out-of-school youth via youth information centers and youth-friendly services. Lastly, HIV has been included in the new national education curriculum for grades 4-12.

ADVOCACY AND COMMUNICATION: Interventions for advocacy and communication is marked by development of an HIV Communication Strategy in 2009 that outlined NACP's approach to communicating HIV messages and increasing awareness and commitment to HIV among key stakeholders and social actors, including religious leaders, communities, mass media, and service providers[90]. In 2009, Advocacy TOT was conducted for NGOs working on harm reduction. Similarly, religious leaders were also sent to Indonesia on a study TOT. As for the general population, MoPH has been launching HIV/AIDS awareness campaigns via health workers, religious leaders, and community elders in a form of short radio and TV clips and skits in 2008-2009, brochures, posters and other visuals were distributed in 8 major urban areas. Finally, the World AIDS Day had been observed nation-wide since 2003 (annually) and HIV and AIDS Media Award Program is announced since 2009.

I.2.2.4 TREATMENT, CARE AND SUPPORT

ART: One of the main recent achievements of the national response has been the establishment of Antiretroviral Treatment (ART) and development of the Adult ART Guidelines in the country. Currently, the MoPH provides HIV treatment services through two ART Centers established in 2009 in the Infectious Diseases Hospital in Kabul and in the Public Health Hospital in Herat. By December 2010, 89 PLVIH have been registered at these centers, including 70 of them currently on treatment. The main services available in the centers are ART treatment services, treatment of opportunistic infections and TB diagnosis. Currently, the ART centers also provide hemoglobin determination, full blood count with differentials as well as CD4 count.

HIV CO-INFECTIONS: Interventions to prevent various common opportunistic infections among HIV infected individuals are available at the 2 ART centers of the country. These include that screening to detect common diseases such TB, Hepatitis, pneumonia, diarrhea and other conditions in children or adults living with HIV are available, and interventions include the provision of Cotrimoxazole for HIV registered cases in ART centers to prevent Pneumocystis Pneumonia (PCP) and Toxoplasmosis in adults and children living with HIV.

INVOLVEMENT OF PEOPLE LIVING WITH HIV (PLVIH): Involvement of the PLHIV in the national AIDS response in Afghanistan reported is presently non-existent, and interventions to strengthen this area have been limited. Similarly, nutritional and socio-economic support programs for PLHIV and their families are not available and nor are psycho-social and continuum of care interventions in place. As of 2010, there has been minimal development of support groups on people living with HIV other than by MDM and other NGOs for a limited number of IDUs living with HIV. The existence of stigma and discrimination associated with HIV is one of the main challenges for the HIV response as whole.

I.2.3. STRATEGIC INFORMATION AND M&E

I.2.3.1 STRATEGIC INFORMATION

[90] For example, 60journalists were trained on HIV and Afghanistan Media Watch have been initiated in 2000

One of the major achievements in this area has been the establishment of 2nd Generation Surveillance in Afghanistan and completion of the first ever comprehensive Integrated Bio-Behavioral Surveillance (IBBS, 2009) among MARPs and vulnerable populations, including IDUs, FSWs, prisoners, and long-distance truck drivers. The results of the survey have important implications for the NACP as the IBBS indicated (a) injecting drug use is increasingly the major source of new HIV infections, with highest rates reported in Western Afghanistan; (b) HIV prevalence is also high among prisoners (mostly IDUs); (c) HIV prevalence is at zero percent among FSWs and road transport workers, suggesting limited sexual transmission in Afghanistan to date, but with (d) high rates of STIs, blood borne viruses and risk behavior in the surveyed groups. Among other studies launched in 2006-2010 include (i) the University of Manitoba (UoM) study in Kabul, Herat, Jalalabad, and Mazar-i-Sharif among at-risk and vulnerable groups in 2006 on 'Social Mapping of High-Risk and Vulnerable Groups'; the University of California at San Diego (UCSD) Sero-behavioral study on IDUs and FSWs in the same locations in 2006-2007; and a (iii) study among TB patients (1,200 persons) in seven provinces, including HIV testing. A second round of IBBS is planned under World Bank funding in 2012 which should serve as a means to establish the foundations of longer term surveillance to ensure surveys are conducted around every 2-3 years. Nevertheless, the need for evidence for programmatic and policy guidance is still essential as little remains known on the trends over time of the epidemic, regional variations, the relative importance of different vulnerability factors, and adapted prevention approaches to programs on sexual transmission .

I.2.3.2 MONITORING AND EVALUATION (M&E)

With regard to the M&E of the HIV response**,** the NACP has taken the role of ensuring the use of standardized and unified M&E and surveillance system at the country level and in quality reporting. At the moment, the NACP is gathering HIV and AIDS data from eight provinces through provincial HIV advisors, Health Management Information System (HMIS) officers and various local and international NGOs. The NACP is then analyzing and interpreting data and utilizing it for decision making, public awareness and other purposes. The World Bank and GFATM Round 7 are also supporting this process of keeping a standard and unified M&E system at the national level. NACP standard tools have been distributed to NGOs to be used at each service delivery point. Reports, updates and other necessary information are widely shared with all stakeholders through HACCA, CCM and HIV/AIDS quarterly reports. The Surveillance Working Group (SWG) has been established in 2007 to provide (a) technical support the development and implementation of an HIV M&E Plan (prepared in 2008) and (b) to ensure its integration with the M&E Strategy of the MoPH. [91] The SWG was able to develop a routine reporting format for harm reduction services, vulnerable populations and VCCT. However, existing human resources for M&E are limited as the NACP includes only one M&E Consultant (national level) responsible to assist the implementation of M&E activities at national and provincial level. Finally, the SWG has not met since 2010.

I.2.5 HEALTH SYSTEMS STRENGTHENING

HEALTH SYSTEMS: Efforts have been made to strengthen health system capacity to provide better HIV services. Currently, HIV services are integrated within the BPHS and EPHS which is a significant milestone. The BPHS is implemented in districts where 85 percent of the country's population resides.[92] The BPHS provide services starting from the health post level. Community Health Workers (CHWs)

[91] SWG consists of World Bank, UNODC, WHO, Johns Hopkins University (JHU), UNICEF, and GTZ and it assists the NACP to apply its available resources and implement the M&E Plan, organize capacity-building for the NACP, ensure adequate surveillance, and timely reporting from all service providers

[92] BPHS, 2009

include HIV messages in their health promotion activities in the community and referral of clients. The Comprehensive Health Centers (CHCs) and the District Hospitals (DHs) include testing and counseling for HIV and also onward referrals. The EPHS also delivers VCCT although little is known on the extent and quality of their service provision. The specialized services for the prevention and treatment of HIV, including harm reduction and ART, will continue to be implemented through a more vertical program with services available in key urban centers across the country until the financial and technical capacity within the national health system is improved. Some examples of progress made includes GFATM Round 7 funding providing training for 700 health care providers of BPHS implementers in 8 provinces conducted by Action Aid. In addition, HIV guidelines were developed by the NACP to 48 NGOs implementing the BPHS in 8 provinces.

I.2.5 CURRENT FINANCING OF THE NATIONAL RESPONSE

Up to November 2010, it is estimated that USD 12 million had been spent on HIV response in Afghanistan in recent years. As prevention remains a top priority, to-date 46 percent of all funding was for this area, while program management and administration accounted for 22 percent. The third major cost was on research (17 percent), as it remained a priority to secure adequate evidence to mount a relevant response (Figure 1). As reflected in Table 2, key donors and development agencies that provide financial support include the GFATM, World Bank, bi-laterals, and the UN.

Figure 1: HIV Spending Categories in 2010

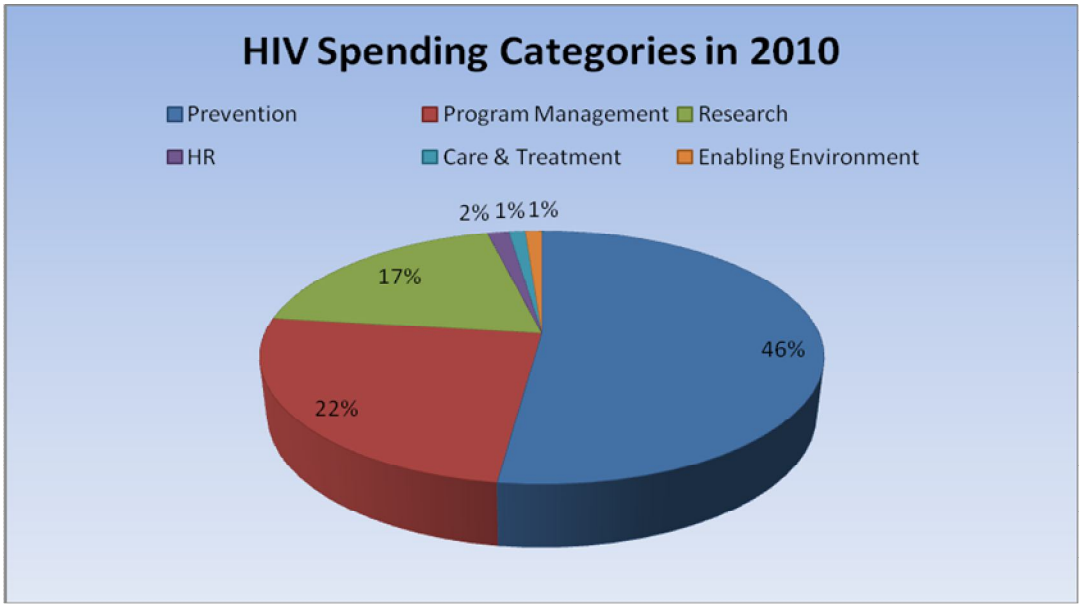

Table 2: Inventory of Funding Per Program, 2009-2011[93]

	Project Name	Funding Source	Amount USD MLN	Duration	Starting Date	Ending Date
1	Afghanistan HIV and AIDS Prevention Project (AHAPP)	World Bank	10	3 Years	Sep 2007	Dec 2010
2	Strengthening HIV/AIDS Provincial Program	GFATM	11	2 years	Oct 2008	Nov 2013
3	HIV and AIDS Prevention, Treatment and Care for Female Injecting Drug Users and Female Prisoners in Afghanistan	UNODC	1.1	2 Years	2008	2010
4	Supporting HACCA	USAID	1	1 Year	2009	2010
5	Prevention among Drug Using Refugees and Returnees	UNODC	1.8	30 Months	2009	Mid 2011
6	Other Programs and Projects [UNICEF, UNAIDS, WHO]	UN Agencies	0.5	--	2009	2011

[93] UNGASS, 2009, *Ibid* and data from the Finance Department of the NACP, MoPH

Part II: Results-Based Strategic Framework for 2011-2015

II.1 KEY PRIORITIES

The NSF-II is elaborated in continuity of the ANASF-I goal to achieve universal access to HIV prevention, treatment, care and support for at-risk and vulnerable populations and people living with HIV. Drawing on the situation and response analysis in Part 1 of this document, key priorities for the NSF-II are defined in this section.

Preventing the further progression of the HIV epidemic among IDUs and their partners will be the foremost priority for the NSF-II, with resources allocated commensurate to the needs to expand coverage of harm reduction and improve the quality of implementation of programmes. Evidence on epidemic dynamics suggests that HIV infection is primarily concentrated among IDUs with rates of HIV infection varying from 1% to 18% prevalence.

Second, Prisons constitutes a second priority though in a more confined setting, given the considerable rate of IDUs among those imprisoned and the potential overlap with unprotected sexual behavior.

Third, the Intersection of risk behaviors, including unsafe injection of drugs with unsafe sex, warrants particular attention in the NSF-II given the potential for onward HIV transmission from IDUs to their sexual partners.

Available evidence also indicates that HIV prevalence is currently 0% among sex workers and is unknown among men who have sex with men, but high rates of STIs and risk behaviors exist coupled with pervasive socio-legal stigma and discrimination. Thus, investment in the development of programmes will be undertaken at appropriate scale to maintain these populations free of HIV infection and improve their access to services.

Similarly, investment on programmes for other identified vulnerable populations will be relatively more limited and targeted to 'hot spot' areas.

With regard to geographical prioritization across the country, based on the current evidence the epidemic is predominantly urban and heterogeneous mainly concentrated in the largest population centers, such as Kabul, and in the Western Provinces of Afghanistan. Focus will, therefore, be placed on increasing quality and expanding coverage in priority provinces.

Investments in investigating the HIV epidemic dynamic and trajectory among risk populations in all urban centers will equally be a priority in order to inform early prevention actions.

In all above thematic areas, special attention will be given to a progressive expansion in the scope, geographical scale and the enhanced quality of services, including prevention with at-risk populations, voluntary counseling and testing, treatment and prevention of mother-to-child transmission over the next five years to ensure effective coverage of populations beginning in the key urban areas of the

country, the Western provinces as well as in other selected provinces. Further expansion of services in the provinces will be guided by national IBBS rounds conducted every two years to discern emerging epidemiological patterns in a phased approach.

The identification of the key outcomes, outputs and strategies summarized below is based on priority programmatic areas identified by the designated 'Core Team' during the preparation of the NSF-II drawing on the results of the (a) situation and (b) response analysis that, in turn, led to the identification of key gaps and recommendations for future directions for the HIV response in the country.[94]

Efforts and resources will focus on developing and implementing adapted local models and, at times, 'indirect' approaches to HIV prevention service-provision to at-risk groups, in particular for sex work and men who have sex with men; reinforcing capacity and the number of implementing public and private sector partners; pursuing the existing policy of integration of certain HIV services within primary health care service provision; increasing allocative efficiency where the majority of resources are invested in programmes that have the largest impact on HIV epidemic [e.g. harm and risk reduction programmes for IDUs and partners]; and placing emphasis on generating additional strategic evidence and on an improved M&E.

The strategies on NSF-II hinge on the following cross-cutting principles:

- The need for effective and efficient implementation of current resources and increased scope and quality of HIV prevention, treatment, care and support services;
- Involvement of concerned populations and people living with HIV in the design of programmes and in service delivery;
- Ensure an equity in access to services for all populations at risk and in need of services, including a focus on addressing gender differences;
- Deliver services through partnership between public and private sectors, and thereby increase efficiency and effectiveness.
- Adopting integrated approaches that link services in a continuum from community outreach to service provision through health services.

II.2 RESULTS FRAMEWORK AND STRATEGIES

This section describes the expected results and strategies necessary to achieve three Impact Results of the NSF-II. The three results include:

[94] Annexes 3 and 4 summarize the details of a series of discussions held to identify the gaps (Annex 3) and propose recommendations (Annex 4) for the NSF-II by the Core Team in between November 2010 and March 2011.

IMPACT RESULT 1 ON PREVENTION: HIV PREVALENCE REDUCED TO < 5 PERCENT AMONG MOST AT-RISK POPULATIONS BY 2015

This will be achieved through programmatic and geographic scale-up of focused prevention programs targeting IDUs and their partners, prisons and other most at-risk and vulnerable populations. When relevant, information and services made accessible for the general population. Priority is given to develop and expand services for the most at-risk populations, including IDU and partners, female sex workers, men have sex with men and prisoners. Focused HIV prevention education and communication, as well as facilitated access to health services, STIs, and prevention means will be ensured to vulnerable populations. Lastly, adapted information and awareness programs will be provided to various segments of the general population, and blood safety and universal precaution measures reinforced across the country.

IMPACT RESULT 2 ON ENABLING ENVIRONMENT: NATIONAL HIV RESPONSE EFFECTIVELY SUSTAINED BY 2015

This will be achieved through strengthening of the enabling institutional and policy frameworks via a range of strategies, including reinforcement of the capacity of the NACP, an improved multi-sector response, resource mobilization, addressing stigma and discrimination, as well as reinforcing strategic information, and integration of the latter within wider health information systems.

IMPACT RESULT 3 ON TREATMENT AND CARE: HIV-RELATED MORBIDITY AND MORTALITY REDUCED AND QUALITY OF LIFE IMPROVED FOR ALL PLHIV BY 2015

This will be achieved through scale-up and strengthening of ART treatment and, for the first time, provision of care and support services for PLHIV and those affected. Efforts will be made to introduce a range of psycho-social and livelihood support for PLHIV and their families, and otherwise ensure their empowerment.

II.2.1 IMPACT RESULT ON PREVENTION: HIV PREVALENCE REDUCED TO <5 % HIV PREVALENCE AMONG MOST AT-RISK POPULATIONS BY 2015

This result will be achieved through the implementation of the strategic framework depicted in the Fig.2. Given that epidemic dynamics are concentrated in the injecting drug use context, the result will measure changes in the HIV epidemic level among most at risk populations. As the epidemiological evidence suggests that the epidemic is unlikely to spread in general population, expected changes among general populations in terms of awareness and reduced stigma will be measured through a specific indicator of this Result.

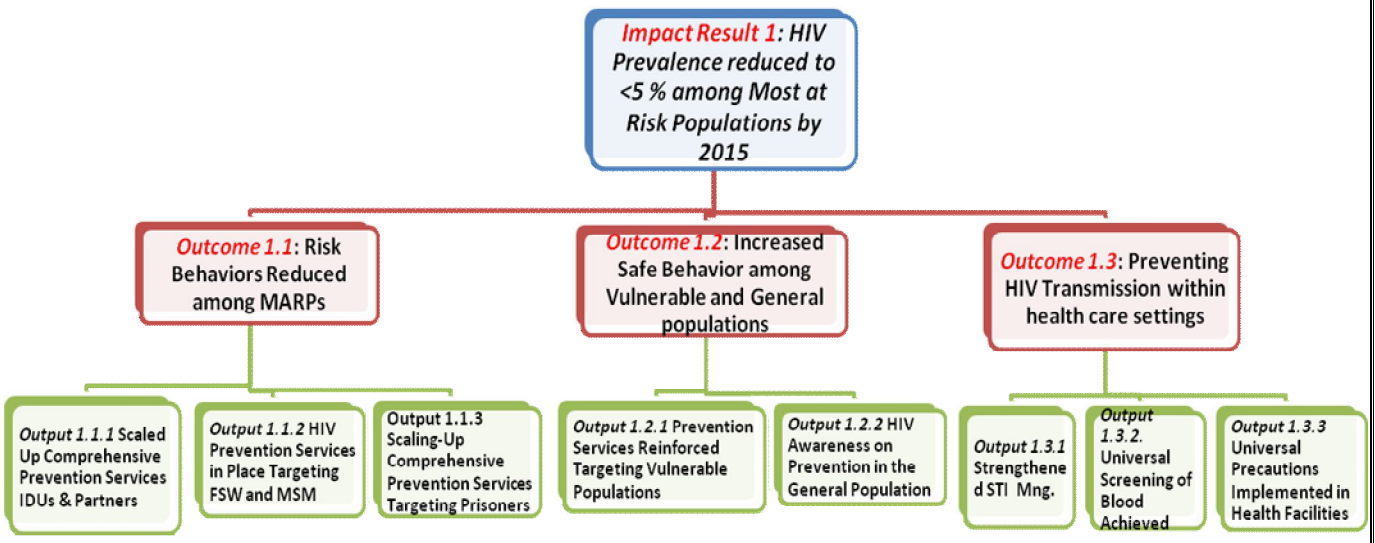

FIG 2..PREVENTION STRATEGIC FRAMEWORK

OUTCOME 1.1: RISK BEHAVIOR REDUCED AMONG MARPS
OUTPUT 1.1.1 SCALING-UP COMPREHENSIVE PREVENTION SERVICES TARGETING IDUS AND PARTNERS

Based on available data, Injecting Drug Use accounts for the main mode of HIV transmission in Afghanistan with the epidemic concentrated in the Western Provinces, where up to 18.8 percent of HIV prevalence was documented (IBBS, 2009).

Hence, the NSF-II will aim to reduce new HIV infections among IDUs in the Western Provinces, with a particular focus on Herat and across all key urban areas where there is a concentration of injecting drug use by geographical scale-up. Focus will also be placed on investigating the epidemic among IDUs in other urban or risk areas of the country. Given relative availability and accessibility of drugs, their use by an important segment of the population as a coping mechanism for the hardships they experience, and the mobility of drug users, new 'hot spots' are emerging in the country.

The strategy will support the implementation of a package of interventions proven effective to reduce HIV among IDUs and partners, i.e. scale-up of NSEP, and implementation of OST, BCC, Condom distribution, VCT, and ART, including for drug users in prison settings, female and juvenile IDUs, as well as PMTCT for female IDUs or partners of IDUs in priority provinces. As many IDU are married and living with their families, it is essential that services also reach their spouses and children.

Also, linkages will be made with STI, TB and VCT services that will additionally be a source of access to condoms for IDUs. Under this output, the NSF-II will ensure:

Strategic Directions: Comprehensive harm reduction services will be provided in Kabul, Mazar-i-Sharif, and Jalalabad where some services are already available. The services will be expanded through a number of priority strategies in Herat Province to reach and increase uptake of services by IDUs and their partners there. The strategy of implementation across the country will be a three-fold one: a) number of sites will be increased to provide the agreed upon package of interventions in Herat province, b) the package will be expanded to include OST in other cities than Kabul, and c) coverage in Kabul will be reinforced.

The key sub-populations that will be targeted and facilitated access to will include: male and female injecting drug users, their partners or spouses, including in prison settings. The specific strategies that will be implemented, building on existing efforts, will include the following:

a) ***Comprehensive harm reduction services*** *are scaled-up in terms of availability, scope and coverage in the priority provinces to reach the currently estimated 20,000 injecting drug users:*

   - Scale-up implementation and delivery of the NSEP to achieve 60% coverage as part of the package of interventions in the priority provinces and expansion of implementation of OST and condom provision in priority provinces and urban centers.

   - Implementation of service delivery will be designed and undertaken through community-based outreach (including peer driven approaches) and include increased access to VCT linked with referral to ART for IDUs and partners, as well as STI services.

   - Targeted information, education and communication (IEC) for IDUs and their sexual partners, coupled with condom distribution and referral to STI services, will be improved, using multiple channels of communications. As condom distribution remains a highly sensitive matter in the country, it will be made available through outreach, peer-educators and social networks facilitated by NGOs working with IDUs.

   - Capacities of community actors, selected NGOs and other service providers will be strengthened.

b) *Street-based IDUs will also be provided with* ***humanitarian and socio-economic support,*** *including blankets, hygiene products, shelter, and food when possible. Unemployment is high among this population and many have no stable source of revenue.*

c) ***Increased integration and referral of services****, in particular linking the peer referral system to access to non-stigmatizing VCT services, and ensuring that VCT serves as an entry point for access to ART.*

d) ***Enhanced supportive environment, policy and legal framework*** *to protect the rights of IDUs and remove barriers to scaling-up harm reduction programmes, particularly OST services beyond Kabul.*

e) ***Improve quality of services*** *through a) the update of national guidelines for HIV prevention comprehensive package among IDUs and partners; b) integrate monitoring and evaluation in the programme implementation to follow up and track progress on scale, coverage and quality and ensure adjustments for effective and efficient response (e.g. number of syringes distributed, number of IDUs reached and of those who have accessed the services, etc.).*

OUTPUT 1.1.2 PREVENTION SERVICES IN PLACE TARGETING FSW AND MSM

Female sex workers (FSW) and men who have sex with men (MSM) constitute populations that are at risk of HIV infections and are highly marginalized. The criminalization of sex work, its largely hidden nature and that sexual contacts between men, coupled with pervasive social stigma and rejection, have resulted in limited understanding of the networks, sexual and risk behaviors of these populations as well as of the magnitude of HIV epidemic among them. The research conducted to date, however, indicates low levels of appropriate knowledge and very high risks. Among MSM, some are also involved in sex work.

Strategic Directions: Thus, the priority focus of the NSF-II for these two populations will be on HIV prevention in the main urban areas aiming to: a) further map and asses these populations' risks behaviors and HIV epidemiology; and b) expand implementation and coverage of prevention programmes adapted to the context of Afghanistan.

Building on existing efforts and rapport established with these populations, the main strategies will include the following:

a) *Further assess and map these populations' risks behaviors and HIV epidemiology in the urban areas where previous mapping has not been undertaken or is limited, as part of strategic information*. Through a 'low profile' approach, initial efforts will be placed to establish rapport and conduct formative assessment to further map the presence, typology, risk settings and behaviors of sex workers and of men who have sex with men. The information generated will inform the design of adapted models of prevention services reaching both populations in largely hidden settings, commensurate to their needs and the level of the HIV epidemic. Lastly, MSM will also be included in future rounds of IBBS to determine HIV prevalence rates.

b) *Expand implementation of HIV prevention services to sex workers and MSM*. Given the level of stigma, the NSF-II will support the design of an adapted approach to deliver HIV prevention services in the urban areas through selected NGOs. The package of interventions will include: a) behavior change communication with messages adapted to the particular needs of the populations and delivered through interpersonal channels; b) condom distribution and lubricants (for men who have sex with men) to promote consistent condom use; c) referral and access to selected health services given current limited access to health care, including STIs, d) empowering approaches through the NGOs. As these programmes are highly sensitive, the services will be made available through outreach workers and peer education, facilitated by NGOs, female sex workers and MSM. Also, linkages will be made with STI, VCT and PMTCT services [where relevant] and referral to ARV treatment, care and support. The NSF-II will support the design of operating procedures of prevention programmes that will serve to ensure quality across the implementation sites and build

capacities of NGOs. Monitoring measures will be integrated as part of the programme package to track progress and coverage, and make adjustments.

OUTPUT 1.1.3 SCALE-UP COMPREHENSIVE PREVENTION SERVICES TARGETING PRISONERS

The second at-risk population with evidence of higher HIV prevalence is in prison settings, with 1.6% (IBBS 2009). Among 18,260 prisoners in the country, evidence also exists of much higher prevalence among incarcerated injecting drug users, reflecting the situation of this population outside of prisons.

Based on the experiences gained in ANASF-I and ongoing HIV interventions, the goal is to provide comprehensive reach and coverage of this growing population in prison and detention centers for both male and female prisoners and in juvenile detention services. Where possible, outreach towards the families of HIV positive prisoners should be initiated.

Strategic Directions: Drawing on global best practice and the package of services already in place through UNODC support, NSF-II will prioritize interventions that will help reach prison populations in general with prevention and treatment and care for those living with HIV through the following strategies:

a) *Maintain policy dialogue with prison and health authorities for the introduction of harm reduction measures and, in particular, OST in prisons.*

b) *Scale-up comprehensive HIV prevention coverage for prisoners upon their entry, during and on release of prisoners, including BCC, VCT, STI Care, condom provision and access to ART and care for those in need.* Upon release, referrals should be provided to harm reduction services provided by NGOs in the community.

c) *Comprehensive coverage is to be provided to all female prisoners and children of prevention services, including PMTCT and continuum of care for women and children living with HIV.*

d) *Prevention services should be integrated with the primary health care provided in prisons, and delivered through a network of peer educators essential to BCC and provision of referrals.*

OUTCOME 1.2: INCREASED AWARENESS ON HIV AMONG VULNERABLE AND GENERAL POPULATIONS

OUTPUT1.2.1 PREVENTION SERVICES REINFORCED TARGETING VULNERABLE POPULATIONS – TRUCKERS, IDPS, REFUGEES AND RETURNEES, AND UNIFORMED SERVICES

In addition to at-risk populations, there is a need to focus HIV prevention on a range of vulnerability factors affecting other segments of the populations, including those that due to their circumstances, occupation, mobility and limited access to health and specialized services may be susceptible to increased HIV-related risk factors. In Afghanistan, vulnerable populations that have been identified include long-distance truck drivers including those that transport good between countries, the army and police personnel, the remaining IDPs due to the conflict, and the returnees among refugees, particularly form Pakistan and Iran, and the labor migrants primarily in the Arab Gulf but also South Asian countries. Displacement, mobility and migration are common features among the Afghan population in search for

security and economic livelihoods, with some evidence that in certain circumstances and among young men and women there is greater exposure to drug and sexual related risks abroad.

While as yet IBBS and specific HIV prevalence studies have detected low HIV prevalence rates, evidence exists of considerable sexual risk and drug use practices affecting men and women. Some, such populations as truck-drivers and uniformed personnel, report sexual contacts with female sex workers. A main concern for all these populations is the absence of access and referral mechanisms to HIV prevention information and means, VCT, STI and TB care.

Strategic Directions: In this context and commensurate with the extent of risk factors, these different populations will be targeted through the following manner:

a) *Mapping of priority 'hot sport' areas and ensuring geographical coverage and access to services.* This will be done by providing on-site and on-route access points to services and referrals through peer education, BCC, VCT, condoms, STI and TB/HIV referral along the main transport routes and hubs of the country (at least in four main regions) as well as in locations where IDPs and returnees are concentrated. Border areas and main airports will also be included for returnees.

b) Enhance coordination through sub-regional initiatives – involving Iran and Pakistan – to ensure comprehensive provision of services to refugees and returnees.

c) Integrate HIV prevention into humanitarian assistance for IDPs, refugees and returnees.

d) Maintain and expand specific training programs and referral mechanisms for the police and army personnel, including for the purpose of reducing punitive policies and stigma and discrimination and enhancing awareness on most at-risk populations, in particular IDUs and FSW.

OUTPUT 1.2.2 HIV AWARENESS ON PREVENTION IN THE GENERAL POPULATION

A combination of high rates of illiteracy, limited access to information particularly among women and young people, isolation of certain regions and other pressing daily concerns, account for what is believed to be very low levels of awareness of the general population on HIV and AIDS in the absence of general population surveys. Limited visibility and stigma related to the very nature of transmission of HIV increases stigma to the HIV and hampers the implementation of targeted prevention programmes to most at risk and vulnerable populations.

Strategic Directions: To this effect, through diverse communication and service-delivery channels, the NSF-II will pursue a focused effort to increase awareness among the general population and reduce stigma through the following:

a) *Effective prevention messages and adapted material developed and delivered through collaboration with mass and local media, health community workers, community and religious leadership.* These will be specific to the varying needs of the general population and their level

of education, gender, ethnic background and occupation – including for women, the illiterate, out-of-school youths, ethnic minorities, etc.

b) *Prevention messages integrated into curriculum of schools and into workplace policies, tailored to the age, gender, and socio-cultural sensitivities of the target population.*

c) *Include specific messages into awareness campaigns addressing social stigma towards PLHIV and those at risk in an effort to create an enabling environment for HIV prevention and support.*

OUTCOME 1.3: PREVENTION OF HIV THROUGH HEALTH CARE SETTINGS

Output 1.3.1 Strengthened STI Management
Output 1.3.2 Universal Screening of Blood Achieved
Output 1.3.3 Universal Precautions Implemented in Health Facilities

OUTPUT 1.3.1: STRENGTHENED STI MANAGEMENT

STI management needs to be strengthened with a particular focus on most at risk and vulnerable populations. Given high rates of STIs founds in certain populations, syndromic management and treatment through specialized services provide an entry point for HIV prevention, condom promotion and onward referral to VCT.

Strategic Directions: The main strategic orientation is to prevent and reduce the prevalence of sexually transmitted infections.

a) *Make available STI guidelines for effective management in health clinics.*

b) *Strengthen capacity of service providers to treat and manage STIs according to national guidelines and reduce stigma to facilitate access and follow up, in particular to most at risk and vulnerable populations referred through prevention community programmes.*

c) *Build a referral system linking community level and outreach for HIV prevention with the STIs services.*

d) *Develop and implement effective procurement and supply chain management systems for STI drugs.*

e) *Develop STI surveillance.*

OUTPUT 1.3.2 UNIVERSAL SCREENING OF BLOOD ACHIEVED

Strategic Directions: This strategy aims to ensure universal screening for all blood units for HIV and other transfusion-transmissible infections in order to meet needs.

Only recently, efforts have been stepped up to ensure that all Blood Units undergo systematic screening for HIV in the country. There is, however, a need to monitor that universal screening actually does take place, including by ensuring the availability of screening equipment and trained personnel at provincial, district and community levels. To do so, the following strategies will be followed:

a) *National Blood Safety Policy will be established to regulate the steps and procedures of universal screening on an annual basis, ensure supervision of central and regional blood banks.* As an interim step, provisions will be made to ensure coverage in all urban areas.

b) National Blood Safety Unit will be established at the MoPH to implement the 'National Blood Safety Policy'.

c) Increase the number of Blood Banks in the country with attention paid to border areas and strengthen their capacity (training of staff and provision of equipments) to screen blood and blood products to ensure 100% blood safety.

OUTPUT 1.3.3 UNIVERSAL PRECAUTIONS IMPLEMENTED IN 100% OF HEALTH FACILITIES

Strategic Direction: The MoPH aims at ensuring 100% adoption of universal precautions as part of infection control measures across all health facilities.

a) Train health care staff and ensure that universal precautions measures are available and adopted in all health facilities.

b) Universal Precautions are also integrated within BPHS and EPHS, to protect the population and health care workers from nosocomial infections through the application of these measures and providing the needed protective equipment.

c) Post-Exposure Prophylaxis (PEP) will be provided at health facilities in case of accidental exposure. Coverage of PEP will be gradually expanded from the selected main urban centers to provincial health services by 2015.

II.2. 2 Impact Result on Enabling Environment: National HIV Response Sustained Effectively by 2015

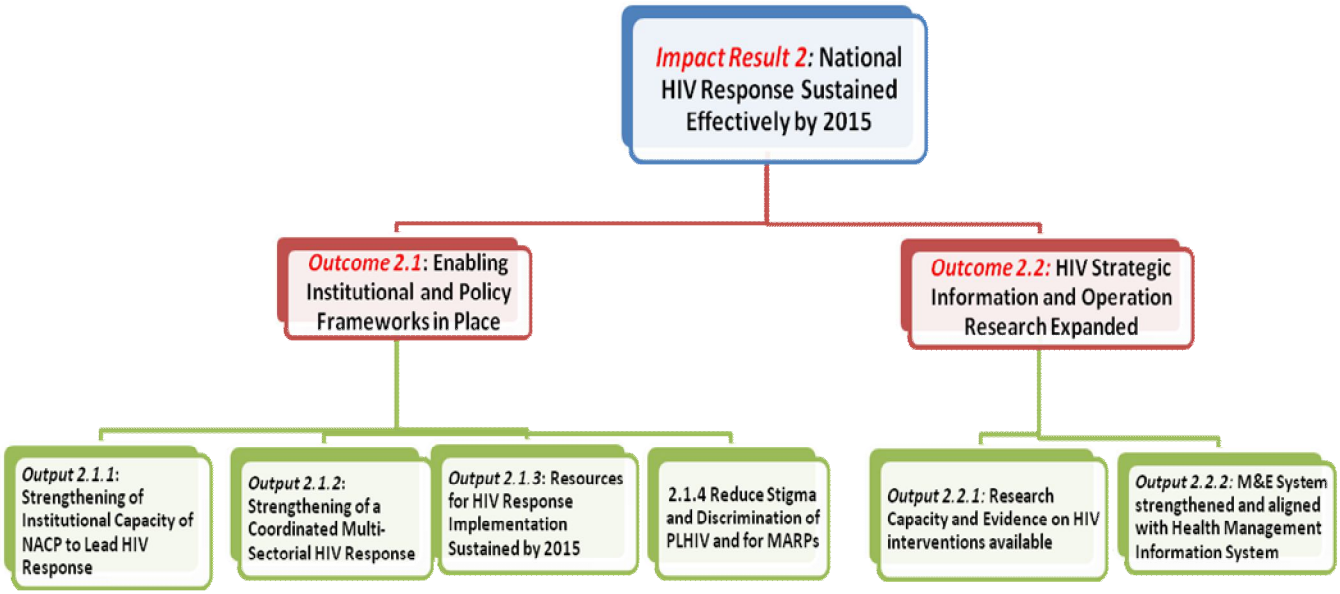

Fig. ...Results for the Instiutional framework to Giude effective and Efficient Implementation of the HIV Response

Outcome 2.1: Enabling Institutional and Policy Frameworks in Place

Strengthening the institutional and policy frameworks for the national HIV response in Afghanistan remains a top priority over the next five years. Adequate human capacity and technical expertise on the one hand and enabling and functioning policy set-ups to facilitate, govern and expand HIV responses on other hand are of critical importance for sustainability of the national response. For the first time in the history of the national response in Afghanistan, an effort will be made to facilitate the more open discussion and involvement of community actors central to an effective national HIV response in prevention, treatment and care. In order to achieve this goal, the outputs and strategies envisaged are described below.

Output 2.1.1 Strengthening Institutional Capacity of NACP to Lead National HIV Response

Tapping on the progress made by the ANASF-I, the NSF-II will ensure substantial improvement in the institutional capacity of the NACP, as well as its provincial counterparts, to lead and coordinate interventions in close collaboration with HACCA, the CCM, when relevant and the already established technical working groups.

Strategic Directions:

a) *Strengthening the organizational structure, management and coordination of the NACP central team in Kabul and the number and capacity of provincial focal points and services.*

b) *Reinforcing the capacity of the NACP and provincial staff in Program Management, Procurement, Financial Management, M&E, and Surveillance.*

c) *Strengthening capacity of the Implementing Partners (NGOs) in Program Management, Procurement, Financial Management, and M&E.*

d) *Developing a Program Operation Plan (POP) for the NSF-II.*

OUTPUT 2.1.2 STRENGTHENING OF A COORDINATED MULTI-SECTORAL HIV RESPONSE

NSF-II will also provide for an effective multi-sector coordination through HACCA for key ministries (i.e. MoPH, MoCN, MoJ, MoI, MoD, and MoHRA). Selected key ministries will play an essential role in policy development and legal issues around Harm Reduction and, in particular, OST, Drug Treatment, Prison Policies, and protection of rights to health and social services for PLHIV as well as for at-risk and vulnerable populations. Other key ministries might be involved in service provision (e.g. prison setting). Operational plans will be developed to reflect specific roles of sectors – i.e. either policy development or both policy development and service provision.

Strategic Directions:

a) *Renewing agreement with key ministries on their thematic areas of contribution and on policy and technical-level representation in HACCA.*

b) *Strengthening political commitment to AIDS across sectors for a sustainable national HIV Response, through an 'Advocacy Communication Campaign' launched at central, provincial and community levels, including on the annual occasion of World AIDS Day and other events.*

c) *Formulate focused POPs for 2011-15 for selected key Participating Ministries.*

d) *Coordination will also focus on streamlining planning, reporting, communication, information-sharing and synergies of the NACP within the MoPH.* This will include Improved Integration of HIV services into BPHS and EPHS in the provinces, with specific attention paid to Border and provinces facing insecurity.

OUTPUT 2.1.3 RESOURCES FOR HIV RESPONSE IMPLEMENTATION SUSTAINED BY 2015

Effective allocation of resources and efficient utilization will be at the center of this output. A long-term and effective HIV response requires better coordination of the allocation of financial resource and mobilization via the development of a 'Resource Mobilization Strategy' inclusive of international, public and private sources that meet the needs of scaling-up geographic expansion and programmatic coverage to MARPs and vulnerable groups, with specific attention paid to the main urban areas and selected provinces. Allocative efficiency will ensure that funds are allocated solely to the NSF priorities commensurate with the priority ranking and the scale of programmes identified, i.e priority to expand programmes for IDUs in western provinces and urban centers. Efficiency will focus on reducing unit costs and "doing more with less".

Strategic Directions:

a) *Conducting a financial gap analysis of the HIV response;*

b) *Ensure that external and internal funding is increased and allocated to the priorities of the NSF;*

c) *Improved routine assessment of the disbursement of funds per individual programs.*

OUTPUT 2.1.4 Reduce Stigma and Discrimination of PLHIV and for MARPs

Despite notable progress in 2006-2010, the populations primarily concerned with HIV infection and those most at-risk remain conspicuously absent from the HIV response. Within the period of 2011-2015, an attempt to change this situation will involve addressing public opinion, policy and the legal frameworks to recognize access to HIV prevention, treatment and care as a right of socially marginalized populations.

Strategic Directions:

a) *Development of policy and legal measures that promote the provision of Universal Access to HIV Services of PLHIV and MARPs, including formulation of an Act to counter stigmatization and discrimination.*

b) *Facilitation of greater Involvement of PLHIV and MARPs in program design and implementation.*

c) *Finalize the HIV 'Advocacy and Communication Strategy' to accompany the implementation of NSF-II.*

d) *Expand sensitization of policy makers, community and religious Leaders, health care professionals, Journalists, educators, police, and the Judiciary.*

e) *Launch an extensive anti-stigma and discrimination campaign at community Level.*

f) *Sensitize PLHIV and their families on their rights, and build capacity through support groups and networks to protect their rights.*

OUTCOME 2.2 HIV STRATEGIC INFORMATION AND OPERATIONS RESEARCH EXPANDED

OUTPUT 2.2.1 RESEARCH CAPACITY REINFORCED AND EVIDENCE ON HIV INTERVENTIONS AVAILABLE

In order to identify and assess trends and dynamics of the HIV epidemic over time and inform the programmatic and geographic focus of the HIV response, NSF-II will include activities to strengthen strategic information and operations capacity of NACP in this area, as well as participating research institutes and NGOs. Priority will be given to generate strategic information that will help inform the further effective targeting of MARPs and vulnerable populations. This will include undertaking Bio-Behavioral surveillance, comprehensive mapping of MARPs and vulnerable groups, as well as needs assessment in specific programmatic areas or provinces.

Strategic Directions:

a) *Development of a 'Strategic Information and Operations Research Strategy' for 2011-2015.*

b) *Strengthening capacities of NACP and local researchers for generating and disseminating strategic information and operations research.*

c) *Establishing clearer mechanisms of collaboration between international research groups and the NACP.*

d) *Needs assessment for expansion of OST and other services undertaken across the country, especially in the Western Provinces of Herat, Nimroz and Farah.*

e) *Strengthening national 2nd Generation Surveillance (SGS) via expansion of surveillance of all MARPs and selected vulnerable groups.*

f) *Mapping and size estimation studies of MARPs and vulnerable groups, and developing national estimations on number of PLHIV, mortality rates and number in need of treatment.*

g) *Conducting an assessment of effectiveness of 1st line HAART in Afghanistan.*

h) *Conducting policy assessments among policy makers.*

i) *Qualitative situation assessments of risks and vulnerability undertaken in new geographic locations.*

j) *Through national M&E framework, establishing mechanisms of dissemination of findings of studies to policy makers and Implementers.*

OUTPUT 2.2.2 M&E SYSTEM STRENGTHENED AND ALIGNED WITH HEALTH MANAGEMENT INFORMATION SYSTEM

The NSF-II will seek to improve overall M&E capacity and align it with the national Health Management Information System (HMIS) of the MoPH. When the current M&E team in the NACP is adequately staffed, the national M&E framework on AIDS should be further aligned with the HMIS. At the same time, M&E frameworks of participating ministries and implementing partners (NGOs) are not aligned to each other. Therefore, there is a need to address these issues via a number of strategies.

Strategic Directions:

a) *Finalize M&E Plan for 2011-2015 to align programme Indicators with UNGASS and National Health Indicators.*

b) *Enhance capacity of Implementing Partners (NGOs) on M&E.*

c) *Improve mechanisms of information dissemination at central, provincial and community Levels via an information dissemination plan.*

d) *Integrate HIV data collection, analysis and dissemination into the overall HMIS.*

II.2.3 Result on Treatment and Care: HIV-related Morbidity and Mortality and Quality of Life Improved by 2015

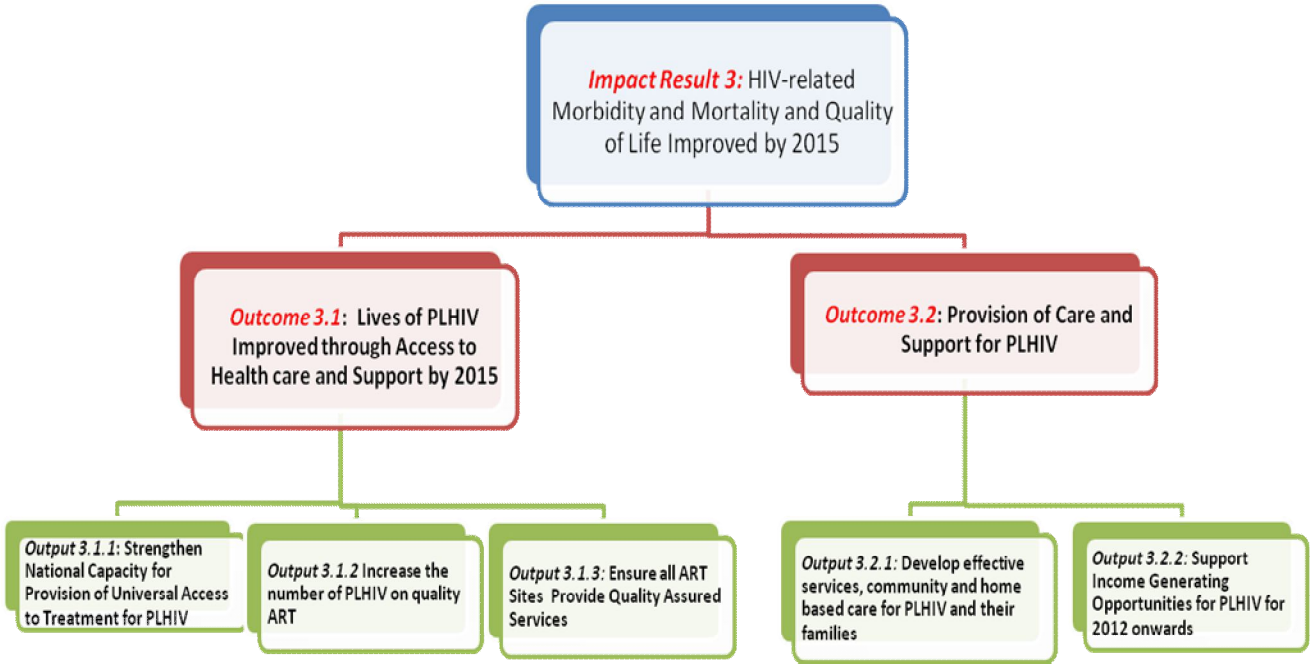

Fig. 3 : Strategic results for Treatment, Care and Support

Outcome 3.1: Lives of PLHIV Improved through Access to Health care and Support by 2015

Output 3.1.1 Strengthen National Capacity for Provision of Universal Access to Treatment for PLHIV

The NSF-II aims at improving the health status and well-being of PLHIV in Afghanistan via systematic provision of ART to all that meet the criteria for treatment and prophylaxis for OIs, which will allow a reduction in morbidity and mortality. To do so, activities will be included that makes universal access to ART possible for all PLHIV. As of end of 2011, ART coverage is very limited, including 70 PLHIV covered through the two ART sites available – in Kabul and Herat. As HIV is further integrated into BPHS and EPHS, the NSF-II will ensure expansion of ART to specific provinces and main urban areas where there are reported HIV cases.

Strategic Directions:

a) *Conducting an assessment of the financial, human resources and technical capacity required for ART Services to be expanded geographically.*

b) *Strengthening technical capacity of health professionals in management of treatment and care and monitoring to meet the geographic expansion of services.*

OUTPUT 3.1.2 Increase the number of PLHIV on ART from 70 to around 1,000 by 2015

Presently, there are 636 PLHIV in Afghanistan. However, only 70 persons are receiving ART available at the two sites. It is important to scale up coverage of ART that it becomes available to all PLHIV that meet the clinical criteria for treatment. Some of the challenges of doing so may be the low level of VCT available across the country, including for MARPs and vulnerable populations. Nevertheless, an attempt will be made to increase access to ART in main urban areas where there are MARPs and PLHIV iendtified. Specific strategies include:

a) *Prioritize ART sites expansion to selected new sites.*

b) *Provide existing and new ART sites with adequate human resources, equipment and supplies.*

c) *Integrate referral to ART services within BPHS, EPHS and TB services.*

d) *Develop and Implement a communication strategy for expanded ART, and establishment of a referral system between VCT, outreach and drop-in centers, as well as private health care services.*

e) *Strengthen HIV-TB Collaborative activities.*

f) *Improve supply chain protocols and procedures for better access and continuous availability of ARVs and OIs drugs.*

g) *Improve Linkages between HIV and Management of STIs, Hepatitis B and C, including provision of vaccines for PLHIV.*

OUTPUT 3.1.3 Ensure all ART Sites are Providing Quality Assured Services

NSF-II will support activities that will ensure quality of ART provision at all sites – existing and those that will be established in new geographic locations based on the projected increase in number of PLHIV identified through VCT. ART Guidelines need to be finalized and implemented to provide quality diagnostic monitoring of ART patients, including follow-up. National capacity for ART services needs to be established in all locations – existing and planned sites. In addition, an ART Working Group (ART WG) will be established at the national level to ensure expert review and oversight of the provision of ART services in Afghanistan. The ART WG will play an important role in quality assurance, monitoring and evaluation of services. A summary of the relevant strategies include:

Strategic Directions:

a) *Finalize and make available guidelines on clinical management, treatment, care and support for PLHIV to relevant health services.*

b) *Establish an implement ART Quality Assurance System.*

c) *Strengthen the national capacity and site-specific capacity of ART programmes to provide quality services.*

d) *Establish ART Working Group (AR-WG).*

OUTCOME 3.2: PROVISION OF CARE AND SUPPORT FOR PLHIV

OUTPUT 3.2.1 DEVELOP EFFECTIVE SERVICE, COMMUNITY AND HOME BASED CARE FOR PLHIV AND THEIR FAMILIES

Currently, there is no care and support system available for PLHIV and their families in Afghanistan. The NSF-II will support development of strategies that will establish an effective and a comprehensive system of care and support for PLHIV and their families. This will include providing access to psycho-social counseling, early detection and treatment of OIs and TB, as well as nutritional and food support. Protocols of home-based care (HBC) and community-based care (CBC) will be developed and approved by 2012. PLHIV will be encouraged to establish support groups and national and local networks to enhance their empowerment. NGOs will be selected and trained in the provision of HBC and CBC.

Strategic Directions:

a) *Scale-up referral and early detection and treatment of OIs for PLHIV.*

b) *Scale-up early detection of TB among PLHIV under chronic care and treatment.*

c) *Integrate nutrition and food support into ART and PMTCT guidelines and NGO-based Community and Home-based Care.*

d) *Provide nutritional and food Supplements through ART and PMTCT sites as well as NGOs.*

e) *Establish PLHIV Support Groups and Associations facilitated by NGOs.*

OUTPUT 3.2.2 SUPPORT INCOME GENERATING OPPORTUNITIES FOR PLHIV FROM 2012 ONWARDS

The NSF-II will support strategies to facilitate and secure livelihoods of PLHIV and families in order to meet their basic nutritional, school education and livelihood needs. This will be conducted through assistance of NGOs and, potentially, public social welfare schemes that will train PLHIV on vocational and entrepreneurial skills to earn incomes or access financial credit for income-generating opportunities. It will also provide PLHIV and their families with start-up capital for small-scale businesses. Priority will be given to families of orphans and widows due to AIDS as well as families of drug users who are HIV positive. Specifically, this will include:

Strategic Directions:

a) Improve vocational and entrepreneurial skills for PLHIV and those affected.

b) Support PLHIV to establish income-generating projects.

III. Risks and Mitigation

Drawing on the experiences of the last five years of the HIV response in Afghanistan, the current NSF-II five-year plan faces numerous and diverse risks that could adversely affect the pace and extent of implementation and, subsequently, the desired Impact Results. While some of these risks are of a contextual nature independent of actual progress made in the roll-out of the NSF-II POPs, they need to be carefully factored in by national partners and, where possible, appropriate mitigation measures introduced to counter them.

First, and foremost, are the occurrence of risks related to the overall **security and political** developments in the country which remain somewhat unpredictable and could result in activities becoming difficult to conduct particularly where access and coordination in provinces is affected for short or longer time periods by insecurity.

Also related to the evolving security and political context of the country, is the overall **policy environment** around key topics central to the AIDS response, including the overall government, development donors and specific sector policies on: drug control and prevention within the larger context of the 'war on drugs', prison reforms as well as public opinion vis-à-vis socio-cultural issues related to sensitive behavioral and life-style aspects. The above can directly impact on the ability to propose policy changes and to undertake activities in relation to scaling-up Harm Reduction and, in particular, OST in the community and prisons; to ameliorate health and day-to-day conditions in prisons and detention centers; to get law enforcement agreement to address sex work which is currently criminalized; and to ensure community and public opinion leaders' acceptance of a 'public health' rationale to reach 'hidden' and sexually marginalized populations.

Another set of risk factors are related to government structures and continuity in program **leadership** that would ensure continued recruitment and retention of staff as well as generally reinforced capacities of the NACP and its provincial counterparts as well as of implementing partners – public, private and community-based. At any one point of time, a small but critical mass of partners needs to be in place with **competences** and know-how to address the HIV response. In addition to government allocation of human resources, the position of the NACP within the architecture of the MoPH, provision of office premises and resources, and pursuing the effective integration of HIV activities within the health system, there is need for continuity in **funding** through the World Bank, The Global Fund and other multi and bi-lateral sources. Specifically, an effort must be made to ensure donor support throughout this five-year period.

Lastly, and as **evidence** of a concentrated epidemic among at-risk populations has now been confirmed through IBBS in 2009, currently the consensus on priorities and the identification of strategies reflected in the NSF-II relies on a very limited evidence base. The progress made on the NSF-II Impact Results, Outcomes and Outputs included in this document will largely rely on the ability to generate new biological, health, behavioral and contextual data through surveillance, mapping, assessments and operational research, to guide programmatic decisions towards more effective results.

Mitigating measures to address the above-mentioned risks are largely already encompassed within the NSF-II strategies. Notwithstanding that some of the risks are 'external' environmental ones (e.g. overall security and within specific provinces), the following mitigation measures can be highlighted: **(a)** decentralizing and reinforcing staffing and capacity of the AIDS program and services at provincial level in the priority areas to ensure continuous reach of the communities in need; **(b)** maintaining a targeted and sustained 'Evidence-based Advocacy and Communication Strategy' through the NSF-II with key sectors such as Public Health, Counter Narcotics, Prison Authorities, Interior, Police, Haj and Religious Affairs, to influence critical policy decisions; **(c)** developing adapted local models and, at times, 'indirect' approaches to HIV prevention service-provision to at-risk groups, in particular for sex work and men who have sex with men; **(d)** reinforcing capacity and the number of implementing public and private sector partners; **(e)** pursuing the existing policy of integration of certain HIV/AIDS services within primary health care service provision; **(f)** rolling-out a 'Resource Mobilization Strategy' with continued emphasis on demonstrating results and allocative efficiency, where the majority of resources are invested in programmes that will have the largest impact on HIV epidemic, i.e programmes for IDUs and partners, and proposal formulation for the Global Fund, World Bank and other donors; **(g)** implement a mid-term review to measure progress towards the outputs and outcomes and make the necessary adjustments; and **(h)** placing priority emphasis on generating additional strategic evidence and on an improved M&E.

In conclusion of this section on risk and mitigation factors, the successful undertaking of at least some of the above proposed measures will contribute towards effective implementation of the NSF-II operational plans.

IV. Monitoring and Evaluation – *[To Be Aligned with the Strategic Framework and Define the Indicators by the M&E Advisor]*

The NSF-II will seek to improve overall M&E capacity and align it with the national Health Management Information System (HMIS) of the MoPH. When the current M&E team in the NACP is adequately staffed, the national M&E framework on AIDS should be further aligned with the HMIS. At the same time, M&E frameworks of participating ministries and implementing partners (NGOs) are not aligned to each other.

The results framework of the NSF will guide the data collection, frequency of surveys to measure outcomes every two years, and the programme data to monitor the delivery of the outputs annually. The mid-term review will lead to the review of the results framework and indicators and the necessary adjustments will be made to the chain of results and targets set.

The table below provides the structure to include indicators per each result (impact, outcomes and outputs), the baseline and targets for the NSF.

IMPACT RESULT 1: HIV PREVALENCE REDUCED TO <5 % AMONG MOST AT-RISK POPULATIONS BY 2015

OUTCOME 1.1: RISK BEHAVIOR REDUCED AMONG MARPS
Output 1.1.1 Scaling-Up Comprehensive Prevention Services Targeting IDUs and Partners
Output 1.1.2 HIV Prevention Services in Place Targeting FSW and MSM
Output 1.1.3 Scaling-Up Comprehensive Prevention Services Targeting Prisoners

OUTCOME 1.2: INCREASED AWARENESS ON HIV AMONG VULNERABLE AND GENERAL POPULATIONS
Output 1.2.1 Prevention Services Reinforced Targeting Vulnerable Populations – Truckers, IDPs, Refugees and Returnees, and Uniformed Services
Output 1.2.2 HIV Awareness on Prevention in the General Population

OUTCOME 1.3: PREVENTING HIV TRANSMISSION WITHIN HEALTH CARE SETTINGS
Output 1.3.1 Strengthened STI Management
Output 1.3.2 Universal Screening of Blood Achieved
Output 1.3.3 Universal Precautions Implemented in of Health Facilities

IMPACT RESULT ON ENABLING ENVIRONMENT: NATIONAL HIV RESPONSE SUSTAINED EFFECTIVELY BY 2015
OUTCOME 2.1: ENABLING INSTITUTIONAL AND POLICY FRAMEWORKS IN PLACE
OUTPUT 2.1.1 Strengthening of Institutional Capacity of NACP to Lead National HIV Response
OUTPUT 2.1.2 Strengthening of a Coordinated Multi-Sectorial HIV Response
OUTPUT 2.1.3 Resources for HIV response mobilized and sustained by 2015
OUTPUT 2.1.4 Reduce Stigma and Discrimination of PLHIV and for MARPs

OUTCOME 2.2 HIV STRATEGIC INFORMATION AND OPERATIONS RESEARCH EXPANDED

OUTPUT 2.1.1 Research Capacity and Evidence on HIV interventions available

OUTPUT 2.2.2 M&E System strengthened and aligned with Health Management Information System

IMPACT RESULT ON TREATMENT AND CARE: HIV-RELATED MORBIDITY AND MORTALITY AND QUALITY OF LIFE IMPROVED BY 2015

OUTCOME 3.1: LIVES OF PLHIV IMPROVED THROUGH ACCESS TO HEALTH CARE AND SUPPORT BY 2015

OUTPUT 3.1.1 Strengthen National Capacity for Provision of Universal Access to Treatment for PLHIV

OUTPUT 3.1.2 Increase the number of PLHIV on quality ART

OUTPUT 3.1.3 ENSURE ALL ART SITES PROVIDE QUALITY ASSURED SERVICES

OUTCOME 3.2: PROVISION OF CARE AND SUPPORT FOR PLHIV

OUTPUT 3.2.1 Develop effective services, community and home based care for PLHIV and their families

OUTPUT 3.2.2 Support Income Generating Opportunities for PLHIV for 2012 onwards

The Impact level targets and indicators are the following:

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Impact Indicators				
1	% of adult men and women (25-49) who are HIV positive				
2	% of MARPs who are HIV positive, including:				
	% of IDUs				
	% of FSWs				
	% of Prisoners				
3	% of adult men and women who are HIV positive and are receiving ART				

Impact Result 1: HIV Prevalence Reduced to < 5 % among MARPs by 2015

OUTCOME 1.1: RISKY BEHAVIOR REDUCED AMONG MARPS

Targets and Indicators for Measuring the Achievement of Outcome 1.1

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Outcome Indicators				
1	% of IDUs reporting using sterile needles and syringes				
2	% of IDUs reporting condom use				
3	% of IDUs who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
4	% of FSWs reporting condom use				
5	% of MSM reporting condom use during anal sex				
7	% of MSM who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
8	% of Prisoners reporting condom use				
9	% of Prisoners who both correctly identify ways of preventing transmission and				

	who reject major misconceptions about HIV transmission				

OUTPUT 1.1.1

Targets and Indicators for Measuring the Achievement of Output 1.1.1

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	Number of IDUs reporting using sterile needles and syringes				
2	Number of IDUs reporting condom use				
3	Number of IDUs who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
4	Number of IDUs receiving ART				
5	Number of IDUs tested for HIV				
6	Number of IDUs reached via BCC				
7	Number of female IDUs reached via PMTC				
8	Number of IDU prisoners reporting using sterile needles and syringes				
9	Number of prisoner IDUs reporting condom use				

10	Number of prisoner IDUs who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
11	Number of prisoner IDUs receiving ART				
12	Number of prisoner IDUs tested for HIV				
13	Number of prisoner IDUs reached via BCC				
14	Number of juvenile IDUs reporting using sterile needles and syringes				
15	Number of juvenile IDUs reporting condom use				
16	Number of juvenile IDUs who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
17	Number of juvenile IDUs receiving ART				
18	Number of juvenile IDUs tested for HIV				
19	Number of juvenile IDUs reached via BCC				

OUTPUT 1.1.2

Targets and Indicators for Measuring the Achievement of Output 1.1.2

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				

1	Number of FSWs treated for STIs				
2	Number of FSWs reporting condom use				
3	Number of FSWs who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
4	Number of FSWs tested for HIV				
5	Number of FSWs reached via BCC				
6	Number of FSWs reached via PMTC				

No	**Indicators**	**Baseline**		**Targets**	
		Value	**Source & Year**	**2012**	**2015**
	Output Indicators				
1	Number of MSM treated for STIs				
2	Number of MSM reporting condom use				
3	Number of MSM who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
4	Number of MSM receiving ART				
5	Number of MSM tested for HIV				
6	Number of MSM reached via BCC				

OUTPUT 1.1.4

Targets and Indicators for Measuring the Achievement of Output 1.1.4

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	Number of Prisoners reporting condom use				
2	Number of Prisoners who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
3	Number of Prisoners receiving ART				
4	Number of Prisoners tested for HIV				
5	Number of Prisoners reached via BCC				
6	Number of Female Prisoners reached via PMTC				

OUTCOME 1.2: RISKY BEHAVIOR REDUCED AMONG VULNERABLE POPULATIONS – TRUCKERS, IDPS, REFUGEES AND RETURNEES, UNIFORMED SERVICES

Targets and Indicators for Measuring the Achievement of Outcome 1.2

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Outcome Indicators				
1	% of Truckers reporting condom use				
2	% of Police Personnel reporting condom use				

3	% of Military Personnel reporting condom use				
4	% of IDPs, refugees, returnees reporting condom use				
5	% of Truckers who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
6	% of Police who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				
7	% of IDPs, refugees, returnees who both correctly identify ways of preventing transmission and who reject major misconceptions about HIV transmission				

OUTCOME 1.3:

Targets and Indicators for Measuring the Achievement of Outcome 1.3

No	**Indicators**	**Baseline**		**Targets**	
		Value	**Source & Year**	**2012**	**2015**
	Outcome Indicators				
1	% of population reached through HIV awareness program				
2	% of people who both correctly identify ways of preventing transmission and who reject major				

	misconceptions about HIV transmission				

OUTCOME 1.4: UNIVERSAL SCREENING (100 %) OF ALL BLOOD UNITS FOR HIV IS ACHIEVED IN QUALITY ASSURED MANNER

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Outcome Indicators				
1	% of donated blood units screened for HIV in a quality assured manner				
2	% of health care personnel reporting accidental exposure to potential HIV infected material				
3	% of HIV negative health care personnel reporting accidental exposure to potential HIV infected material				

OUTPUT 1.4.2 UNIVERSAL PRECAUTIONS IMPLEMENTED IN 100 % OF HEALTH FACILITIES

Targets and Indicators Measuring the Achievement of Outputs 1.4.1 and 1.4.2

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	Number of donated blood units screened for HIV in a quality assured manner				
2	Number of health facilities with PEP kits				
3	Number of health facilities implementing				

	universal blood safety precautions				
4	Number of persons provided with HIV PEP				

OUTCOME 1.5: MANAGEMENT OF STIS IS MAINTAINED EFFECTIVELY

Targets and Indicators Measuring the Achievement of Output 1.5.1

No	**Indicators**	**Baseline**		**Targets**	
		Value	**Source & Year**	**2012**	**2015**
	Output Indicators				
1	Number of STI patients (adult men and women) counselled and tested for HIV				
2	Number of STI patients (MARPs) counselled and tested for HIV				
3	Number of STI patients (Vulnerable People) counselled and tested for HIV				

Impact Result 2: HIV Response Sustained Effectively by 2015

OUTCOME 2.1: ENABLING INSTITUTIONAL AND POLICY FRAMEWORKS OF HIV RESPONSE FUNCTIONING EFFECTIVELY

Targets and Indicators Measuring the Achievement of Outcome 2.1

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Outcome Indicators				
1	Institutional Coordination Capacity of NACP is Improved				
2	Coordination Mechanisms - HACCA, CCM and technical working groups are Improved				
3	Policy Frameworks Improved to achieve better synergies on Harm Reduction, Drug Treatment, Prison Administration, Protection of Human Rights of IDUs, FSWs, prisoners, MSM and PLHIV				
4	Policy and Legal Set-ups are Formulated for Rights-Based Universal Access to HIV Services				
5	Organizational Capacity- NACP staff expanded to meet the Program's needs				
6	Technical Capacity of NACP is Improved for M&E, Surveillance				
7	Financial Management of HIV				

	Response Improved				
8	Research Capacity – Second Generation Surveillance Improved				
9	Program M&E is Improved and Functional				
10	Resources Mobilized for the next 5 years				

OUTPUT 2.1.1 STRENGTHENING OF INSTITUTIONAL CAPACITY OF NACP TO LEAD NATIONAL HIV RESPONSE

Targets and Indicators Measuring the Achievement of Output 2.1.1

No	**Indicators**	**Baseline**		**Targets**	
		Value	**Source & Year**	**2012**	**2015**
	Output Indicators				
1	Number of new NACP staff, including those to cover geographic expansion to Western Provinces				
2	Number of training for NACP staff				
3	Number of training for Implementing NGOs				
4	Program Operational Plan developed and approved				

OUTPUT 2.1.2 STRENGTHENING OF A COORDINATED MULTI-SECTORAL HIV RESPONSE

Targets and Indicators Measuring the Achievement of Output 2.1.1

No	**Indicators**	**Baseline**		**Targets**	
		Value	**Source & Year**	**2012**	**2015**
	Output Indicators				

1	Number of Memorandums of Understanding (MoUs) signed between the NACP and Participating Ministries				
2	Number Operational Plans developed and approved in Participating Ministries				
3	Advocacy and Communication Program Launched in key sectors				
4	Number of Policies Developed to achieve better synergies on Harm Reduction, Drug Treatment, Prison Administration, Protection of Human Rights of IDUs, FSWs, prisoners, MSM and PLHIV				
5	Number of key sectors policies that included HIV				
6	Number of leaders expressing their support for HIV				
7	Number of National Level High Meetings/Events where HIV is Publicly Recognized				
8	Number of new BPHS and EPHS facilities with HIV services opened and functioning				
9	Number of community-based NGOs providing HIV services				

OUTPUT 2.1.3 REDUCE ANTI-STIGMA AND DISCRIMINATION OF PLHIV AND MARPs

Targets and Indicators Measuring the Achievement of Output 2.1.3

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	HIV Policy to Safeguard Rights-Based Universal Access to HIV Services Finalized and Operational				
2	Number of Support Groups for PLHIV established				
3	Number of Support Groups for MARPs established				
4	HIV Advocacy and Communication Strategy Developed				
5	HIV Advocacy and Communication Strategy Launched				
6	HIV Workplace Policy Developed and Approved				
7	Number of Anti-Stigma and Discrimination Campaigns Launched at Community Level				
8	Number of People Reached via Anti-Stigma and Discrimination Campaigns				
9	Number of PLHIV and their families sensitized about their Rights				
10	% of men and women expressing acceptance attitude to PLHIV				
11	Number of men and women reached with				

	anti-stigma messages				
12	Number of PLHIV and those affected sensitized on their rights				
13	Number of public sector agencies and NGOs that provide support, care and legal support to PLHIV				

OUTPUT 2.1.4 RESOURCES FOR HIV RESPONSE MOBILIZED AND SUSTAINED BY 2015

Targets and Indicators Measuring the Achievement of Output 2.1.4

No	**Indicators**	**Baseline**		**Targets**	
		Value	**Source & Year**	**2012**	**2015**
	Output Indicators				
1	A Resource Mobilization Strategy developed				
2	Resource Mobilization Strategy Operational				
3	Resources Mobilized per Funding Agency				
4	Number of Financial Gap Analysis Conducted				
5	Number Financial Progress Assessments Conducted				
6	Number of Routine Financial Management Assessment Conducted				

OUTPUT 2.1.5 HIV STRATEGIC INFORMATION AND OPERATIONS RESEARCH CAPACITY STREGTHENED

Targets and Indicators Measuring the Achievement of Output 2.1.5

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	A Strategic Information Strategy is Developed				
2	Guidelines and Protocols for SGS finalized and approved				
3	2nd Round IBBS launched in new locations				
4	2nd Round Size Estimation and Mapping of all MARPs conducted in Western Provinces				
5	Size Estimation and Mapping of vulnerable groups conducted in Border Provinces				
6	OST Needs Assessment conducted				
7	Number of KABP studies conducted among general population				
8	Number of KABP studies conducted among policy makers, health professionals, police and military				
9	Qualitative risk and vulnerability assessment launched among MARPs and vulnerable groups				
10	Training to NACP provided				
11	Training to local research groups				

	provided				

OUTPUT 2.1.6 HIV PROGRAM M&E STREGTHENED AND ALIGNED WITH HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Targets and Indicators Measuring the Achievement of Output 2.1.6

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	M&E Plan Finalized				
2	Number of new NACP staff for M&E				
3	Number of training provided to NACP staff on M&E				
4	Number of trained NGOs on M&E				
5	Information Dissemination Plan Developed and Approved				
6	HIV data is incorporated into HMIS				

Impact Result 3: HIV Related Morbidity and Mortality Reduced

OUTCOME 3.1: LIVES OF X PLHIV HAVE BEEN IMPROVED FROM X % IN 2011 TO Y % IN 2015

Target and Indicator Measuring the Achievement of Outcome 3.1

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Outcome Indicators				
1	% of adults and children PLHV whose lived have been improved 2015				

Output 3.1.1 Strengthen National Capacity for Provision of Universal Access to Treatment,

Targets and Indicators Measuring the Achievement of Output 3.1.1

No	Indicators	Baseline		Targets			
		Value	Source & Year	2012	2013	2014	2015
	Output Indicators						
1	Guidelines on Clinical Management, Treatment, Care and Support finalized and made available						
2	Needs Assessment of Financial, Human and Technical Capacity Conducted						
3	Number of Technical Capacity Training provided						

OUTPUT 3.1.2 INCREASE THE NUMBER OF PLHIV ON ART FROM 70 TO 636 IN 2015

Targets and Indicators Measuring the Achievement of Output 3.1.2

No	Indicators	Baseline		Targets	
		Value	Source & Year	2012	2015
	Output Indicators				
1	Number of adults and children PLHIV receiving ART				
2	Number of new ART sites				
3	Number of ART sites receiving new furniture, equipment				
4	Number of ART officers hired				
5	Number of ART sites integrated into BPHS, EPHS, TB, VCT				
6	Communication Strategy for ART developed and operational				
7	% of TB patients tested for HIV				
8	% of HIV patients on ART receiving referral				

OUTPUT 3.1.3 ENSURE 100% ART SITES PROVIDING QUALITY ASSURED SERVICES ANNUALLY

Targets and Indicators Measuring the Achievement of Output 3.1.3

No	Indicators	Baseline		Targets			
		Value	Source & Year	2012	2013	2014	2015
	Output Indicators						
1	ART Guidelines Finalized						
2	Number of health personnel trained						

	for ART service provision						
3	Number of health facilities providing ART in line with the ART Guidelines						
4	Number of PLHIV receiving ART based on ART Guidelines						
5	ART Working Group estabslished						

OUTCOME 3.2: INCREASE PERCENTAGE OF PLHIV RECEIVING CARE AND SUPPORT FROM X IN 2011 TO Y IN 2015

Targets and Indicators Measuring the Achievement of Outcome 3.2

No	Indicators	Baseline		Targets			
		Value	Source & Year	2012	2013	2014	2015
	Outcome Indicators						
1	% of PLHIV on HIV treatment and care who receive cotrimoxazole in the last 12 months						
2	% of PLHIV who enrolled in chronic care						
3	% of PLHIV receiving nutritional and food support						

Output 3.2.1 Increase Percentage of PLHIV on Cotrimoxazole from X in 2011 to Y in 2015

Output 3.2.2 Integrate Nutritional and Food Support in 100 % of ART services by 2015

Output 3.2.3 Strengthen PLHIV Access to Psychosocial Support

Targets and Indicators Measuring the Achievement of Outputs 3.2.1 – 3.2.2 – 3.2.3

No	Indicators	Baseline		Targets			
		Value	Source & Year	2012	2013	2014	2015
	Output Indicators						
1	Number of PLHIV on HIV treatment and care who receive cotrimoxazole						
2	% of ART and PMTCT sites integrating nutrition in care & support services						
3	Number of PLHIV provided with food						
4	No of PLHIV reached through Home Based Care						
5	No of PLHIV reached through Community Based Care						
6	Number of NGOs providing HBC and CBC						

Output 3.2.4 Provide Support to PLHIV with Income Generating Opportunities by 2015

Target and Indicator Measuring the Achievement of Output 3.2.4

No	Indicators	Baseline		Targets			
		Value	Source & Year	2012	2013	2014	2015
	Output Indicators						
1	Number of men and women PLHIV with						

	viable income-generating projects						
2	Number of men and women from the families of PLHIV with viable income-generating projects						