Islamic Republic of Afghanistan
Ministry of Public Health
DG Preventive Medicine and PHC
National HIV/ AIDS and STI Control Programme

Afghanistan National Strategic Framework for HIV/ AIDS

(2006-2010)

Final Version 07/06/08

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Foreword: By Minister of Public Health

[*To be added, NACP to arrange*]

Acknowledgements

[*To be added by NACP*]

[List of participants at Annex 1]

[*To be added by NACP*]

1 Executive Summary

Afghanistan faces a high risk of HIV/AIDS epidemic. In responding to the challenge, the Afghanistan National Development Strategy (I-ANDS) established a five year goal as: "By Jaddi 1389 (end-2010), a low prevalence of HIV positive cases (<0.5%) in the population will be maintained in order to reduce mortality and morbidity associated with HIV/AIDS"

Accordingly the National AIDS Control Programme (NACP) through a comprehensive process with a wide range of stakeholders and development partners have developed an HIV/AIDS National Strategic Framework (2006 – 2010) as Afghanistan's broad vision and strategic objectives to address and mitigate the impact of HIV/AIDS on Afghanistan National Development Strategy (ANDS).

1.1 Overview of Situation of HIV/ AIDS in Afghanistan

Afghanistan is considered to be a country of low HIV prevalence but at high-risk for spread of HIV infection. The reasons behind this are several: over two decades of protracted armed conflicts, the extremely low socio-political and economic status of women, huge numbers of people displaced internally and externally, the extremely poor social and public health infrastructure, drug trafficking, use of injecting drugs and lack of blood safety and injection practices. These risk factors lead officials to warn of the urgent need for early interventions to prevent a potentially rapid spread of HIV in Afghanistan.

No systematic data on the prevalence of HIV/ AIDS or other sexually transmitted infections (STI) are available due to absence of surveillance in Afghanistan. The two current sources of data on HIV/ AIDS are the Central Blood Bank Kabul and the Voluntary Counselling and Testing Centre at Kabul started in 2005. The data from the Central Blood Bank Kabul indicates the detection of the first HIV positive case in Kabul in 1989. Between 1989 and 2005 the central blood bank reports a total of 67 HIV/ AIDS positive cases out of 125832 blood samples screened at central and provincial levels for HIV/AIDS through rapid testing kits.

With regards to the impact of drug abuse, Afghanistan is one of the world's largest producers of opium. Opium and heroin abuse appear to be more severe in areas where those drugs are produced. There is currently no data on the number of Afghans who inject drugs, although indicators suggest there is an increase in injecting drug users in areas such as Kabul, Gardez, Farah and Herat. All of the Afghan drug users who had sex had never used a condom. In a UNDCP report [1] on Afghan street heroin addicts in Peshawar and Quetta, most heroin addicts reported smoking or inhaling as the main method of ingesting heroin. Still the report warns that there are intravenous users in Afghanistan who risk spreading HIV/AIDS.

A recently published study conducted by UNODC on Kabul heroin users indicates that heroin abuse is spreading in the city. This study found out that there are at least 7015 heroine addicts in Kabul city, out of which around more than 400 are injecting drug users. Another study by UNODC and Ministry of Counter Narcotics 920,000 drug users in the country and 14 percent intravenous drug users. Neighbouring Iran, Tajikistan and recently Pakistan have each reported outbreaks of HIV among injecting drugs users. This is an area of critical concern for Afghanistan.

The ORA International study[1] in 4 districts of Kabul reports that knowledge on HIV/ AIDS among the 126 sex workers surveyed as well as condom use was less than one percent. The study also noted myths and misperceptions on HIV/AIDS such as it being a "foreign' disease.

According to an IOM brief, there are currently an estimated 440,000 people displaced by conflict and natural disasters in camps and cities across Afghanistan [2]. The Ministry of Refugees and Repatriation with partners facilitates a program for voluntary, safe and gradual

return of estimated 1.2 million refugees and 300,000 internally displaced persons [IDPs]. Though UNHCR informs of a health component in some of the IDP camps in the country, this programme currently does not include a component on HIV/ AIDS prevention. International experience provides evidence of spread of HIV along main transport routes. Afghan truck drivers can be considered to be a high risk group for acquiring and transmitting HIV as they travel along such routes and into countries surrounding Afghanistan, all of which have large or developing HIV/ AIDS and STI problems.

The poor state of blood transfusion facilities throughout the country is of primary concern in the control of the spread of AIDS. An estimated half of the country's 44 hospitals that perform surgery do not systematically test the blood for HIV before transfusions. There are 19 centres testing for HIV by the government but the supplies are limited, particularly HIV/ AIDS testing kits. Some NGOs are also supporting blood screening for HIV/ AIDS. Consequently blood transfusion is a major concern- not only for the spread of HIV/ AIDS but also for Hepatitis.

As mentioned earlier there are no confirmed data on STI prevalence in the country. However, information from clinical records particularly from private clinics in large towns suggests that there is perhaps high prevalence of sexually transmitted infections (STI). Private clinics in Kabul report regularly/daily managing STI clients.

Condoms are available through MCH clinics, pharmacies as well as in the shops, even on streets on the street-side sellers. Some NGOs such as Marie Stopes International are initiating social marketing in the country. There are no statistical data on heterosexual multi-partner activities in Afghanistan nor on knowledge on HIV/ AIDS, though the later is very likely to be quite low. A 2005 study by ORA international among high-risk groups for HIV/ AIDS in four districts of Kabul reported of less that 1 percent use of condoms among commercial sex workers.

1.2 Key Responses to HIV/ AIDS in Afghanistan

The key responses to HIV/ AIDS in the country are as follows:

1.2.1 Government of Afghanistan

- A Harm Reduction and HIV/ AIDS Strategy developed by the Ministry of Counter-Narcotics has been approved.
- The National Health Communications Policy and Strategy, 2004-2007 developed by the MoPH includes a specific objective on HIV/ AIDS. In addition the TB and Reproductive Health Strategies have integrated HIV/ AIDS into their programming.
- The Ministry of Youth Action Plan 2006 includes a component "Role of Youth fighting against HIV/ AIDS.
- Training of school teachers has been conducted and a draft teacher training module on HIV/ AIDS developed.
- The Ministry of Public Health has recently included HIV/ AIDS in the Basic Package of Health Services (BPHS) at various levels of health service delivery.
- In selected provinces the MoPH has initiated reproductive health and HIV/ AIDS projects specifically for out of school youth by establishing youth information centres and youth friendly services. A general life skills module (not specifically for HIV/ AIDS) has also been developed for primary students.
- The MoPH has developed a comprehensive plan for strengthening access to safe blood in the country. The NACP reported procurement and distribution of 20,000 kits

for HIV/ AIDS through the blood banks. Training of laboratory technicians, nurses and blood bank staff has also been conducted.

- The MoPH has completed a Draft National Guidelines on VCT and trained staff in voluntary counseling in Iran, while plans have been initiated to establish VCTs and conduct staff training in other cities in the country.

1.2.2 Non-Governmental Organizations and International Agencies:

- Ora International has conducted a survey on behaviour and practices among high risk and vulnerable populations and initiated a small program with sex workers in selected districts of Kabul. This includes a drop-in centre with counselling and health facilities.
- Action Aid has undertaken research into HIV/ AIDS risks among vulnerable groups; this includes truck drives, sex workers, drug users, migrant workers, and returnees in four (4) cities in Afghanistan.
- World Food Program conducted training for truck drivers.
- IFRC has a program on STI prevention and is providing syndromic treatment in their clinics as well as training service providers.
- AMI is providing HIV testing kits at Maiwand hospital and conducting training of laboratory technicians.

1.3 Afghanistan National HIV/ AIDS Strategic Framework (ANASF: 2006 -2010)

The National Strategic Framework was developed through highly participatory and consultative processes including revisions among government officials, nongovernmental stakeholders and development partners.

1.3.1 Purpose

The ANASF is a broad strategic framework designed to guide Afghanistan's response to HIV/ AIDS. It will serve as a guide for a wide range of stakeholder involvement in the response to HIV/ AIDS prevention, care and treatment in the country. It will assist stakeholders to develop their own strategic plans so that all initiatives in the country can be harmonized to maximize efficiency and effectiveness. It is based on analysis of the limited available data, and takes into account the resource constraints of the country in both human and financial terms. It establishes fundamental principles and identifies clear priority areas where increased attention is likely to have the greatest impact on HIV/ AIDS in Afghanistan. Finally, it recognises that HIV/ AIDS is a development issue, and requires a broad multi-sectoral response that addresses the complex web of underlying causal factors as well as its equally complex consequences.

1.3.2 Guiding Principles

The Afghanistan National HIV/ AIDS Strategic Framework for HIV/ AIDS is underpinned by a number of basic guiding principles which support and provide guidance for the objectives, strategies and interventions. These guiding principles are based on moral and ethical values which are held important throughout Afghanistan, in combination with best professional practice in preventing HIV/ AIDS. They are also firmly rooted in the new Afghanistan National Development Strategy.

- All persons have the right to protection from HIV infection and other STIs. Information, Education and Communications (IEC), and counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times.

- The vulnerable position of women in society shall be addressed to ensure that they do not suffer from any form of discrimination, nor remain unable to take effective measures to prevent infection.
- Confidentiality and informed consent with regard to HIV testing and test results shall be protected. All HIV tests should be voluntary with guaranteed confidentiality and adequate pre and post-test counselling, except in those cases where testing occurs under unlinked and anonymous conditions for screening of donated blood [where blood is discarded on initial reactivity and results are not communicated to the donor].
- Full community participation in prevention as well as care shall be developed and fostered.
- All interventions shall be subjected to critical evaluation and assessment. Continued efforts should be made to constantly improve HIV/ AIDS programmes, taking into account lessons learned at national, regional and/ or global level.
- Afghan capacity building will be emphasized to accelerate HIV/ AIDS prevention and control measures.
- People living with HIV/ AIDS shall be involved in all prevention, intervention and care strategies.
- People living with HIV and AIDS, their families and friends shall not suffer from any form of discrimination.
- The formulation of socio-economic development policies and programmes should include consideration of the impact of HIV/ AIDS.
- All efforts to combat HIV/ AIDS should considered and be sensitive to the socio-economic and cultural context of Afghanistan.
- In line with international experience a harm reduction approach will underpin the HIV/ AIDS strategy

1.4 Goal

"By Jaddi 1398 (end-2010), a low prevalence of HIV positive cases (<0.5%) in the population will be maintained in order to reduce mortality and morbidity associated with HIV/AIDS

1.5 Objectives

1. To strengthen strategic information to guide policy formation, programme planning and implementation.
2. To gain political commitment and mobilise resources necessary to implement the national HIV/ AIDS/ STI strategy.
3. To ensure development and coordination of a multi-sectoral HIV/ AIDS response and develop institutional capacity of all the sectors involved.
4. To raise public awareness on HIV/ AIDS and STI prevention and control, ensure universal access to behaviour change communication on HIV, especially targeting vulnerable and at risk groups
5. To ensure access to prevention, treatment and care services for high-risk and vulnerable populations

6. To strengthen the health sector capacity to implement an essential package of HIV/ AIDS prevention, treatment and care services within the framework of BPHS and EPHS

2 Introduction

While Afghanistan does not yet have a large number of reported HIV/ AIDS cases, a number of vulnerabilities and patterns of risky behaviours signal the need to take action now, before it is too late to make a difference to the course of the epidemic. Towards that end the Ministry of Health in collaboration with the HIV/ AIDS Task Team and partners and stakeholders in the country has undertaken the development of the Afghanistan National Strategic Framework for HIV/ AIDS for the period 2006-2010. In light of the current circumstances in Afghanistan a detailed action plan and budget for 2006 will be developed by the HIV/ AIDS task force and the NACP. Yearly action plans will be developed for the remainder of the Strategy.

2.1 Socio-Economic Context

Years of conflict and neglect have taken a devastating toll on human, social and economic indicators in Afghanistan, resulting in some of the lowest human development indicators in the world. With and estimated HDI vale of 0.346, Afghanistan falls at the bottom of the 177 countries ranked by the global HDR report of 2004, just above few African countries. The literacy rate in Afghanistan is one of the lowest among developing countries. Only 28.7 percent of Afghans over the age of 15 can read or write. Life expectancy in Afghanistan at 44.5 years at birth is at least 20 years lower than all its neighbouring countries. The mean Maternal Mortality Ratio is 1,600/100,000 live birth that is death of a women every 30 minutes in the country from causes related to pregnancy and child birth. With respect to poverty, according to the NRVA study, 20.4 per cent of the rural population consumes less than 2070 calories per person per day. Under the post-Taliban Government, Afghanistan's economy has recovered. Non-drug GDP rose to about US $4.05 billion in 2002- a yearly recovery of 25-30 percent. The impact of years of discrimination against women, coupled with prevailing poverty and insecurities, has meant that Afghan women have some of the worst social indicators in the world today. Afghans comprise the second largest number of refugees and IDPs in the world[1].

2.2 Situation of HIV/ AIDS in Afghanistan

No systematic data on the prevalence of HIV/ AIDS or other sexually transmitted infections (STI) are available due to absence of surveillance in Afghanistan. The two current sources of data on HIV/ AIDS are the Central Blood Bank Kabul and the Voluntary Counselling and Testing Centre at Kabul started in 2005.

The data from the Central Blood Bank Kabul indicates the detection of the first HIV positive case in Kabul in 1989. Between 1989 and 2005 the central blood bank reports a total of 67 HIV/ AIDS positive cases out of 125832 blood samples screened at central and provincial levels for HIV/ AIDS through rapid testing kits. Table 1 below provides data of the HIV/ AIDS testing records from the Central Blood Bank. From the 67 positive cases, 37 were living in Afghanistan and the rest were refugees/ returnees from Pakistan, Iran, Saudia Arabia and Dubai. 35 HIV positive cases were reported from the Central Blood Bank Kabul and the remaining from the provinces of Nangahar, Hirat, Balkh, Jozgan and Kunduz.

Table 1. HIV testing data from Central Blood Bank Kabul

[1] Afghanistan National Human Development Report 2004. UNDP & Islamic Republic of Afghanistan.

Year	Test Area	Total Tested	HIV Positive
1989	Central Blood Bank	Unknown	1
1994	Central Blood Bank	unknown	1
2000	Central Blood Bank	6844	1
2001	Central Blood Bank	6691	6
2002	Central Blood Bank	11,586	1
2002	Mazar	964	2
2003	Central Blood Bank	10,674	6
2003	Nangarhar	3,629	1
2004	Central Blood Bank	10,514	10
2004	Nangarhar	3,535	13
2004	Quandahar	NA	1
2004	Juzjan	1,264	1
2005	Central Blood Bank	7,684	7
2005	Nangarhar	2,145	9
2005	Hirat	2,185	1
2005	Quandahar	1,867	3
2005	Kunduz	826	1
Total	**Blood samples tested for HIV till 2005**	**125,832**	**67**

[Source: Statistics by Director, Central Blood Bank Kabul]

2.3 Risk Factors & Vulnerabilities

Afghanistan is considered to be a country of low HIV prevalence but at high-risk for spread of HIV infection. The reasons behind this are several: over two decades of protracted armed conflicts, the extremely low socio-political and economic status of women, huge numbers of people displaced internally and externally, the extremely poor social and public health infrastructure, drug trafficking, use of injecting drugs and lack of blood safety and injection practices. These risk factors lead officials to warn of the urgent need for early interventions to prevent a potentially rapid spread of HIV in Afghanistan.

(i) Drug abuse: Afghanistan is one of the world's largest producers of opium. Opium and heroin abuse appear to be more severe in areas where those drugs are produced. There is currently no data on the number of Afghans who inject drugs, although indicators suggest

there is an increase in injecting drug users in areas such as Kabul, Gardez, Farah and Herat. Recent reliable reports from Gardez town in Paktia province suggest that there are well over 100 IDUs, injecting heroin, morphine and sosegon (pentazocine). Research conducted by the Johns Hopkins Bloomberg School of Public Health on Pakistani and Afghan drug users at high HIV risk[2] indicates that only 16 percent of the study participants had heard of HIV/ AIDS. All of the Afghan drug users who had sex had never used a condom. In a UNDCP report[3] on Afghan street heroin addicts in Peshawar and Quetta, most heroin addicts reported smoking or inhaling as the main method of ingesting heroin. Still the report warns that there are intravenous users in Afghanistan who risk spreading HIV/ AIDS[4]. Besides, although only 6.3 percent of the respondents had reported drug injection, 43 percent of this group had shared injecting equipment, on average with 4 to 6 users at one time. A very recently published study conducted by UNODC on Kabul heroin users indicates that heroin abuse is spreading in the city. This study found out that there are at least a minimum of more than 7015 heroine addicts in Kabul city, out of which around more than 400 are injecting drug users.

A recent UNODC and Ministry of Counter Narcotics Study reports 920,000 drug users in the country, with an estimated 15% of 50,000 heroin users injecting their drugs"

"Neighbouring Iran, Tajikistan and recently Pakistan have each reported outbreaks of HIV among injecting drugs users. As long ago as 2001 it was estimated that 67 per cent of the rising HIV transmission rate in Iran was caused by drug injectors sharing equipment, with needle sharing being of particular concern throughout a prison system where more than 50 per cent of inmates were incarcerated for drug-related offences. It is of critical concern to Afghanistan that neighbouring countries have high HIV infection rates among their IDU populations."

(ii) Commercial Sex Work: There is evidence of increasing commercial sex work in larger cities and towns. There is information on two studies conducted with commercial sex work in Afghanistan. The ORA International study[5] in 4 districts of Kabul reports that knowledge on HIV/ AIDS among the 126 sex workers surveyed as well as condom use was less than one percent. The study also noted myths and misperceptions on HIV/ AIDS such as it being a "foreign' disease. Four male sex workers were also included in the study. 78 percent of the female commercial sex workers were married.

(iii) Mobile populations: refugees, internally displaced persons, truck drivers and migrant workers: Refugees and internally displaced persons are particularly vulnerable to HIV for various reasons, including exposure to sexual abuse, violence, and lack of access to information and education. Over 5 million Afghans have been living as refugees or displaced persons in the past decade, with over two million of those refugees living in Pakistan. Although there is a risk of refugees bringing in the disease there was also a danger of them being stigmatised for this. According to an IOM brief, there are currently an estimated 440,000 people displaced by conflict and natural disasters in camps and cities across Afghanistan[6]. The Ministry of Refugees and Repatriation with partners facilitates a programme for voluntary, safe and gradual return of estimated 1.2 million refugees and

[2] Strathdee Steffanie et al. (2003*), "HIV Knowlege and Risk Behaviors among Pakistani and Afghani Drugs Users in Quetta, Pakistan"*. Journal of Acquired Immune Deficiency Syndromes. April 2003

[3] UNDCP (2000), Community Drug Profile #3. "*A comparative study of Afghan street heroin addicts in Peshawar and Quetta".*

[4] AIDS Statistics unknown due to social repression. Ron Synovitz. 11 July 2002. www.reliefweb.int

[5] April 2005 Ora International

[6] IOM Press briefing notes 9 July 02. www.reliefweb.int

300,000 internally displaced persons [IDPs]. Though UNHCR informs of a health component in some of the IDP camps in the country, this programme currently does not include a component on HIV/ AIDS prevention. International experience provides evidence of spread of HIV along main transport routes. Afghan truck drivers can be considered to be a high risk group for acquiring and transmitting HIV as they travel along such routes and into countries surrounding Afghanistan, all of which have large or developing HIV/ AIDS and STI problems. There are thought to be around 2,000 international truck drivers and 60,000 domestic truck drivers in Afghanistan. There is at present no data regarding HIV risk behaviours or the prevalence of HIV/ AIDS amongst truck drivers in Afghanistan. There are no accurate figures available but it is estimated that around 1,000,000 Afghan people leave Afghanistan yearly to work in surrounding countries. Many are working in countries and cities with significant HIV/ AIDS prevalence. These workers may spend long periods away from home and family. Workers from neighbouring countries also come into Afghanistan to work. There are no data available on risk behaviours or prevalence of HIV amongst Afghan migrant workers.

(iv) Blood safety: The poor state of blood transfusion facilities throughout the country is of primary concern in the control of the spread of AIDS. An estimated half of the country's 44 hospitals that perform surgery do not systematically test the blood for HIV before transfusions. There is no exact information on the percentage of blood screened. A WHO brief[7] states that neither the number of transfusions carried out in Afghanistan nor the number screened for transmissible agents is well documented. The figures usually quoted are around 60,000 transfusions per year with 12000-16,000 in Kabul alone, of which no more than 30 percent have been tested for transmissible agents including HIV/ AIDS. There are 19 centres testing for HIV by the government but the supplies are limited, particularly HIV/ AIDS testing kits. Some NGOs are also supporting blood screening for HIV/ AIDS. Consequently blood transfusion is a major concern- not only for the spread of HIV/ AIDS but also for Hepatitis.

(v) Sexually Transmitted Infections: As mentioned earlier there are no confirmed data on STI prevalence in the country. However, information from clinical records particularly from private clinics in large towns suggests that there is perhaps high prevalence of sexually transmitted infections (STI). Private clinics in Kabul report regularly/daily managing STI clients. Interviews during the mission informed of gonorrhoea being the most common STI. Though syphilis-testing facilities are available at the Maiwand Hospital in Kabul, there is no report on any case of syphilis since many years from the hospital. In 2000 IRC performed 1000 RPR tests for Syphilis among Afghan refugees and all were negative. However, ARCS/IFRC clinic information as well as from the MoH Central Laboratory revealed syphilis chancre clients during recent months**.**

(vi) Condom use & Knowledge on HIV/ AIDS: The 2000 MICS[5] reports a current use of contraception by 2 percent of married women in South Eastern region and 8 percent of married women in the Eastern region of Afghanistan. Injectables appear to be the most common contraceptive and condom use is reported to be low. Condoms are available through MCH clinics, pharmacies as well as in the shops, even on streets on the street-side sellers. Some NGOs such as Marie Stopes International are initiating social marketing in the country. There are no statistical data on heterosexual multi-partner activities in Afghanistan nor on knowledge on HIV/ AIDS, though the later is very likely to be quite low. A 2005 study by ORA international among high-risk groups for HIV/ AIDS in four districts of Kabul reports of less that 1 percent use of condoms among commercial sex workers.

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[7] Blood transfusion service in Afghanistan.WHO Kabul note given during mission meeting. 23 June 03.

(vii) Gender and Socio-Economic aspects: Two decades of conflict and human displacement, compounded by 3 years of drought, together with a history of discrimination against women from policies of controlling authorities, have had a severe impact on Afghanistan's health sector with women being hardest hit. The 1996 UNDP Human Development Report placed Afghanistan 169th out of 175 countries in the Human Development Index. Due to lack of data, Afghanistan's status has not appeared in subsequent reports. However, though there is little confirmed data on national health indicators, there is clear evidence of very high rates of maternal morbidity and mortality. Women's health is extremely poor due to malnutrition, frequent pregnancies without basic care or trained delivery assistance, and lack of access to information or services. The March 2002 Afghanistan ECOSOC report[8] paragraph 21 on violence against women and girls, its consequences and causes discusses instances of rape, sexual assault, forced prostitution and forced marriage. The civil war and militarisation of society led to an increase in number of abductions of young girls and women by the fighters. It is difficult to obtain exact numbers as families have been reluctant to come forward and report cases of abductions due to the social stigma attached to a daughter or sister kidnapped or sold for sex. 54 percent of girls under the age of 18 were reported to be married.

2.4 Issues and Challenges

- There is urgent need to increase political commitment in view of the changes in Afghanistan's political structure.
- There is no national policy on HIV/ AIDS, and there are gaps in other national policies to address HIV and AIDS. Thus there is need for comprehensive review of existing national policies to ensure they are supportive of the fight against HIV/ AIDS.
- There is no established HIV/ AIDS surveillance system. This component is a high priority. Only by better understanding of Afghan's knowledge, attitudes, and practices related to HIV/ AIDS and its risk factors can public education campaigns be effectively designed and implemented.
- Need to assess and build capacity of NACP to enhance effective institutional coordination, programmes monitoring and evaluation and resource mobilization and utilization.
- Need to enhance public sector responses and mainstream HIV/ AIDS into all national development projects.
- There are no services for HIV/ AIDS treatment, care, and support including no prevention of mother to child transmission (PMTCT) services available in the country.
- Strengthen the health sector systems to provide comprehensive gender-sensitive prevention care, treatment and support services to the general, vulnerable populations and those infected.
- Build capacity and protect health care workers.
- Strengthen the technical and operations capacities of VCTS, and improve quality of testing services

[8] Discrimination against women and girls in Afghanistan. Economic and Social Council 4-15 March 2002. Report of the Secretary General.

- The rising population of refugees and returnees calls for urgent HIV prevention programmes.
- Promote awareness and capacity building of media agencies.
- Increase the involvement of youth, women, and people living with AIDS (PLWA) in policy advocacy, communications and social mobilization.
- Promotion of cross-border collaboration of target HIV/ AIDS interventions.

3 Response to HIV/ AIDS in Afghanistan

The Ministry of Public Health drafted a Strategic Plan on HIV/ AIDS and STI in Afghanistan for the period 2003-2007. A review of HIV/ AIDS response in the country based on the outputs and targets of the plan is summarised below:

3.1 Policy, Planning and Institutional Development

Following the approval of the Strategic Plan in 2003 Ministry of Public Health established the National AIDS Control Programme (NACP) with one Manager and 3 technical experts and new office space in the Ministry campus. A Harm Reduction and HIV/ AIDS Strategy developed with the Ministry of Counter Narcotics has been approved. An HIV/ AIDS Task Force was established with key partners and stakeholders that is chaired by the NACP Manager. To mobilise resources for HIV/ AIDS the Ministry submitted two proposals on HIV/ AIDS component to the Global Fund – one of which was approved and is being implemented. The NACP has also developed draft National Guidelines on Voluntary Counselling and Testing in the country during 2005. Several Policy documents of the Islamic Republic of Afghanistan have included HIV/ AIDS[9]. The recent Afghan National Development Strategy states that by Jaddi 1389 (end 2010) a low prevalence of HIV positive cases [,0.5%] in the population will be maintained in order to reduce mortality and morbidity associated with HIV/ AIDS. The Ministry of Public Health has recently included HIV/ AIDS in the Basic Package of Health Services [BPHS] at various levels of health service delivery.

3.2 HIV/ AIDS programming for vulnerable populations

There are some small initiatives implemented by NGOs working with vulnerable populations. For examples needle and syringe access and disposal programmes (NSPs), distribution of condoms and other harm reduction initiatives through the VCT centre in Kabul and the NGOs Nejat, KOR and WADAN in Kabul, Qandahar and Gardez." include: Programming for IDUs in Kabul including needle exchange, distribution of condoms is being done at the VCT Centre in Kabul, by NGOs Nejat and KOR. Wadan has a drug treatment centre in Kandahar. Police have been trained nationally on drug misuse by KOR. There is very limited coverage of the interventions needed for an effective national response to HIV/ AIDS. *Ora International* has conducted a survey on behaviour and practices among high risk and vulnerable populations and initiated a small program with sex workers in selected districts of Kabul. This includes a drop-in centre with counselling and health facilities. *Action Aid* has undertaken research into the HIV/ AIDS risks among vulnerable groups. This included truck drivers, sex workers, drug users, migrant workers, returnees others in 4 cities in Afghanistan. The results of the work are awaited Training of truck drivers by the World Food Programme in Afghanistan has also been conducted. Twenty four staff from drug treatment centres have received a 2-week comprehensive training programme in harm reduction, including the development of NSPs and safer injecting techniques".

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[9] See Annex Documents

3.3 IEC/ General Awareness among different groups

The National Health Communications Policy and Strategy 2004-2007, MoPH includes a specific objective on HIV/ AIDS. The strategy mentions targeting the following 4 behaviours in the context of HIV/ AIDS- Lack of condom use, re-using and not cleaning syringes and needles, marginalizing and stigmatising PLWHA and using dirty razors and other instruments [barbers etc].

World AIDS Day 2002 the United Nations urged swift action by the international community to support Afghanistan's AIDS awareness campaign**.**

3.4 Young People

The Ministry of Youth draft strategy and the Child/Adolescent Dept of the MoPH draft strategy both include references to HIV/ AIDS. The Ministry of Youth Action Plan 2006 has included an item 'Role of Youth fighting against HIV/ AIDS'. Training of school teachers has been conducted by the Ministry of Education and a draft teacher training module on HIV/ AIDS developed.

In selected provinces the MoPH has initiated integrated reproductive health and HIV/ AIDS projects specifically for out of school youth through establishing youth information centres and youth friendly services have been initiated by MoPH. These are available through youth information services and youth friendly services, also established by the MoPH. A general life skills module [not specifically for HIV/ AIDS] has also been developed for primary students.

3.5 STI Services

STI services are not part of the basic package of services offered in health facilities. However NGOs are providing RTI/STI services as part of integrated RH services. STI clinics have also been established by NGOs such as in Hirat. IFRC has a programme on STI prevention and is providing syndromic treatment in their clinics as well as training service providers on the same. Another NGO, AMI is providing HIV testing kits at Maiwand hospital and conducting training of laboratory technicians.

3.6 Linkages with National Reproductive Health & Tuberculosis program

Several draft Strategies being developed in the country such as by the Youth Ministry, Tuberculosis Strategy, Reproductive Health Strategy have included HIV/ AIDS and envisage linkages with NACP. The reproductive health programmes include condom programming but this is primarily positioned for family planning than for dual protection. There are no prevention (of any kind) of mother to child transmission [PMTCT] services available in the country. The draft tuberculosis strategy has included integrating HIV/ AIDS information at DOTS centres. A study on HIV/ AIDS in TB clients is currently on going supported by the Global Fund.

3.7 Voluntary Counselling and Testing

The MoPH has established on VCT centre in Kabul in 2005. Draft National Guidelines on VCT were developed and VCT staff trained in Iran. Plans have been initiated to establish VCT at other cities in the country shortly and training in the same.

3.8 Blood Safety

Current HIV/ AIDS activities in Afghanistan are focused on efforts to increase blood safety in major health facilities. The central blood bank receives reports from 11 provinces where it has functioning branches. In the remaining 22 provinces in the country, CBB branches are partially functioning or not functioning at all. In these areas therefore, blood transfusions are

undertaken without any screening for HIV and other Blood Borne Diseases (BBDs). The Ministry of Public Health through support from external donors [French Embassy] has developed a comprehensive plan for strengthening access to safe blood in the country. The NACP reports procurement and distribution of 20,000 kits for HIV/ AIDS testing through the blood banks. Training of laboratory technicians, nurses and blood bank staff has also been conducted.

3.9 Treatment, Care and Support

There are no services for HIV/ AIDS treatment, care and support in the country.

3.10 Harm Reduction

Harm reduction is about reducing or minimising the actual or potential harms arising from a damaging activity that will most certainly occur. There is now a considerable international evidence base showing that harm reduction initiatives within a public health framework are essential to prevent the spread of HIV/ AIDS among IDUs and from this group to the wider population. Problem drug use, including injecting drug use, is generally linked to a range of health, as well as economic, social and legal, harms, including the spread of HIV/ AIDS and other STIs. To protect individuals, families and the community from injecting drug use and its associated harms, special harm reduction measures and strategies are required in all countries. These strategies are detailed in the *The National Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan,* HIV/ AIDS Unit Ministry of Public Health Demand Reduction Section, Ministry of Counter Narcotics, May 2006 (Annex 1). The recommendations in this strategy are to be considered when developing priorities for action on HIV/ AIDS related to IDU in Afghanistan"

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3.12 Surveillance

There is no established system of HIV/ AIDS surveillance in Afghanistan. This is a priority need.

4 National HIV/ AIDS & STI Strategic Framework

4.1 Rationale for revision of the National Strategic Plan

There have been a number of important changes since the development of the National HIV/ AIDS and STI Strategic Plan in 2003:

- The earlier strategy was developed during the time of the Transitional Government. There is a new environment including the establishment of the National Parliament and elected government.
- A new Afghanistan National Development Strategy [ANDS] has been developed which has identified addressing HIV/ AIDS as well as in 2005 HIV/ AIDS has been included in the basic package of health services.
- HIV/ AIDS has been incorporated in the Basic Package of Health Services for Afghanistan, 2005/1384 (BPHS)
- A Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/ AIDS Prevention in Afghanistan, developed by the HIV/ AIDS Unit Ministry of Public Health Demand Reduction Section, Ministry of Counter Narcotics was approved in 2005
- The institutional mechanisms and targets set by the earlier strategy needed to be revised to scale-up HIV/ AIDS action in the country in line with the international agreements and commitments that are mainly "Three Ones": ONE agreed AIDS action framework, One national AIDS coordinating authority and ONE agreed monitoring and evaluation framework; the UN General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/ AIDS; and the last World Summit commitment on Universal Access to treatment by 2010 for those who need it.

A Five-Year Strategic Framework and Plan is needed to:

- Outline the key priority areas and overall objectives to address the risk of HIV/ AIDS prevention in the country.
- Provide a rough estimation of financial resources required for HIV/ AIDS prevention and control in Afghanistan 2006 - 2010.
- Guide international partners in channelling their financial and technical assistance to support national objectives.
- Identify the institutional mechanism, human resource development and management plan needed to implement the objectives.
- Provide direction and basis for preparation of annual operational plans

4.2 Strategic Plan Revision Process

The process of revision of the National Strategic Plan was initiated by the HIV/ AIDS Task force meeting in December 2005 when the need for review and revision of the plan in the context of the new environment was identified. The NACP endeavoured to make the prevision process of the strategy very participatory to ensure inputs from various stakeholders and partners. A consultative meeting was organised with the HIV/ AIDS Task team on 17 January 2006 to initiate the participatory process and solicit inputs on achievements, constraints, challenges and recommendations[10].

A NACP strategy review and revision mission met individually with partners from UNAIDS cosponsor agencies, NGOs, donors, different departments of MoPH [IEC, RH, TB] and various ministries [Youth, Women's Affairs others] to solicit inputs and suggestions on the strategy and build partnership in the area of HIV/ AIDS[11]. Two consultative workshops were held on 24 January and 6 March 2006 to provide input to the review and revision process.

[10] See list of participants and minutes of the meeting of 17 January 2006.

[11] See List of Contributors

Working groups were established in the areas of (i) Leadership and Capacity Development (ii) High Risk and vulnerable populations and (iii) Health to provide inputs on the strategy and develop the operational plan and budget in each of the three areas. NACP officers were active in coordinating the review process.

The consultative process sought insight from policy makers, workers in the field and experiences from wide range of stakeholders to ensure a strong basis for designing the revised plan. The comments and suggestions given by the individuals and groups have been incorporated in this draft.

This draft strategy will be translated in Dari and Pashto and shared for review and inputs from the provincial level.

4.3 Purpose and Guiding Principles

4.3.1 Purpose

The document is a broad strategic plan designed to guide Afghanistan's response to HIV/ AIDS. It will serve as a guide for a wide range of stakeholder involvement in the response to HIV/ AIDS prevention, care and treatment in the country. It will assist to Stakeholders to develop their own strategic plans so that all our initiatives as a country can be harmonised to maximise efficiency and effectiveness. It is based on analysis of the limited available data, and takes into account the resource constraints of the country in both human and financial terms. It establishes fundamental principles and identifies clear priority areas where increased attention is likely to have the greatest impact on HIV/ AIDS in Afghanistan. Finally, it recognises that HIV/ AIDS is a development issue, and requires a broad multi-sectoral response that addresses the complex web of underlying causal factors as well as its equally complex consequences.

4.3.2 Guiding Principles

The Afghanistan National HIV/ AIDS Strategic Framework for HIV/ AIDS is underpinned by a number of basic guiding principles which support and provide guidance for the framework's more specific, objectives, strategies and interventions. These guiding principles are based on moral and ethical values which are held important throughout Afghanistan, in combination with best professional practice in preventing HIV/ AIDS. They are also firmly rooted in the new Afghanistan National Development Strategy. To translate these in the context of HIV/ AIDS prevention the following statements of principle are articulated:

- All persons have the right to protection from HIV infection and other STIs. Education, counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times.
- The vulnerable position of women in society shall be addressed to ensure that they do not suffer from any form of discrimination, nor remain unable to take effective measures to prevent infection.
- Confidentiality and informed consent with regard to HIV testing and test results shall be protected. All HIV tests should be voluntary with guaranteed confidentiality and adequate pre and post-test counselling, except in those cases where testing occurs under unlinked and anonymous conditions for screening of donated blood [where blood is discarded on initial reactivity and results are not communicated to the donor].
- Full community participation in prevention as well as care shall be developed and fostered.

- All interventions shall be subjected to critical evaluation and assessment. Continued efforts should be made to constantly improve HIV/ AIDS programmes, taking into account lessons learned at national, regional and/or global level.
- Afghan capacity building will be emphasised to accelerate HIV/ AIDS prevention and control measures.
- People with HIV/ AIDS shall be involved in all prevention, intervention and care strategies.
- People with HIV and AIDS, their families and friends shall not suffer from any form of discrimination.
- The formulation of socio-economic development policies and programmes should include consideration of the impact of HIV/ AIDS.
- All efforts to combat HIV/ AIDS should considered and be sensitive to the socio-economic and cultural context of Afghanistan.
- In line with international experience a harm reduction approach will underpin the HIV/ AIDS strategy

5 Goal

The National Strategic Framework is a summary of the strategies and interventions identified through a consultative planning process. The plan forms the basis of the national response to HIV/ AIDS.

5.1 Goal

By Jaddi 1389 (end-2010), a low prevalence of HIV positive cases (<0.5%) in the population will be maintained in order to reduce mortality and morbidity associated with HIV/ AIDS [from -Afghanistan National Development Strategy]

6 Objectives

The six objectives in the plan are:

1. To strengthen strategic information to guide policy formation, programme planning and implementation in line with national targets set in the COMPACT as well as internationally agreed targets and commitments that are: "The Three Ones", The UN General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/ AIDS, and the September 2005 World Summit target of Universal Access to treatment by 2010 for all who need it.
2. To gain political commitment and mobilise resources necessary to implement the national HIV/ AIDS/STI strategy.
3. To ensure development and coordination of a multi-sectorial HIV/ AIDS response and develop institutional capacity of all the sectors involved
4. To raise public awareness on HIV/ AIDS and STI prevention and control, ensure universal access to behaviour change communication on HIV, especially targeting vulnerable and at risk groups
5. To ensure access to prevention, treatment and care services for high-risk and vulnerable populations

6. To strengthen the health sector capacity to implement an essential package of HIV/ AIDS prevention, treatment and care services within the framework of BPHS & EPHS.

6.1 Objectives, Key Strategies and Outputs

The priority areas identified in the situation and response analysis developed through meetings with stakeholders are elaborated in the six objectives of the strategic framework. The objectives, their outputs and key strategies are discussed in this section of the strategy

6.1.1 Objective 1: To strengthen strategic information to guide policy formation, programme planning and implementation

6.1.1.1 Surveillance

As of yet, no routine surveillance system for HIV exists within Afghanistan. The true extent to which HIV has penetrated the population of Afghanistan is not known. Limited HIV testing capacity exists, yet results of tests performed at these facilities are rarely reported back to MOPH. It is imperative that a viable surveillance system be developed.

The main objective of surveillance is to inform policy makers and programme managers about trends in HIV rates and risk behaviours over time across different regions and population groups. Surveillance information is needed to guide decision making on appropriate interventions and for the evaluation of their impact. In low-level epidemics where relatively low HIV prevalence is measured in any group, surveillance systems focus largely HIV infection and behaviours in groups at high risk.[12]

Key Strategies:

- Constitute a multi-disciplinary technical HIV/STI surveillance working group including all partners involved in HIV/STI surveillance to advise and support the MoPH/NACP. Define who will work with partners and implementing agencies to coordinate strategic information and data for integration
- Develop a surveillance framework (outlining the surveillance system) based on internationally recommended HIV/ STI surveillance guidelines (WHO/UNAIDS) with technical guidelines and tools for surveillance activities
- Define roles and assign responsibilities within the MoPH for the NACP, the M&E and HMIS departments and develop appropriate linkages in order to develop integrated capacity to manage the flow of data and to interpret information.
- Build information management capacity of the NACP, HMIS team and laboratory staff at the national and provincial level and of all partners involved (incl BPHS) to collect, analyse and interpret data and to ensure that ethical principles are observed
- Establish routine surveillance (case reporting) and carry out periodic surveillance (sentinel sero-surveys and behavioural surveys) according to progress made in developing the required capacity.
- Assess HIV prevalence among most at risk populations

Output 1.1: Effective surveillance system developed and functional

[12] Initiating second generation HIV surveillance systems: practical guidelines. UNAIDS & WHO.2002

6.1.1.2 Monitoring & Evaluation

Monitoring and evaluation are key elements for an expanded and comprehensive response to HIV/ AIDS. They allow programme managers and policy makers to assess whether existing programmes and interventions are sufficient and to determine challenges to achieving successful outcomes. The monitoring and evaluation plan is strongly linked to the planning process and needs to be put in place at the start of any programme. Thus planning an intervention and designing an evaluation strategy are inseparable activities.

N.B. Monitoring is measuring of inputs and outputs or it is process evaluation.

Evaluation is measuring of outcomes and impact or it is effectiveness evaluation.

Key Strategies:

- Establish multi-sectorial monitoring and evaluation technical working group affiliated to the NACP unit and NAC desk (MoPH) involving M&E focal points of all sector ministries and key national and international partners
- Develop monitoring and evaluation framework correlating inputs, processes, outputs and outcomes (see figure 1) including indicators and their means of verification
- Develop M&E technical capacity at all levels of the government M&E system, (the NACP, all sectors and civil society organizations involved)

Output 1.2: Effective monitoring and evaluation system developed and functional.

6.1.1.3 Operational Research

Operational research is one source to provide strategic information to planners and decision makers. It can help to involve, guide and coordinate the roles of care providers from government, the private sector, nongovernmental organizations, communities, faith-based organizations and the workplace, in the HIV/ AIDS response. Equally importantly, such research is needed to measure and monitor in a standardized way the impact of different interventions, as for example; antiretroviral therapy in terms of parameters such as additional years of healthy life, fewer deaths, economic progress across society, development of drug resistance, and adherence to treatment. In Afghanistan, it is needed to use this source of information in a useful way, through proper guidance, identifying country HIV/ AIDS priorities, and using the research results in policy and planning process.

Key Strategies:

- Establish scientific committee to guide and ensure scientific and ethical soundness of operational research activities and to identify operational research priorities
- Develop operational research capacity of NACP and MoPH
- Develop mechanisms for operational research to inform HIV/ AIDS policy and strategy development

Output 1.3: Scientific evidence for an effective HIV/AIDS response available through operational research.

6.1.2 Objective 2: To gain political commitment, build partnerships and mobilize resources necessary to implement the national HIV/ AIDS/STI strategy

Globally AIDS has proved to be an exceptional crisis, by any standard —that can only be countered by an exceptional response. AIDS is incomparable is because there is simply no precedent in history for an epidemic with such damaging and long-lasting effects on social and economic development.

Afghanistan has the unique opportunity to turn the tide on the AIDS epidemic. While the Afghani people are increasingly vulnerable to HIV infection, currently there are still a small number of cases reported. What precedent has taught us, is that countries; where national leaders are mainstreaming the response to AIDS, speaking about it frankly and mobilizing all government sectors and civil society to address AIDS and its underlying causes, have seen the spread of the epidemic reversed.

6.1.2.1 Political Commitment

This priority component seeks to increase awareness and generate the political leadership and legal support required for an effective response throughout various levels of leadership in Afghanistan including parliamentarians, religious leaders, different ministries of government and others.

Key Strategies:

- Inform the President of Afghanistan of the current window of opportunity that exists to mitigate the impact of HIV/ AIDS and request his esteemed leadership on this issue.
- Using evidence based internationally recognized good practice in AIDS prevention, treatment and care, sensitize government, religious and other leaders on the importance of speaking openly about the epidemic and creating an enabling environment for the people of Afghanistan to protect themselves against the virus.
- Advocate for and facilitate the public expression of commitment from high level political leaders, including military leaders, to confront AIDS and in particular stigma and discrimination related to the epidemic.
- Advocate to the National Elected Assembly to devote time to review the progress made in combating AIDS.

Output 2.1: High level political commitment demonstrated.

6.1.2.2 Enabling Policy Development and Legislative Environment

This priority component seeks to ensure that all legislation and national policies protect, respect and fulfil the rights of vulnerable populations in Afghanistan including people infected and affected by HIV and women. In particular the right of access to education, health care, inheritance, social services - including prevention, care and treatment, legal protection and confidentiality.

Key Strategies:

- Facilitate the development of a National AIDS Policy that ensures the rights of people to prevention, care and treatment services and that diminishing stigma and discrimination.
- Review all current legislation and national polices that affect vulnerable populations, PLHIV and women.
- Advocate for discriminatory laws and policies to be changed and enacted.
- Establish on-going dialogue with religious and community leaders to ensure support and advocacy.
- Inform civil society of their rights and mobilize them as informed partners in the response to AIDS including all efforts to enact rights based legislation and polices.

Output 2.2: Enabling policies and legislative environment created

6.1.2.3 Resource Mobilisation and Development.

This priority component seeks to ensure adequate and consistent funding for the national response to AIDS. It also aims to guarantee that there is donor harmonization to avoid poor use of funds and multiple donor reporting obligations.

Key Strategies:

- Establish a donor support group to coordinate and monitor donor funding and resources allocation
- Review all current and possible funding available.
- Develop resource mobilization strategy
- Develop resource mobilisation strategy and guidelines for the allocation and utilization of resources and donor support according to national strategic framework
- Advocate for a national budget line specific for AIDS activities.
- Mobilize resources from traditional and non-traditional donors such as public and private corporations and foundations in the region and beyond.
- Build capacity within sector ministries and civil society organizations in resource mobilization

Output 2.3: Resources mobilized from internal and external sources

6.1.3 Objective 3: To ensure development and coordination of a multi-sectorial HIV/ AIDS response and develop institutional capacity of all sectors involved

Turning the tide on the HIV/ AIDS epidemic requires a concerted commitment and action from all government and non government sectors. Experience in battling HIV/ AIDS prompted heads of governments to articulate the concept of multi-sectoriality in the Declaration of Commitment signed by them in the UN General Assembly Special Session on HIV/ AIDS in 2001. Specifically commitment 37 states that all governments should *"ensure the development and implementation of multi-sectorial national strategies and financing plans for combating HIV/ AIDS that address the epidemic in forthright terms"*.

To effectively respond to HIV/ AIDS in a multi-sectorial way a nation needs:

- one National HIV/ AIDS Strategic Framework and Plan,
- one strong coordinating body with a multi-sectorial mandate and
- one monitoring and evaluation system.

With these three things in place multi-sector involvement with national government sectors (health and non health) the United Nations, other multilateral groups, bilaterals, non governmental organizations, special interest groups and other donors can enhance the national response to HIV/ AIDS.[13]. A second guiding principle is that in the absence of data, the response must be realistic and targeted, building on what we know about the epidemic and improving the capacity of all actors to respond to HIV/ AIDS.

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[13] On 25 April 2004, UNHIV/ AIDS, co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national HIV/ AIDS responses led by the affected countries themselves.
They endorsed the "Three Ones" principles , to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- One agreed HIV/HIV/ AIDS Action Framework that provides the basis for coordinating the work of all partners.
- One National HIV/ AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- One agreed country-level Monitoring and Evaluation System.

Coordination of the National Strategic Framework will be facilitated by the National HIV/ AIDS Control Programme (NACP) currently under the Ministry of Public Health in conjunction with a multi-sectorial advisory board and technical working groups.

6.1.3.1 Institutional Framework for HIV/ AIDS co-ordination

Key Strategies:

- Develop and disseminate the institutional framework for HIV/ AIDS to ensure a clear communication strategy and the flow of information between all partners.
- Form a Presidents Advisory Group on HIV/ AIDS (PAGA), which will assist and advise the NACP on coordinating, monitoring and evaluating the implementation of the NSF. Clear terms of reference should be developed.
- Establish Provincial HIV/ AIDS Councils (PACs), which include Governors, representatives of line ministries, civil society private sector, development partners and special interest groups to facilitate coordination of the HIV/ AIDS response at Provincial level and ensure the link with the national partners.
- Establish multi-sectorial Technical Working Groups (TWGs) for priority programme areas involving all relevant sectors to coordinate planning, implementation and monitoring
- Establish a focal point on HIV/AIDS in each of the sectors, clearly defining the expected role of this focal point.
- Ensure coordinated planning and implementation through regular planning and implementation review meetings/workshops of the NACP, PACs, TWGs and the Presidents Advisory Group on HIV/ AIDS (PAGA) and periodic policy and technical dialogues on focused themes.
- Ensure an effective mechanism within the NACP responsible for liaising with all sectors, organizing and following up on meetings, coordinating the development and dissemination of all communications to national, regional and international partners.
- Map the activities of all partners currently involved in HIV/ AIDS activities in Afghanistan. [government sectors (health and non health), United Nations, other multilateral groups, bilaterals, non governmental organizations, special interest groups, donors and others]
- Re-position the NACP within the Ministry of Public Health to ensure visibility, decision making power and access to policy makers.
- Develop a web-site and electronic data base to assist in information sharing on and co-ordination of the national HIV/ AIDS response.

Output 3.1: Institutional framework and mechanisms for the coordination of the multi-sectorial HIV/ AIDS response in place and functional

6.1.3.2 NACP Capacity Development

Key Strategies:

- Recruit an international consultant to work with the NACP to assist in operationalising and coordinating the national response to HIV/ AIDS while building the capacity of the NACP in this area.
- Develop terms of reference and an organogram for NACP at national and provincial level.

- Develop a work plan for the NACP based on the National HIV/AIDS Strategic Plan
- Ensure adequate human resources [in terms of numbers and capacity] for NACP.
- Develop a technical resource centre within the NACP comprising of appropriate technical publications, and documents delineating best practices.
- Provide educational exchange visits with other countries with the aim of learning from experiences to enhance the national programme
- Conduct annual assessment of technical and managerial capacity of NACP staff

Output 3.2: Technical and managerial capacity of the NACP strengthened for effective coordination

6.1.3.3 Public Sector Capacity Development

Key Strategies:

- Conduct a capacity needs assessment with regard to resources and commitment within key line ministries and government institutions.
- Develop and implement national capacity programme to equip focal persons from key sector ministries at national and provincial level with the required technical knowledge and managerial skills for effective HIV/AIDS programme planning and management through training, periodical briefings on technical innovations and participation in regional and international workshops.
- Assist key sectors to develop action/operational plans for HIV/AIDS under the framework of the National HIV/AIDS Strategic Plan. Once completed these plans should form an integral annex of the National Plan.
- Assist focal persons in advocacy efforts to ensure high level commitment to HIV/ AIDS programmes within each sector.

Output 3.3: Technical and managerial capacity of all public sector's programmes strengthened

6.1.3.4 Civil Society Capacity

Key Strategies:

- Conduct capacity needs assessment of civil society organizations involved in the HIV/AIDS response
- Develop and implement a capacity plan based on the assessment for society should be present at all workshops organized or supported by NACP
- Involve civil society organizations in all NSP review and planning processes.
- Facilitate the link between national civil society organizations and NGO's with similar organizations in neighbouring countries.
- Assist national CSO's and NGO's to access funding.

Output 3.4: Technical and managerial capacity of civil society organizations (CSO') strengthened

6.1.4 Objective 4: To raise public awareness on HIV/ AIDS and STIs prevention and control, ensure universal access to behaviour change communication on HIV for the population, especially targeting vulnerable and risk groups.

6.1.4.1 National Knowledge and Awareness

It is vital that the nation's citizens are provided with information, skills and tools that they need to protect themselves from becoming infected with HIV/AIDS. First the public needs to be informed about the risks posed by HIV/AIDS, how HIV can be transmitted, how HIV transmission can be prevented and what are the services available. The public also needs to be aware of other STIs [including the role of STIs in the spread of HIV] and of the need to create a supportive environment for people living with HIV/AIDS. Next the public needs to be empowered through skills development in communication and decision making to enable utilization of their new knowledge.

Four components to a behaviour change communication strategy for HIV/AIDS and STIs prevention and control are proposed:

- Develop the strategy
- Implement the strategy; ensure universal access to information, skills and tools.
- Integrate HIV/AIDS and STIs into the education system (formal and non-formal) through Life Skills-Based Education
- Multi-sectoral collaboration:

Key Strategies:

- Develop a behaviour change communication strategy for HIV/AIDS and STIs prevention and control.
- Utilise appropriate media channels in the Afghan context for the delivery of HIV/AIDS awareness and prevention messages in local languages.
- Multi-sectoral collaboration in raising awareness
- Life Skills-Based Education
- Produce language and culturally specific IEC messages and materials
- Support peer education initiatives for various general public target groups
- Provide organized sectors e.g. military, police, education, universities, etc. with HIV/AIDS messages and information.
- Use HCWs to disseminate HIV/AIDS messages to community members at health care facilities

Output 4.1: Increase HIV awareness and general public's access to appropriate information on HIV/AIDS through different channels

6.1.4.2 Supportive Environment – Policy

Key Strategies:

- develop National Behaviour communication strategy for HIV/AIDS and STIs prevention
- Translate and disseminate HIV/AIDS BCC strategy and guidelines to all partners

Output 4.2: HIV/AIDS Behaviour Change Communication Strategy and guidelines developed and disseminated

6.1.4.3 BCC Capacity Building

Key Strategies:

- Conduct BCC capacity needs assessment and provide implementation support to partners in all sectors
- Provide "Training of Trainers" for HIV peer educators in all sectors
- Evaluate the effectiveness and impact of HIV education and BCC activities in communities
- Sensitize Mobilize and provide training for media in HIV prevention and behaviour change communications

Output 4.3: Increase in HIV education and Behaviour Change implementation strengthened in all sectors

6.1.4.4 Supportive Environment Religious and Community Partnership

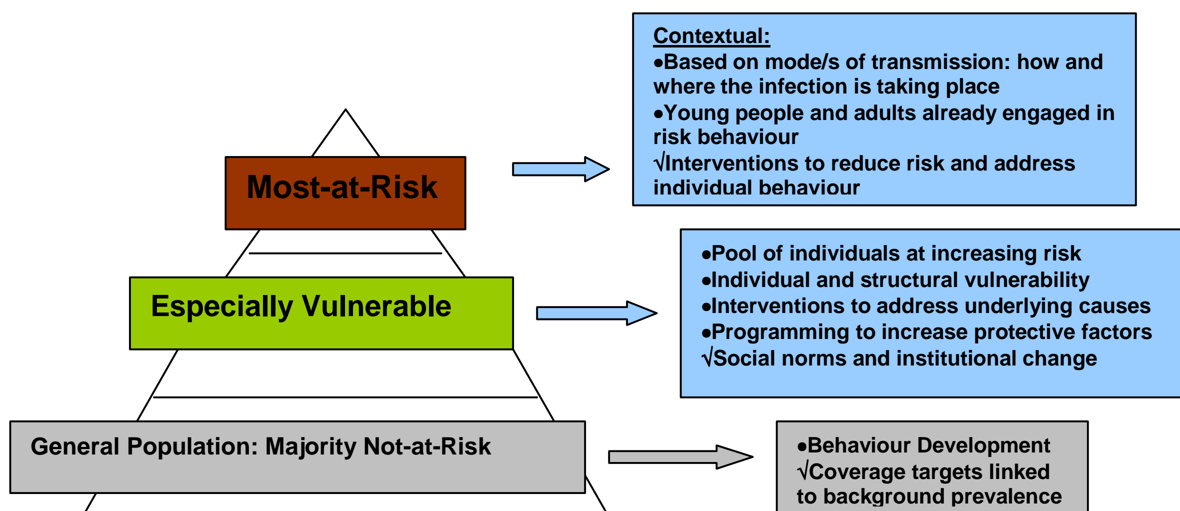
Key Strategies:

- Provide training and support for religious leaders in HIV education
- Conduct community and parent-youth dialogues on healthy behaviours and wellness
- Provide training support for community groups in HIV education and to conduct outreach activities
- Provide training and support for parents on adolescent reproductive health issues and HIV education

Output 4.4: Religious Community leaders and parents trained and supported to provide HIV/health education in communities

6.1.5 Objective 5: To ensure access to prevention, treatment and care services for high risk and vulnerable populations

Prevention programs should target the Most-at-Risk and Especially Vulnerable segments of the population. Refer to the below hierarchy of risk and vulnerability.



6.1.5.1 Support to MARP - IDUs

Available data suggests that injecting drug use (IDU) is widespread and increasing and has been the cause of a number of the HIV positive cases in Afghanistan. The National Drug Use Survey of 2005 estimated that there were 50,000 heroin users in Afghanistan of whom around 15% inject their drugs. This means that there may be already over 7,000 IDUs in the country who risk share injecting equipment, contracting HIV/ AIDS and spreading it to the wider population. Injecting drug use is associated with a high risk of transmission of HIV/ AIDS and other blood borne viruses such as hepatitis C. This risk is present amongst IDUs as well as from IDU to other people such as their sexual partners. This risk is further extended through HIV positive mother-to-child transmission of HIV/ AIDS. It is crucial to raise awareness amongst drug users about HIV/ AIDS. Information is needed to reduce risk amongst those who currently inject and to minimise transition to injecting amongst those who currently consume drugs in ways other than injecting. A comprehensive harm reduction service needs to be established, including needle and syringe access and disposal programmes and advice on safer injecting. Access to drug treatment services is also important in reducing HIV/ AIDS risk amongst drug users.

Any work in this regard should be informed by the following Government of Afghanistan documents:

- *Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/ AIDS Prevention in Afghanistan,* HIV/ AIDS Unit Ministry of Public Health, Demand Reduction Section, Ministry of Counter Narcotics (May 2005).
- *National Drug Control Strategy, 5-year strategy (1381-1386) for tackling illicit drug problems in Afghanistan,* presented by the National Security Advisor.

Key Strategies:

- Ensure provision of comprehensive information regarding HIV/ AIDS, hepatitis C and other infections for all IDUs.
- Ensure IDUs have access to harm reduction services, including needle and syringe access and disposal programmes..
- Ensure provision of comprehensive information regarding HIV/ AIDS for drug users who are not currently IDU. This should include harm reduction strategies
- Ensure all drug users have access to drug treatment including drug substitution therapies.

Output 5.1: HIV/ AIDS prevention and intervention services scaled up to IDUs with provision of harm reduction kits

6.1.5.2 Support to MARP - Commercial Sex Workers

Commercial sex workers are vulnerable and often at high risk of acquiring and transmitting HIV. The risks include transmission from and to sexual partners including IDU, mother to child transmission

International experience suggests CSW are sexual partners of IDU and at time IDU themselves. Sexwork is often an illegal, hidden and stigmatised occupation and HIV information, prevention, treatment and care strategies wit CSW require very careful development if they are to be successful.

There is very little information regarding the extent and nature of CSW in Afghanistan. Commercial sex work in Afghanistan remains hidden due to strong religious sanctions and legal penalties. There are reports of an increase in commercial sex work in larger cities and

towns in Afghanistan. In a survey in 4 districts of Kabul of groups at high risk of contracting STIs and HIV[14], 90% of CSW surveyed gave poverty as the reason they became involved in sex work. Less than 1% of CSW used condoms. Knowledge of HIV was also less than 1%. Of those surveyed who were still working as sex workers none had been tested for HIV. The study noted myths about HIV/ AIDS such as it being a "foreign disease" Four of the 126 sex workers surveyed were male. Seventy eight percent (78%) of the female sex workers surveyed were married. No information was available about rates of HIV/ AIDS amongst this group.

Key Strategies:

- Ensure appropriate targeting of work
- Provide basic knowledge to CSW re STI and HIV/ AIDS prevention
- Protect CSW and customers from STI and HIV/ AIDS
- Promoting safe sex among CSW
- Confirmation of HIV status
- Assist sex workers to develop alternative livelihoods

Output 5.2: Increase knowledge of HIV/AIDS and practice of safer sex by commercial sex-workers

6.1.5.3 Support to MARP – Truck Drivers

International experience provides evidence of spread of HIV along main transport routes. Afghan truck drivers can be considered to be a *high risk group* for acquiring and transmitting HIV as they travel along such routes and into countries surrounding Afghanistan, all of which have large or developing HIV/ AIDS and STI problems. There are thought to be around 2,000 international truck drivers and 60,000 domestic truck drivers in Afghanistan. There is at present no data regarding HIV risk behaviours or the prevalence of HIV/ AIDS amongst truck drivers in Afghanistan. It is thought that some truck drivers do engage in homosexual sexual activity with their generally young assistants or "conductors". International experience suggests that truck drivers do engage the services of CSW. A proportional are also IDU, generally using amphetamines, initially to overcome fatigue associated with the long hours of long distance driving.

Activity to date regarding HIV and STI among truck drivers in Afghanistan includes the following: Action AID have carried out a KAP study in Kabul, Kandahar, Herat and Iran border area , World Food Program has provided HIV/ AIDS training to their truck drivers, other countries have programs for truck drivers.

Key Strategies:

- Conduct an assessment of truck driver's knowledge of HIV/ AIDS and STI [Action Aid has already done this;.]
- Ensure truck drivers in Afghanistan have access to information about HIV/ AIDS and STI risk behaviour and protection.
- Assess HIV prevalence amongst truck drivers (move to first objective)

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[14] Survey of Groups at High Risk of Contracting Sexually Transmitted Infections and HIV/ AIDS in Kabul, Dr M Farid Bazagar, Andrew T Young, ORA International (2005)

- Develop programming for prevention information and materials in coordination with the Ministry of Transportation.

Output 5.3: Safe sex practices adopted by truck drivers and access to social marketing products

6.1.5.4 Support to MARP - Prisoners

Prisons are extremely high-risk environments for HIV because of overcrowding, poor nutrition, limited access to health care, continued drug use and unsafe injecting practices, unprotected sex and tattooing. Many prisoners come from marginalized populations, such as IDU, already at elevated risk of HIV. In most cases, high rates of HIV infection in prisons are linked to the sharing of injecting equipment and to unprotected sexual encounters. Syringe-sharing rates are invariably higher in prisons than outside them. This situation is exacerbated by high rates of tuberculosis (often multi-drug-resistant), sexually transmitted infections and hepatitis B and C. There is no information about the rates of HIV/ AIDS or HIV risk behaviours amongst prisoners in Afghanistan. The health of people in prison is connected to those outside in many ways. Protecting prisoners will also protect prison staff and broader communities.

Key Strategies:

- Assessment of HIV risk factors and prevalence amongst prisoners
- Provide HIV education and distribute IEC materials in prisons
- Provide harm reduction kits and tools for safe sex and safe drug use to prisoners

Output 5.4: Increase HIV prevention services and access to social marketing commodities for prisoners

6.1.5.5 Support to Youth - prevention/ BCC

There is very little documentation about the extent to which these young people engage in behaviors which may put them at risk of HIV infection or about young people's STI/HIV/ AIDS awareness levels. However, available evidence indicates that while some young Afghans may possess limited knowledge about reproductive sexual health/HIV/ AIDS, the majority of young people do not have even the most basic knowledge. When they do possess some knowledge it is inaccurate or incomplete. In addition myths and misconceptions about sexuality, STIs and reproductive health are in general common place.

Preventing HIV infections among young people is vital. Of the 40 million people living with HIV/ AIDS worldwide, one third are aged 15-24 years and roughly half were infected during their youth. This makes it imperative that young people be at the center of prevention actions, both in focus and in involvement, to ultimately halt the pandemic. As many behavioral lifestyles are formed during the early adolescent years, and as acquisition of HIV in young people is predominantly through sexual activities, this period in life provides the opportune time to positively influence behaviors, choices and lifestyles that will hopefully last into adulthood.

Key Strategies:

- Create a supportive environment for the implementation of effective interventions for youth
- Life skills and HIV/ AIDS prevention education in the formal school curriculum and for out of school young people

- Empower young people with the knowledge and life skills to avoid HIV/ AIDS /STI infections
- Provide package of youth friendly information and services to young people, particularly vulnerable young people
- Strengthened participation of informal support structures and institutions in efforts to reduce the HIV/ AIDS vulnerability and risk of young people.

Output 5.5: Increase HIV knowledge and practise of appropriate sexual behaviour among youth

6.1.5.6 Support to Women - Prevention and Empowerment

Women's vulnerability to HIV/ AIDS infection is increased by economic dependence on men and cultural attitudes that make it inappropriate to be knowledgeable about sex or suggest condom use. Women are also more biologically vulnerable to HIV infection than men. The impact of years of discrimination against women from the policies of controlling authorities, coupled with prevailing poverty and insecurities has meant that Afghan women experience extremely low socio-political and economic status and have some of the worst social indicators in the world today. There is clear evidence of very high rates of maternal mortality and morbidity. In a number of countries where HIV/ AIDS has spread widely a major risk factor for women is sexual relations with their husbands.

Key Strategies:

- Comprehensive mapping of key players, structures and institutions to support women protecting themselves
- In coordination with the Ministry of Women's Affairs, develop strategies to increase knowledge of women about HIV/ AIDS, routes of transmission and of the ways to protect themselves against infection.
- Develop ways to inform men of their responsibilities toward women
- Develop and enact laws to protect the rights of women

Output 5.6: Reduced vulnerability, increased protection of rights, and empowerment of women

6.1.5.7 Support to Vulnerable Children – Prevention and Protection

Street children (also referred to as "at risk youth") are generally at greater risk of acquiring and transmitting HIV than other young people. Their lifestyle and daily struggle for food, shelter and safety may lead them to provide sexual favours to obtain the necessities of life or to drug taking to dull the impact of their harsh life. Globally they have been considered a high risk group for HIV transmission and specialised programming has been implemented to reduce the risks they face. This must include alternatives to homelessness and street life, nutrition and health care as well as HIV/ AIDS prevention, care and treatment strategies.

Key Strategies:

- Conduct mapping and basic needs assessment of street children and orphans
- Ensure non-discrimination and equal enjoyment of access to education, shelter, social and health services
- Develop and implement appropriate services
- Provide HIV/AIDS information, life skills education and interpersonal counselling

Output 5.7: Children at risk supported with basic livelihood and provided with life skills-based HIV education and protected

6.1.5.8 Support to Disabled People – Prevention and Protection

Disabled people have a right to access HIV/ AIDS prevention, treatment and care information and services. International studies suggest that people with disabilities have equal or greater exposure to all known risk factors for HIV infection. These should include information and services provided to the general public as well as that suited to the specific needs of the disabled. There is at present no data, research findings or other information available regarding the extent and nature of HIV risk factors, prevalence or incidence amongst disabled people specific to Afghanistan.

Key Strategies:

- Ensure that people with disabilities have access to the same HIV/ AIDS education prevention, treatment and care information and services as the general public.
- Ensure that people with disabilities have access to HIV/ AIDS education prevention, treatment and care information and services suitable to their needs, where these differ from those of the general public
- Ensure that data, research findings or other information regarding the extent and nature of HIV risk factors, prevalence or incidence amongst disabled people in Afghanistan is routinely collected.

Output 5.8: Disabled people provided with HIV IEC materials and supported with basic livelihood

6.1.5.9 Support to Uniformed Personnel

The working environment of police and other uniformed service personnel exposes them to situations where the risk of HIV transmission can be high. This includes needle stick injury when searching drug users, and contact with blood in violent encounters with offenders or during battles. Unscrupulous officers may also engage in sexual activity with members of the public in exchange for granting the offender freedom or not imposing a fine. Drug use amongst officers far from home or in stressful situations may occur and involve HIV/ AIDS risk. If well informed about HIV/ AIDS transmission, prevention, treatment and care, police can also be of great support to HIV/ AIDS service provision. They have close and often long involvement with high risk groups such as IDU, know where they are located and can cooperate with health and other services to ensure HIV/ AIDS services are freely available to those who need them.

Key Strategies:

- Raise awareness of high ranking police and other uniformed service personnel
- Assessment of the HIV/ AIDS knowledge of police and other uniformed service personnel
- Development and implementation of appropriate training programs and IEC materials.

Output 5.9: Reduce risk of HIV transmission through increased HIV knowledge police and other uniformed services

6.1.5.10 Support to Vulnerable Populations

One of the major factors in the spread of HIV in many countries is the movement of people within countries and across national borders. Some refugees and internally displaced persons

may be at risk of HIV infection for reasons such as exposure to sexual abuse and other trauma, psychological distress, drug misuse and a lack of access to HIV information and education. There is very little data available regarding the HIV/AIDS vulnerabilities or risks of internally displaced persons or returnees to Afghanistan. Of the three newly reported HIV positive cases to date in 2006, all were refugee returnees.

Key *Strategies:*

- Assessment of HIV knowledge of returnees at border catchment centres
- Develop guidelines/resources for use with these populations
- Integrate information on HIV vulnerabilities and risks of these groups into health worker training and training received by police and other uniformed personnel – include information regarding stigma

Output 5.10: Increase in access to HIV prevention care and treatment for returnees/refugees and internally displaced persons

6.1.5.11 Support to Mobile Populations

One of the major factors in the spread of HIV is the movement of people within countries and across national borders. There are no accurate figures available but it is estimated that around 1,000,000 Afghan people leave Afghanistan yearly to work in surrounding countries. Many are working in countries and cities with significant HIV/AIDS prevalence. These workers may spend long periods away from home and family. HIV/AIDS risk behaviours may include unprotected sexual activity and injecting drug use. There is no data available on risk behaviours or prevalence of HIV amongst Afghan migrant workers. Workers from neighbouring countries also come into Afghanistan to work.

Key Strategies:

- Assessment of migrant workers knowledge of HIV/AIDS and STI, including reduction of transmission risk
- Assessment of migrant workers risk behaviours in other countries and on return to Afghanistan
- Development of appropriate resources and prevention strategies for this group

Output 5.11: Reduce Vulnerability and increase of HIV knowledge among migrant workers

6.1.5.12 Supportive Environment for infected and affected population

Key Strategies:

- Ensure laws to protect PLWAs and families from discrimination and stigmatization
- Provide basic living support to PLWA and families
- Provide information and access to care and treatment services

Output 5.12: People living with HIV/AIDS (PLWA) mobilized, supported and strengthened in prevention

6.1.6 Objective 6: To strengthen the health sector capacity to implement an essential package of HIV/ AIDS prevention and care services within the framework of BPHS and EPHS

6.1.6.1 Supportive Environment for Health Workers and Professionals

It is crucially important to raise awareness among the health care providers in both formal and informal sectors about HIV/ AIDS. This information is needed for them to know how to protect themselves and how to deal with HIV/ AIDS cases safely and without fear. In addition, health care providers are often a 'front line' resource in awareness raising campaigns for the community.

The risk of exposure from needle sticks and other means exists in many settings where protective supplies are limited and the rates of HIV infection in the patient population are high. The availability of PEP may reduce the occurrence of occupationally acquired HIV infection in health care workers. It is believed that the availability of PEP for health workers will serve to increase staff motivation to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace provide vaccines for health workers to prevent blood borne disease (Hepatitis)

Key Strategies:

- Conduct training courses on HIV/ AIDS prevention and available services for all categories of health care workers, to raise their awareness and enhance their skills for provision of HIV/ AIDS information to the community and contribute to the prevention of HIV transmission.
- Develop guidelines for PEP
- Information about PEP disseminated
- PEP disseminated to sites, and properly stored, used and replaced.

Output 6.1.1: All health care providers have basic information on HIV/ AIDS prevention and available services.

Output 6.1.2: Post-Exposure Prophylaxis (PEP) available to all exposed health care workers (HCWs) and other occupational groups

6.1.6.2 Blood Transfusion and Safety

The HIV/ AIDS pandemic has brought particular attention to the inherent dangers of blood and the importance of preventing transfusion-transmitted infections. Although HIV screening tests have been available since 1985, an estimated 5 to 10 percent of all HIV infections worldwide are transmitted by transfusion of contaminated blood and its products. Yet prevention of transfusion-transmitted HIV infection is both achievable and cost-effective. In Afghanistan, blood safety should be improved as only 30 percent of the blood currently is screened for HIV/ AIDS in the country as outlined above in the situational analysis.

Key Strategies:

- Reduce unnecessary transfusions by effective clinical use of blood by strict adherence to clinical guidelines for blood transfusions.
- Obtain blood from safe donors
- Strengthen blood transfusion system
- Screen all donated blood for infectious agents

Output 6.2: Risk of parenteral transmission of HIV and other blood born infections reduced

6.1.6.3 Infection Prevention

HIV transmission from patient to patient is usually associated with improper infection control practices. However small the proportion of HIV cases attributed to this method, these transmissions could have been avoided. Adherence to standard infection control practices, including aseptic technique, cleaning and disinfecting or sterilizing equipment between patients, safe injection practices and appropriate handling of single-use devices and equipment, needs to be fulfilled as an integral part of quality curative care.

Key Strategies:

- Liase with Infection Prevention Working Group (IPWG) at Ministry of Public Health
- Adapt and tailor the already developed IP policy and guidelines in terms of including HIV/ AIDS topic in it
- Raise awareness of HCWs on IP
- Adequate supply of IP equipment and supplies
- Continuous monitoring of adherence to IP guidelines

Output 6.3: Adherence to Infection Prevention (IP) policy and guidelines ensured

6.1.6.4 Prevention of Mother to Child Transmission

A package of specific interventions has been identified to prevent HIV transmission from an infected mother to her child. It includes antiretroviral drug use, safer delivery practices and infant feeding counselling and support. In addition to this package a comprehensive strategy for prevention of mother to child transmission includes also primary prevention of HIV infection in women and men, prevention of unintended pregnancy among HIV-infected women, and lastly care for HIV-infected mothers and their children

Key Strategies:

- Establish a Technical Working Group on PMTCT
- Determine prevalence and barriers to testing for HIV and other vertically-transmitted infection among women in Afghanistan.
- Develop national guidelines for rapid testing in labour and PMTCT
- Integrate HIV counselling and testing into the maternal health care components of the BPHS that includes antenatal care.
- Establish comprehensive PMTCT reference services including ART prophylaxis
- Integrate PMTCT and paediatric HIV care components in BPHS.
- Prioritize children and pregnant women that are HIV infected for care, support and treatment programs.

Output 6.4: Prevention of Mother to Child Transmission of HIV services established

6.1.6.5 STI Treatment Services

There is an increased interest in STI control due largely to the HIV epidemic. Earlier reports of the association between STIs and HIV infection have been supplemented by virological studies showing that STIs increase levels of HIV in genital secretions. Accordingly it has shown that treatment of STIs can reduce HIV transmission possibilities.

There is a need in Afghanistan to address the STIs as an intervention to control HIV spread. This should start by developing national guidelines for STI management, using WHO

syndromic algorithms which are simple and suitable for the Afghani context. Measures should be taken to strengthen STI medical services by capacity building, expansion

Key Strategies:

- Develop national STI management guidelines adapting the WHO syndromic case management guidelines
- Strengthen STI reference clinics at provincial, district hospital, CHC
- Integrate STI management in primary health care (BPHS)

Output 6.5: Access to STI treatment and care services expanded

6.1.6.6 VCT Services

Voluntary counselling and testing (VCT) services have become an integral part of HIV prevention and care programmes in many countries. VCT plays a critical role as an entry point to HIV prevention and care. In Afghanistan, expansion of VCT will help in discovering more HIV cases which are expected to exist due to the HIV risk factors present in the country. VCT services are already mentioned in the BPHS 2005 as part of component 4: Communicable disease treatment and control.

Key Strategies:

- Finalize already developed draft national guidelines on VCT.
- Evaluate of VCT centre and hospital services in Kabul
- Integrate VCT in primary care according to the BPHS 2005.
- Ensure continuous supply of kits, reagents and consumables.

Output 6.6: VCT services expanded to cover all provinces.

6.1.6.7 TB/ HIV Collaboration

The HIV pandemic presents a massive challenge to the control of TB at all levels. In addition, TB is one of the most common opportunistic infections among PLWHA. It has an adverse effect on HIV progression and is a leading cause of death among PLWHA. Accordingly TB care and prevention should be priority concerns of HIV/ AIDS programmes, and HIV/ AIDS prevention and care should be priority concerns of TB programmes.

Key Strategies:

- Establish mechanisms for collaboration between TB and HIV/ AIDS programmes at MoPH, that operate at all levels.
- Carry out joint TB/HIV activities according to the joint plan
- Decrease the burden of TB among PLWHA.
- Decrease the burden of HIV among TB patients

Output 6.7: HIV and TB patients have access to comprehensive TB/HIV services.

6.1.6.8 Treatment

Provision of ART to all persons including children that may benefit from such treatment should be a priority to the National AIDS Control Programme. In order to initiate ART, national guidelines should be in place, counselling of patients on ART should be practiced, health care workers should have necessary knowledge to use ART, sustainable supply of the drugs should be ensured, laboratories should be ready to diagnose and monitor the treatment

of the patients, and adherence of patients to drugs should be ensured as far as possible. Collaboration with other programmes, as TB and drug use programmes, in order to cover more patients with ART is also a recommended intervention in Afghanistan.

No doubt that provision of drugs to prevent and treat opportunistic infections is an essential element of comprehensive treatment of PLWHA.

Key Strategies:

- Develop national treatment guidelines for PLWA (ART & opportunistic infections), paediatric AIDS and Co-trimoxazole prophylaxis.
- Develop terms of reference for comprehensive HIV case management services and define minimum quality standards (ART & opportunistic infections, psychosocial support).
- Establish HIV treatment clinics in major border provinces, through integration in infectious disease clinics, VCTs, drug dependence treatment clinics and TB centres
- Train medical teams on comprehensive HIV case management including ART
- Procure ARV drugs and ensure sustainable supply.
- Establish quality assurance system

Output 6.9: Access to ART and treatment of opportunistic infections for all PLWA ensured

6.1.6.9 Laboratory Services

Laboratory services constitute an important supporting component of health care services necessary for a successful HIV/ AIDS and STI response. Laboratories help to identify infected individuals, perform screening of blood before transfusion and monitor ART if the HIV infected person is put on therapy.

Key Strategies:

- Develop national guidelines for HIV/ AIDS/STI laboratory services.
- Train laboratory technicians and develop laboratory capacity to test according to the national guidelines.
- Include laboratory methods for diagnosis of HIV and STIs, as well as ART monitoring in curricula of laboratory technicians.
- Ensure continuous supply of kits and reagents to the laboratories supporting HIV and STI services.
- Develop laboratory network
- Develop quality assurance system
- Develop procedures for bio-safety in laboratories
- Involve community and religious leaders in IEC issues

Output 6.10: Laboratory services for HIV diagnosis and treatment monitoring available

7 Resources

The framework will be translated into a 5 year action plan, reflecting the summary of plans of all relevant partners. This plan will be costed and funding will be sought from appropriate sources.

7.1 Sources of Funds

National resources including those from government, private sector and NGOs will be mobilised to provide the funds. The government contribution will be in kind- existing staff from the Central Blood bank Kabul, existing institutions and health staff, etc.

7.2 Resource Mobilisation

The required funds would be mobilised from external sources. Following finalisation of the operational plan and estimated budget, NACP will proactively mobilise resources from various donors and partners for different components of the plan. Proposals will be developed and submitted for funding for HIV/ AIDS programming. The NACP and the UNAIDS co-sponsor agencies [UNDP, World Bank, WHO, UNICEF, UNFPA, ILO, UNODC and UNESCO] will play a crucial role in mobilising external resources from among UNAIDS, its co-sponsors and other bilateral and multilateral agencies.

8 Result Framework

No	Objective	Outputs	Performance Targets	Indicators	Who is responsible
1.	To strengthen strategic information to guide policy formation, programme planning and implementation.	1.1.Effective surveillance system developed and functional. 1.2.Effective monitoring and evaluation system developed and functional. 1.3.Scientific evidence for an effective HIV/AIDS response available through operational research	-Annual sero-prevalence surveys -Annual "KAP" Studies of vulnerable and most-at-risk populations -Established standards for quality assessment -90% of HIV/AIDS implementing partners providing data and information	-No of people trained in strategic information /M&E/ Surveillance/HMIS -Published in formation on prevalence No of "KAP" studies -No of stakeholders with data collecting tools and methods -No of targeted programme evaluations conducted	
2.	To gain political commitment and mobilize resources necessary to implement the national HIV/ AIDS/ STI strategy.	2.1.High level political commitment demonstrated. 2.2.Enabling policies and legislative environment created. 2.3.Resources mobilized from internal and external sources	-HIV/AIDS issues on at least 75 % of national/ sectoral meeting agendas -Quarterly consultative meetings with various stakeholders at all levels -Budget allocation for HIV/AIDS -National HIV/AIDS budget fully supported by donors	-No of public statement on HIV issues -No of policies reviewed and adopted for HIV/AIDS related issues -Amount of national funds and resources allocated government to HIV/AIDS -No of advocacy meetings at central/subnational levels	
3.	To ensure development and coordination of a multi-sectoral HIV/AIDS response and develop institutional capacity	3.1.Institutional framework and mechanisms for the coordination of the multi-sectoral HIV/AIDS response in place and functional	-Annual Multi-sectoral Action Plans developed, supported and implemented	-Institutional framework developed, approved with guidelines disseminated to all stakeholders	

No	Objective	Outputs	Performance Targets	Indicators	Who is responsible
	of all the sectors involved.	3.2.Technical and management capacity of the NACP strengthened for effective coordination, resource mobilization, monitoring and evaluation 3.3.Technical and managerial capacity of all public sector's programmes strengthened 3.4.Technical and management capacity of Civil Society Organizations (CSO')/ private organizations/associations strengthened	-Mainstreaming HIV/AIDS into all national development projects -Quarterly institutional coordination meetings on HIV/AIDS at all levels and across sectors -All sectors sensitized, capacity developed and supported -NACP fully staffed with appropriate remuneration	-No of coordination meetings/levels/sectors -No of trainings/on-the-job capacity building for NACP team -No of networks/coalitions on HIV/AIDS -No of businesses with HIV/AIDS workplace police -No of organizations, type of technical assistance for sectoral capacity development	
4.	To raise public awareness on HIV/ AIDS and STI prevention and control, ensure universal access to behaviour change communication on HIV, especially targeting vulnerable and at risk groups	4.1.Increase in HIV awareness and general publics access to appropriate information on HIV/AIDS through different channels 4.2.HIV/AIDS Behaviour Change Communication Strategy and guidelines developed and disseminated 4.3.Increase in HIV education and Behaviour Change implementation strengthened in all sectors 4.4.Religious Community leaders and parents trained and supported to provide HIV/health education in communities 4.5: Multi-sectoral capacity building to implement BCC at all levels	-At least 80% of general population are aware and have appropriate knowledge of HIV -100% access to STI services at all levels -BCC messages disseminated through all channels -At least 70% of provinces implementing HIV prevention activities -National coverage of VCT centres in all provinces -Access to legal and social support by infected and affected persons	-No of stakeholders trained in STI/HIV prevention -No/% of general population reached by prevention programmes/have correct knowledge of HIV prevention -No of radio messages aired on HIV -No of youth reached/% of young people with correct knowledge of HIV prevention -No of women (female adolescents) reached -No of HIV prevention programmes and target	

No	Objective	Outputs	Performance Targets	Indicators	Who is responsible
		4.6: Develop and implement targeted prevention intervention strategies for high risk and vulnerable populations 4.7: Develop framework for the safeguarding of human rights of high risk and vulnerable groups and people affected by the disease, thus facilitating access to these groups 4.8: Monitor and evaluate the impact of prevention and control measures employed		groups -No of anti-AIDS clubs formed -No of Religious/Community leaders/parents trained -No of Community-based organizations supported -No of teachers trained -No of “TOT” conducted -No of Peer educators trained -No of clients seen at VCT centres -No of new VCT sites -No of PMTCT sites -No of women provided with PMTCT information -% of STI patients treated and counselled	
5.	To ensure access to prevention, treatment and care services for high-risk and vulnerable populations	5.1. HIV/ AIDS prevention and intervention services scaled up to IDUs with provision of harm reduction kits 5.2.Increase knowledge of HIV/AIDS and practice of safer sex by commercial sex-workers 5.3.Safe sex practices adopted by truck drivers and access to to social marketing products 5.4.Increase HIV prevention services and access to social	-At least 80% of high-risk/vulnerable populations reached and have correct knowledge of preventing HIV -Availability of condoms at patient entry points/public outlets/high-risk areas -80% of youth have access to RH/VCT services	-No/% of high-risk/vulnerable populations reached by prevention programs -% of high-risk/vulnerable populations practicing safe sex -No of condoms distributed -No of outlets for condoms at central/provincial	

No	Objective	Outputs	Performance Targets	Indicators	Who is responsible
		marketing commodities for vulnerable and high-risk populations 5.5.Increase HIV knowledge and practise of appropriate sexual behaviour among youth 5.6.Reduced vulnerability, ensure protection of rights and provide empowerment of women 5.7.Children at risk supported with basic livelihood and provided with life skills-based HIV education and rights protected 5.8.Disabled people provided with HIV IEC materials and supported with basic livelihood 5.9.Reduce risk of HIV transmission through increased HIV knowledge/STI services for personnel police and other uniformed services 5.10.Increase in access to HIV prevention care and treatment for returnees/refugees and internally displaced persons 5.11.Reduce vulnerability of and increase of HIV knowledge among migrant workers 5.12.People living with HIV/AIDS (PLWA) mobilized, supported and strengthened in prevention, care and treatment	-80% of children-at-risk	district -No/% of IDUs who avoid sharing injecting equipment -% of commercial sex workers (male/female) reporting use of condom with most recent client -No of mobile population reached -No of disabled population reached	

No	Objective	Outputs	Performance Targets	Indicators	Who is responsible
6.	To strengthen the health sector capacity to implement an essential package of HIV/ AIDS prevention, treatment and care services within the framework of BPHS and EPHS	6.1.1. All health care providers have basic information on HIV/AIDS prevention, treatment and care services. 6.1.2. Post-Exposure Prophylaxis (PEP) available to all exposed health care workers (HCWs) and other occupational groups. 6.2.Risk of parenteral transmission of HIV and other blood born infections reduced 6.3.Adherence to Infection Prevention (IP) policy and guidelines ensured 6.4.Prevention of Mother to Child Transmission of HIV Services established 6.5.Access to STI treatment and care services expanded 6.6.VCT services expanded to cover all provinces. 6.7.HIV and TB patients have access to comprehensive TB/HIV services. 6.8.Access to ART and treatment of opportunistic infections for all PLWA ensured 6.9.Laboratory services for HIV diagnosis and treatment monitoring available	-100% PEP available -100% treatment coverage	-No of health care providers trained in STI/HIV prevention, treatment and care services -No of health care workers receiving PEP -No of people receiving ARVs -No of ART sites -% of transfused blood unit screened	

9 Annexes

1. List of participants in the strategy revision process

List of persons who contributed to the development of the strategic framework through participation in the Meeting on Review and revision of the framework on 17 January 2006 [18 people], Participation at the consultative workshop on 24 January 2006 [58 persons] and at the workshop on 05.03.06

Persons who provided inputs during the individual meetings with the review and revision mission during

Working Group Members in the 3 areas of [1] leadership and capacity development [2] High risk and vulnerable populations and [3] Health Sector

2. Operational Plan and budget for different components

3. Revised Organogram for the NACP

4. Documents

National Drug Treatment Guidelines for Afghanistan, Demand Reduction Directorate, Ministry of Counter Narcotics and Treatment Sub-Group, National Demand Reduction Working Group, February 2006

Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/ AIDS Prevention in Afghanistan, HIV/ AIDS Unit Ministry of Public Health Demand Reduction Section, Ministry of Counter Narcotics, May 2006

Afghanistan Drug Use Survey 2005, United Nations Office on Drugs and Crime, Government of Afghanistan, Ministry of Counter Narcotics. November 2005,(Executive Summary)

Swedish Committee for Afghanistan (SCA) HIV/ AIDS Programme

*Afghanistan National Strategic Framework for HIV/ AIDS (2006-2010),*Working Draft 29/1/06, National AIDS Control Program, Ministry of Public Health, Islamic Republic of Afghanistan

HIV/ AIDS & STI National Strategic Plan for Afghanistan, 2003-2007, 27/9/06, Ministry of Public Health, Transitional Islamic Republic of Afghanistan

National Drug Control Strategy, 5 Year Strategy (1381-1386) for Tackling Illicit Drug Problems in Afghanistan, presented by the National Security Adviser, Transitional Islamic Republic of Afghanistan.