UNGASS Country Progress Report
Afghanistan

Reporting Period: January 2008 to December 2009

Islamic Republic of Afghanistan
Ministry of Public Health
Director General of Preventive Medicine & Primary Health Care
Communicable Disease Directorate (CDC)

NATIONAL AIDS CONTROL PROGRAM

30 March 2010

FOREWORD

د افغانستان اسلامی جمهوریت

جمهوری اسلامی افغانستان

Islamic Republic of Afghanistan
Ministry of Public Health

March 29, 2010

Foreword

The Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan is happy to submit its first United Nations General Assembly Special Session (UNGASS) country progress report on HIV&AIDS to add to the richness of global strategic information in response to HIV and AIDS.

Afghanistan was witness of considerable achievements in the past two years in response to HIV and AIDS which have been reflected in this report. This report will serve as the baseline for reporting on UNGASS indicators, as a way to track Afghanistan progress in achieving Declaration of Commitment on HIV&AIDS. This gives the current state of the national response and progress towards achieving national targets for universal access to prevention, treatment, care and support in Afghanistan.

Afghanistan, being an integral part of the international community, has adopted the "Declaration of Commitment on HIV&AIDS". The declaration was adopted by 189 countries in the United Nations General Assembly Special Session (UNGASS) on HIV&AIDS in 2001. The Declaration reflects global consensus to achieve the Millennium Development Goal of halting and beginning to reverse the HIV epidemic by 2015.

Afghanistan faces a high risk of an HIV epidemic. Despite a low HIV prevalence in the country, Afghanistan is at high-risk for spread of HIV infection for several reasons: almost 3 decades of protracted armed conflicts, huge numbers of people displaced internally and externally; poor economy, poppy cultivation and use of injecting drugs and lack of blood safety and injection practices. These risk factors led officials to warn of the urgent need for early interventions to prevent a potentially rapid spread of HIV in Afghanistan. In responding to the challenge, the National AIDS Control Program was established in 2003 within the structure of the MoPH.

Despite being a young program, Afghanistan National AIDS Control Program has had good progress especially in the past two years. However, this program is yet to tackle many issues associated with effective implementation of the HIV services in the country. Afghanistan Ministry of Public Health is strongly committed to deliver the health services in the country according to national standards and the international best practices.

The MoPH is grateful for the generous contribution of the international community not only to the HIV and AIDS program, but to Afghanistan health sector as a whole. Finally, we will continue to work, together with our national and international partners, to provide better and affordable health services for all citizens of Afghanistan.

Sincerely,

Dr. Suraya Dalil
Acting Minister and
Deputy Minister for Policy and Planning
Ministry of Public Health
Kabul-Afghanistan

GLOSSARY

ANSAF	Afghanistan National Strategic Framework
AFP	Agence Française de Development
AFGA	Afghan Family Guidance Association
ANDS	Afghanistan National Development Strategy
ARCS	Afghan Red Crescent & Society
ART	Anti Retro viral Therapy
ASAP	AIDS Strategy and Action Plan
BPHS	Basic Package of Health Services
DIC	Drop-in-Centre
CBO	Community Based Organisation
CGHN	Consultative Group on Health and Nutrition
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
EPHS	Essential Package of Hospital Services
GOA	Government of Afghanistan
GTZ	German Technical Cooperation - International Services
FGI	Futures Group International
FSW	Female Sex Worker
HEFD	Health Economics and Financing Department
HMIS	Health Management Information Systems
HRG	High Risk Group
IBBS	Integrated Bio-Behavioural Surveillance
IDU	Injecting Drug User
INGO	International Non-Government Organization
LSE	Life Skill Education
KOR	Khateez Organization for Rehabilitation
MDG	Millennium Development Goal
MDM	Medecina Du Mond
MARP	Most At Risk Populations
MICS	Multiple Indicators Cluster Survey
MIS	Management Information System
MoPH	Ministry of Public Health
MosJE	Ministry of Social Justice and Empowerment
MOU	Memorandum of Understanding
MSM	Men having Sex with men
MSW	Male Sex Worker
NACP	National AIDS Control Programme
NCPI	National Composite Policy Index
NRVA	National Risk and Vulnerability Assessment
NVP	Nevirapine
NGO	Non-Governmental Organisations
OST	Opioid Substitution Therapy
OTCD	Organization of Technical Cooperation for Community Development
PIP	Program Implementation Plan
PLHA/PLHIV	People Living with AIDS/ Persons living with HIV
PPTCT	Prevention of Parent to child Transmission
RTW	Road Transport Worker
RTI	Reproductive Tract Infection
SAEP	School AIDS Education Program
SAF	Solidarity for Afghan Families
SDO	Sanayee Development Organization

SHDP	Social & Health Development Program
SHRO	Shahamat Health & Rehabilitation Organization
SPHP	Strengthening Provincial HIV Program
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TB	Tuberculosis
TI	Targeted Intervention
UNAIDS	United Nations Joint Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United National Children's fund
UNODC	United Nations Office of Drugs and Crime
USAID	United States Agency for International Development
VCTC	Voluntary , counselling and testing centres
WHO	World Health Organization

I. CONTENTS

II. STATUS AT A GLANCE

(a) Inclusiveness of stakeholders in the report-writing process:

The process of preparation of this report included an initial consultation meeting of the Government, civil society and academicians, which planned for data collection and interviews for the NCPI component and other UNGASS indicators. Work was divided out amongst various stakeholders. Data collection took about one month. The first ever IBBS of Afghanistan was completed just when the report was being written up; it has been fortuitous timing. Using secondary data, primary data from IBBS, interviews of the NCPI and funding matrix responses, two consultants[1], working closely with the MoPH prepared the first draft of the report. This was presented to a wide variety of stakeholders (22 of them) including the Government, civil society and academicians. The comments of the consultation were incorporated into this report. Overall, the NACP has taken care to include all relevant stakeholders and information and had jointly planned and validated the data. More on the process is included in Annex B.

(b) Status of Epidemic:

Data on HIV prevalence has been scarce until very recently. With a health system which is being rebuilt, the HIV and other STI surveillance systems are basic. Available data shows Afghanistan is considered a low HIV prevalence country. As of 2008, the HIV prevalence in the country's general population is estimated to be below 0.5% (UNAIDS, WHO. Report on the global AIDS epidemic. July 2008).

There is no robust information on the prevalence rates of HIV amongst general population – there are neither HIV sentinel surveillance sites nor case reporting systems. The information available includes blood banks and VCT Centres; quality assurance in these centres is still at initial stages. There have also been no general population household studies or Behavioural surveillance in the general population. In 2009, 636 HIV-positive cases have been recorded, mostly through blood screened at the central blood bank [MIS of NACP]. The number of deaths due to AIDS was estimated at less than 10 in 2009.

Within the Afghanistan context, Most at Risk Populations include Injecting Drug Users who share needles, Female Sex Workers and Men who have Sex with Men. In addition two 'bridge' population groups are also addressed – Truck drivers and Prisoners. These form the core groups for Afghanistan's' response.

The Afghanistan Drug Use Survey in 2005 by UNODC estimates injecting drug users (IDUs) in the country at between 19,000 – 25,000. IDUs surveyed are known to be mobile, with almost 80% reporting that they had changed residence at least once. According to the IBBS 2009 (conducted in three cities), the HIV prevalence among IDUs was estimated to be between 1-18 %. 94 % of IDUs used sterile needles in their last injection, 86 % Herat and 98 % in Kabul. Knowledge levels of IDUs to HIV are still very low - only 29 % of the IDUs could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. About 22 % of the IDUs have ever tested and know their HIV status (in Kabul just 19 %). About 9-12 % of the IDUs have bought sex in last six months. Of these only 17-32 % of IDUs used condom in their last sexual encounter (in the last six months).

[1] Shiv Kumar and Dr Angela Chaudhuri of Swasti Health Resource Centre (www.swasti.org)

There are an estimated 1,160 FSWs in three major cities of Afghanistan, of which Kabul accounts for over 77 % (Mapping study of University of Manitoba, 2005). While this is recognised to be a conservative estimate, given the social cultural background, identification of FSWs and working with them is a significant challenge. The IBBS 2009 conducted in the three major cities of Kabul, Mazar and Herat provides states only 4 % of FSWs know their HIV status (tested in the last 12 months; no variation in age groups). While the program coverage data (MIS of NACP) shows 400 FSWs being reached, IBBS 2009 reports program exposure is <0. 1 %. Knowledge levels on HIV amongst FSWs is abysmally low – only 2 % could both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. Only 58 % of female sex workers report using condom with their most recent client. Despite the above, the prevalence rate amongst FSWs remains zero as per the latest IBBS.

Although 100 MSMs were identified by a study (Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan – Naz Foundation, 2009). Currently, there are no robust estimates or behavioural or biological measures for this risk group.

There are an estimated 60,000 Truckers living and operating in Afghanistan and another 2,000 international truckers (NSP-2006-2010). Action Aid had undertaken research into HIV risks among vulnerable groups. In this survey, 34 percent of truck drivers said that they had heard of HIV and AIDS. 7 percent (25) of the 390 truck drivers in this study admitted to having paid for sex in the previous 12 months; less than a quarter of them had used condoms. However, the recent IBBS in 2009 has shown 0 % sero positivity of HIV amongst Truck drivers and about 23 % of Truck drivers buying sex and about 51 % of them using condoms.

HIV prevalence among prisoners is 0.57-1.57 % (IBBS 2009); there are links to injecting and the prevalence. There are 10,590 prisoners and detainees in Afghanistan's 35 prisons in 2007.

Afghanistan, until 2009 was categorized as the low-prevalence epidemic country with prevalence in high risk groups less than 5 percent. However, the recent finding of IBBS 2009 in Kabul, Herat and Mazar-e-sharif cities showing an average sero-prevalence of 7.1 percent among injecting drug users (IDUs), indicates that the country is entering into concentrated HIV epidemic. However there are wide variations in HIV prevalence among the cities 1 %, 3 % and 18 % in Mazar-e-Sharif, Kabul and Herat respectively. Among prison inmates, the IBBS showed a HIV prevalence of 0.57 to 1.57 in Kabul and Herat respectively. The study indicated zero HIV prevalence among truckers and female sex workers. The study also revealed risky behaviours among IDUs that could lead to spill-over to other high risk groups and from there to the general population. The new findings suggest that there should be an urgent scale-up of interventions for IDUs in the western provinces of the country. In addition, there is a need for providing comprehensive harm reduction services in prisons which has several structural and legal constraints.

There was considerable progress during 2008 and 2009; however, the coverage of services is still a challenge and there is a need for expansion of services to most areas of the country.

Given the evidence till date, the HIV epidemic is in its early stages - largely concentrated within the high risk groups – particularly IDUs and Prisoners. The potential for a rapid increase in these groups is very real. In addition, given the interaction between IDUs and FSWs (and MSMs of which very less is known), and given the low levels of knowledge and safe sex practices amongst FSWs, there is a likelihood of the prevalence rates increasing within FSWs, MSMs, Prisoners and Truckers – who currently are at 0 %.

(c) Programme and Policy Response

The Afghanistan National HIV and AIDS Strategic Framework (ANASF: 2006 -2010) sets the policy and guides the response. It was developed through consultative and iterative processes involving the government, non-governmental stakeholders and development partners. The ANASF is designed to guide Afghanistan's response to HIV/ AIDS and assist stakeholders to develop their own strategic plans so that all initiatives in the country can be harmonized. It was based on analysis of the limited available data (in 2005), and takes into account the resource constraints of the country in both human and financial terms. It established fundamental principles and identified clear priority areas where increased attention is likely to have the greatest impact on HIV/ AIDS in Afghanistan.

The Guiding Principles include right to protection from HIV and STI, cultural, social and language sensitivity, supportive of vulnerable populations, particularly women, confidentiality and informed consent, full community participation (including PLWHA) in prevention as well as care. Interventions were to be critically evaluated and improved based on lessons learnt at national, regional and/ or global level. Focus will be on Afghan capacity building.

The Framework comprehensively provides for six objectives, key strategies and 34 outcomes, that include components for HIV surveillance; VCT and HIV treatment, care and support; targeted interventions for most at risk populations and other vulnerable groups, including harm reduction for IDUs and prisoners, outreach for sex workers and their clients; joint HIV and TB services, and advocacy and communication for community leaders and the general population.

To address the multi-sectoral issues, the Afghanistan HIV/AIDS Coordination Committee (HACCA) was established in 2007. The HACCA acts as a policy forum for different ministries, NGOs, and civil society involved in the fight against HIV and AIDS and have in the last one year been energised.

Interventions for Most at Risk Populations have taken off only in 2009. IDUs, FSWs are covered in key cities through targeted interventions. Prison interventions have just begun and trucker's interventions address part of the large number of truckers. There are no interventions for MSM. Programme scale up is limited in reach and in limited number of cities. ARV treatment has also begun in 2009 and currently is being provided to 19 (95 registered. Source, ART Registry, NACP).

(d) UNGASS Indicator overview table:

S. NO.	COMPONENT	INDICATOR	STATUS	References	Comments
1	National Commitment and Action	Domestic and International AIDS spending by categories and financing	Afghanistan raised and spent 8.5 million USD in the years of 2008-09.	Funding matrix sent by partners	World Bank (54%), INGOs (15%), and Global Fund (14 %), UN agencies 10%, bilateral 6%. Money has been spent on prevention (46 %), Programme Management and Administration (22%), Research and Surveillance (17%) and Human resources (13%)
2	National Commitment and Action	National Composite Policy Index	Completed and in Annex D & E	NCPI interviews	NCPI interviews
3	National Programme	Percentage of donated blood units screened for HIV in a quality assured manner	52 %.	Blood Bank report	Total units collected in 2008 and 2009 through public blood banks are 31,239. Screening happens in quality assured manner in six of the 12 blood banks. Currently no quality monitoring of private blood banks exists.

4	National Programme	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Not available.	-	ART initiated and rolled out only in end of 2009. Currently 95 patients are registered in the ART clinics of Kabul and Herat. Of these 13 are female, 3 are children (<15) and 29 are 18-24 years of age. There are no robust size estimations and therefore the denominator for this indicator is unavailable. In addition, without CD 4 count machine availability, advanced HIV infection is not tracked systematically.
5	National Programme	Percentage of HIV infected pregnant women who received ART to reduce the risk of mother to child transmission	Not available.		Given that it is a low prevalence country, there is no PPTCT programme in place.
6	National Programme	Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	1 % in 2009	MIS - NACP	In 2009, 394 TB positive cases were screened for HIV and about 4 were positive for HIV.
7	National Programme	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	0.16 %	VCT data and the UN Population Division	19,875 persons tested themselves for HIV in 2008-9, of which 0.35% tested positive. According to UN Population Division, there are 12,212,000 Afghans in the age group of 15-49 years
8	National Programme	Percentage of most at risk populations who received an HIV test in the last 12 months and who knows their results	22 % of IDUs (ever tested) and 4 percent of FSWs (last 6 months).	IBBS 2009	There are no significant differences in geographical locations or across two age strata (18-24 and 25+).
9	National Programme	Percentage of most at risk populations reached with HIV prevention programmes	17 % of IDUs and 0.1 % of FSWs.	Midterm review and IBBS-2009	The IDU data could be slightly biased as the data was collected in the cities where intervention was taking place (only 17 % of IDUs covered as per programme data). There is programme data which shows 30 % reach in the case of FSWs. Problems include the lack of definition of reach and the lack of robustness of the denominators.
10	National Programme	Current school attendance among orphans and non-orphans aged 10–14	Not applicable		
11	National Programme	Percentage of schools that provided life skills based HIV education in the last academic year	1 %.	ARCS and MoE	Number of schools covered with LSE programme is 122 of the total 12,000 schools. In addition, HIV education is mainstreamed into school programme.
12	National Programme	Percentage of orphaned and vulnerable children aged 0–17 whose house-holds received free basic external support in caring for the child	Not applicable		Only for high prevalence countries.
13	Knowledge and Behaviour	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission	Not available.		No population based study or general population BSS exists.

14	Knowledge and Behaviour	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission	29 % of the IDUs and 2 % of FSWs	IBBS-2009	IDUs in Mazar have the least knowledge – with only 5 % correct knowledge on HIV Correct knowledge levels on HIV amongst FSWs are only 2 %. It is only 0.7% in the case of younger sex workers (18-24 years).
15	Knowledge and Behaviour	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not available		No population based study or general population BSS exists.
16	Knowledge and Behaviour	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Not available		No population based study or general population BSS exists.
17	Knowledge and Behaviour	Percentage of women and men aged 15-49 who have more than one partner in the past 12 month reporting the use of a condom during their last sexual intercourse	Not available		
18	Knowledge and Behaviour	Percentage of female and male sex workers reporting the use of a condom with their most recent client	58 % of female sex workers report using condom with their most recent client.	IBBS-2009	As condoms are more seen as a contraception device, usage is as high as 58%, despite low levels of knowledge of HIV.
19	Knowledge and Behaviour	Percentage of men reporting the use of a condom the last time they has anal sex with a male partner	Not available.		Current interventions do not cover MSM or male sex workers.
20	Knowledge and Behaviour	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	35 %	IBBS-2009	Of the IDUs reporting sexual intercourse in the last six months, 35 % or 83/237 (of IDUs) report using a condom.
21	Knowledge and Behaviour	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	94 %.	IBBS-2009	In three major cities of Kabul, Herat and Mazar, 94%, 86 % and 98% respectively used sterile needles in the last time they injected. There are no significant differences in age pattern across the cities in terms of sharing needles (18-24 and 25+).
22	Impact	Percentage of young women and men aged 15-24 who are HIV infected	Not available		No surveillance or case reporting system in place.
23	Impact	Percentage of most at risk populations who are HIV infected	IDUs – 7.13[2] %; FSWs – 0 %; MSMs – Not available; Prisoners -0 %	IBBS-2009	In the case of IDUs – ranges from 1 % in Mazar, to 3 % in Kabul to 18 % in Herat. All the tested cases were male. In the case of prisoners, .0.57 % and 1.57 % were the results in Kabul and Herat respectively.

[2] The Validation workshop held on 27th March noted the need for 'one' figure for the prevalence rate for the whole country. However, IBBS study was conducted only in three cities and it was recognized that this was not fully representative of the whole country. Given the severe constraints that Afghanistan faces and the fact that there are results available only for three cities at this moment, and the need for a single figure (UNAIDS software does not allow for a range), an overall figure of all cases tested positive as numerator and all cases tested as denominator has been taken here. It is clearly recognized by the validation meeting that this is technically incorrect; however given the needs and circumstances, this provides optimal representation of the picture until further data is available.

24	Impact	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not available		

III. OVERVIEW OF THE AIDS EPIDEMIC

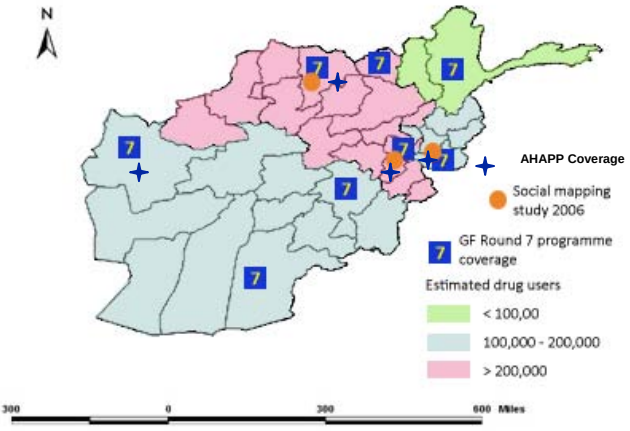
Afghanistan has an estimated population of about 28 million in 2009[1], with the gross domestic product estimated at USD$ 724 per capita[2]. The country is made up of 34 provinces. Infant mortality rate is at 157 per 1,000 live births, life expectancy at birth at 43.8 years[1], and literacy rate at 28%[2]. The Human Development Index is a low 0.346[2]. Afghanistan shares its border with Iran, Pakistan, China, Tajikistan, Turkmenistan and Uzbekistan. Economic migration occurs into countries of the Persian Gulf, Pakistan and India.

Over two decades of armed conflict have resulted in breakdown of the country's infrastructure and institutions, severely affecting its capacity to respond to the HIV epidemic. Hundreds of thousands of people are internally displaced by conflict and natural disasters, staying in camps and cities across the country. In addition, external displacement is also significant, particularly refugees to Iran and Pakistan.

EPIDEMIC SITUATION ANALYSIS

Data on HIV prevalence has been scarce until very recently. With a health system which is being rebuilt, the HIV and other STI surveillance system is basic. Available data shows Afghanistan is considered a low HIV prevalence country. As of 2008, the HIV prevalence in the country's general population is estimated to be below 0.5% (UNAIDS, WHO. Report on the global AIDS epidemic. July 2008).

There is no information on the prevalence rates of HIV amongst general population – there are neither HIV sentinel surveillance sites nor case reporting systems. The information available includes blood banks and VCT Centres. Quality assurance in these centres is still at initial stages. There have also been no general population household studies or Behavioural surveillance in general population.



Estimated number of drug users, coverage of GF Round 7 programmes, and sites for Social Mapping study 2006.

By the end of 2009, 636 HIV-positive cases have been recorded, mostly through blood screened at the central blood bank and HMIS. The number of deaths due to AIDS was reported estimated at less than 10 in 2009.

Most at risk populations:

Within the Afghanistan context, Most at Risk Populations include Injecting Drug Users who share needles, Female Sex Workers and Men who have Sex with Men. In addition two 'bridge' population groups are also addressed – Truck drivers and Prisoners. These form the core groups for Afghanistan's' response.

A social mapping study was conducted in 2006 on most at-risk populations (MARPs) in Afghanistan provides some indication of the scenario, at least in three cities – Kabul, Mazār-i-Sharif and Jalalabad[7].

As these are major cities in Afghanistan, it is assumed the estimates do somewhat represent the national situation. Estimates from this study:

- 2.2 IDUs per 1,000 urban adult men across the three cities (Highest in Mazār-i-Sharif with 2.4 per 1,000 men). This translates to an estimated 16,000 IDU nation-wide, slightly lower than previous estimates.
- There are an estimated 1160 FSWs in the three major cities. It is widely believed that the study results are an underestimate due to the complex dimensions of sex work in Afghanistan.

Injecting Drug Users:

Afghanistan is the world's largest producer of opium (HIV and AIDS in Afghanistan, The World Bank, 2008) and significant drug trafficking and injecting drug use is reported. The Afghanistan Drug Use Survey in 2005 by UNODC estimated 920,000 total drug users (injecting and non-injecting) making up 3.8% of the total population. Estimates of injecting drug users (IDUs) in the country range between 19,000 – 25,000[6]. The large numbers of total drug users, and the intensification of the war on drugs through the reduction in heroin availability may push more drug users towards injecting, thus increasing vulnerability. More pressures on access, usually pushes up the numbers of those injecting. IDUs surveyed are known to be mobile, with almost 80% reporting that they had changed residence at least once. Much of the mobility appears to be related to various phases of the conflict in the country. Almost 70% of Mazār-i-Sharif IDUs and 80% of those in Jalalabad had lived outside Afghanistan. Those in Jalalabad were most likely to have lived in Pakistan whereas a high percentage of the Herat and Mazār-i-Sharif IDUs had lived in Iran and/or Pakistan.

Afghanistan's vulnerability to an HIV epidemic:

- Widespread poverty, high unemployment and low literacy.
- The existence of vulnerable groups: MARPs and displaced populations.
- Drug production and trafficking.
- Large numbers of drug users and injectors.
- Vulnerability of women - low social status and exploitation.
- Poor social and public health infrastructure, including lack of blood safety and unsafe surgical practice; various competing health priorities.
- Possibly very limited knowledge of HIV/AIDS.

Among the various routes of transmission, shared needles by IDUs is considered the key driver of the epidemic in Afghanistan. The HIV prevalence among IDUs was estimated to be between 1-18 % (in three cities, IBBS 2009).

Sterile needles: As per the latest IBBS (2009) conducted in three major cities of Kabul, Herat and Mazar, 94% of IDUs use sterile needles in their last injection; this is least in Herat 86 % and highest in Kabul with 98 %. There are no significant differences in age pattern across the cities in terms of usage of sterile needles (18-24 and 25+). A similar study in 2005 in the same cities estimated that those not using sterile needles were as high as 47 %. While this can be partly explained through the scaled up Program and partly due to the sampling bias (study cities of IBBS were already covered through interventions).

Knowledge: Knowledge levels of IDUs to HIV are still very low. Latest IBBS in 2009 shows only 29 % of the IDUs could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. IDUs in Mazar have the least knowledge – with only 5 % knowing about HIV; amongst the younger IDUs the knowledge level is 0 %. About 22 % of the IDUs have ever been tested and know their HIV status (in

Kabul just 19 %). This finding is slightly contradictory in Mazar, given the low level of knowledge.

Beyond needles: Risk behaviour of IDUs goes beyond just sharing of needles – high risk sexual activity with male and/or female is known to occur. According to the IBBS 2009, 55-70 % of the IDUs have ever bought sex from a sex worker; 9-12 % of the IDUs have bought sex in last six months. Of these, only 17-32 % of IDUs used condom in their last sexual encounter (in the last six months). In Mazar, younger men are three times more likely to use condoms than older men. About 1-3% of the IDUs have had sex with another man.

Female sex workers:

There are an estimated 1,160 FSWs in three major cities of Afghanistan, of which Kabul accounts for over 77 %. While this is recognised to be a conservative estimate, given the social cultural background, identification of FSWs and working with them is a significant challenge. FSWs in Afghanistan are also significantly different from other countries in the region – for example, they have only about 4.4 clients per month (IBBS 2009). Another study [Action Aid HIV AIDS in Afghanistan - A Study on Knowledge, Attitude, Behaviour and Practice in High Risk and Vulnerable Groups in Afghanistan, 2006] highlights that 84 % of female sex workers had 1-2 clients per day and the rest 3 clients and more per day.

The IBBS conducted in the three major cities of Kabul, Mazar and Herat provides a slightly different picture - only 4 % of FSWs know their HIV status (tested in the last one year; no variation in age groups). While the program coverage data shows 400 FSWs being reached, IBBS program exposure is <0. 1 %. Knowledge levels on HIV amongst FSWs is abysmally low – only 2 % could both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission; It is only 0.7 in the case of younger sex workers (18-24 years). Only 58 % of female sex workers report using a condom with their most recent client. Despite the above, the prevalence rate amongst FSWs remains zero as per the latest IBBS.

Men who have sex with Men:

Although 100 MSM were identified by a study (Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan – Naz Foundation, 2009), currently there are no robust estimates or behavioural or biological measures for this risk group.

Long distance truckers:

There are an estimated 60,000 truckers living and operating in Afghanistan and another 2,000 international truckers [NSP-2006-2010]. Action Aid had undertaken research into HIV risks among vulnerable groups. In this survey, 34 percent of truck drivers said that they had heard of HIV and AIDS; 7 percent (25) of the 390 truck drivers in this study admitted to having paid for sex in the previous 12 months; and less than a quarter of them had used condoms. However, the recent IBBS in 2009 has shown 0 % sero-positivity of HIV amongst truck drivers while about 23 % of truck drivers buy sex and 51 % use condoms.

Prisoners:

HIV prevalence among prisoners is growing and appears to be related to the proportion of injecting drug users in prison (0.57-1.57 % tested positive for HIV - IBBS 2009). There were 10,590 prisoners and detainees in Afghanistan's 35 prisons in 2007.

Given the evidence till date, the HIV epidemic is in its early stages - largely concentrated within the high risk groups – particularly the IDUs. The potential for a rapid increase in this group is very real. In addition, given the interaction between IDUs and FSWs (and MSM of which very less is known), and given the low levels of knowledge and safe sex practices amongst FSWs, there is a likelihood of the prevalence rates increasing within FSWs, MSM, Prisoners and Truckers – who currently are at 0 %.

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

History and Key Strategies of the NACP:

The Afghanistan National HIV/ AIDS Strategic Framework (ANASF: 2006 -2010) was developed through consultative and iterative processes involving the government, non-governmental stakeholders and development partners. The ANASF is a broad strategic framework designed to guide Afghanistan's response to HIV/ AIDS and assist stakeholders to develop their own strategic plans so that all initiatives in the country can be harmonized. It was based on analysis of the limited available data (in 2005), and took into account the resource constraints of the country in both human and financial terms. It established fundamental principles and identified clear priority areas where increased attention is likely to have the greatest impact on HIV/ AIDS in Afghanistan.

The Guiding Principles of ANASF include right to protection from HIV and STI, cultural, social and language sensitivity, supportive of vulnerable populations, particularly women, confidentiality and informed consent, full community participation (including PLHA) in prevention as well as care. Interventions were to be critically evaluated and improved based on lessons learnt at national, regional and/ or global level. Focus was given to Afghan capacity building.

The Framework comprehensively provides for six objectives, key strategies and 34 outcomes, that include components for HIV surveillance; VCT and HIV treatment, care and support; targeted interventions for most at risk populations and other vulnerable groups, including harm reduction for IDUs and prisoners, outreach to sex workers and their clients; joint HIV and TB services, and advocacy and communication for community leaders and the general population.

To address the multi-sectoral issues, the Afghanistan HIV/AIDS Coordination Committee (HACCA) was established in 2007. The HACCA acts as a policy forum for different ministries, NGOs, and civil society involved in the response to HIV and AIDS and have in the last one year been energised.

Prevention amongst most at risk populations:

The MoPH/NACP started implementation of harm reduction activities in 2008 among high-risk groups including injecting drug users, sex workers, truck drivers and prisoners. These interventions are being implemented by 10 NGO contractors. Interventions include outreach, drop-in centres (DIC) and behaviour change communication in the four major cities - Kabul, Herat, Mazar-e-Sharif, Ghazni, Badakhshan, Kunduz, Kandahar and Jalalabad.

Scale up and coverage: The Programme has faced significant challenges in scale up - due to poor security situation and other internal constraints; implementation progress has been slow or often been hampered. For example the World Bank supported Project had spent only about 50% and the remaining were undisbursed. However, the "project progress is still very remarkable and the seeds have been planted for very successful interventions, especially amongst IDUs" [Midterm Review of the Project – 2010]. The Project now covers only about 17 % (3,250 of 19,000) – [Source: Midterm Review mentioned above] of the IDUs regularly through a comprehensive programme which includes a package of services. However this falls significantly lower than 60 % (Universal Access targets) needed to have comprehensive impact. The IBBS study in 2009 shows some encouraging results in programme coverage – 17 % of IDUs report receiving needles and condoms. However the coverage is very uneven across the three major cities. It is important to note here that the recent IBBS did not cover Jalalabad (as the estimated population of IDUs was comparatively less). A study in 2007-08 on high risk group's

sero surveillance notes that "the most rapid dynamics are observed in the simulations for Jalalabad, driven by the much higher contact rates".

Interventions have been established in Kabul, Balkh, Herat, Nangrarhar, Kunduz, Badakhshan, Kandahar and Ghazni provinces and progress has been made toward achieving targets. Progress has also been made on several policy initiatives – the broader harm reduction as well as an OST policy. Capacity of staff and government officials has been built to some extent through training and study tours for government staff. Advocacy especially related to initiating methadone programs has led to the development of OST policy and the recent import of methadone.

The current service package available to IDUs contains most of the key elements of needles, condoms, STI treatment and referral to testing and counselling (HIV). However, programs are not currently reaching sex partners of male drug users and vaccination for Hepatitis B is not available. Given that a substantial number of the IDUs are returnees, the issue of homelessness and joblessness is not addressed in conjunction with HIV prevention. The basic package of services offered by the interventions include - Distribution of Safe-Injecting kits, collection of used needles and syringes, counselling for blood borne diseases including VCT for HIV, Hepatitis C/B testing, condom promotion, Syndromic management of STIs, abscess management, overdose management, referral for TB services, referral to ARV centre for HIV+ clients, referral for drug detoxification and abstinence based treatment, primary health checkups, hygiene kits, IEC and other social services. The package of services offered through outreach and at Drop in Centres is clearly in line with global guidance regarding the components of a comprehensive package for prevention, treatment and care. During 2008-09 in all services were provided to 1812 IDUs. Needles distributed were 383,409. Abscess treatment was accessed by 1319 patients [source MIS-NACP].

Female sex workers:

In spite of the constraints of working in a difficult environment, where stigma and shame are directed at sex workers, targeted interventions have made significant progress; two clinics for sex workers have been established in Kabul and Mazar, reaching 400 sex workers in these cities. Through this programme, it is reported that over 49% of female sex workers use condoms with their most recent client while, 24% of sex workers have had an HIV test in the last 12 months and know their results. IEC impact indicators demonstrated over 65% of sex workers correctly identified ways to prevent sexual transmission of HIV. [Source for all figures in this para: Midterm review of the World Bank, 2010].

There is significant (and potentially sensitive) work still left to reach FSWs to keep the epidemic at the current level in this high risk group.

Men who have sex with Men:

Significant work still exists to build consensus on working with MSM and to conduct a comprehensive mapping to identify the numbers and reach them.

Long distance truckers:

Three Truckers Implementation Units (TIU) in Kabul and Jalalabad have been established. Although condom distribution was not part of the start-up phase, uptake is increasing. HIV counselling and testing, STI management and primary health care services are provided through these centres, in addition to core outreach work.

Prisoners

The Program has succeeded in getting approval of Institutional Review Board (IRB) of the MOPH for operational research on OST in the prison. An MOU has been signed between the Ministry of Justice (MOJ) and the SDO to provide harm reduction services in the prison. The implementing NGO has identified 370 drug users including 63 IDUs in Kabul Policharkhy prison and some basic services are being provided at the Prisons, despite severe legal and other constraints.

Summary of indicators and progress:

Percentage of most at risk populations who received an HIV test in the last 12 months and who knows their results (UNGASS Indicator 8)

22 % of IDUs (ever tested) and 4 % of FSWs (last 12 months) – IBBS 2009. There are no significant differences in geographical locations or across two age strata (18-24 and 25+).

Percentage of most at risk populations reached with HIV prevention programmes (UNGASS Indicator 9)

17 % of IDUs and 0.1 % of FSWs (IBBS-2009).

17 % of the IDUs report being reached with services (i.e. at least two critical services) while only 0.1 % of FSWs report being reached. However, programme data shows 17 % of IDUs (of the estimated 19,000) and 30 % of FSWs (of estimated 1200) are being reached. Currently there are no programmes to reach MSMs. Of the long distance truckers, 1 % (of the estimated 60,000) are being reached. The IDU data could be slightly biased as the data was collected in the cities where interventions were in place Other problems include the lack of definition of 'reach' and the lack of robustness of the denominators.

Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission I UNGASS Indicator 14)

Latest IBBS (2009) shows only 29 % of the IDUs could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.

Correct knowledge levels on HIV amongst FSWs is abysmally low – only 2 % could both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. It is only 0.7 % in the case of younger sex workers (18-24 years).

Percentage of female and male sex workers reporting the use of a condom with their most recent client (UNGASS indicator 18)

58 % of female sex workers report using condom with their most recent client (IBBS-2009)

Percentage of men reporting the use of a condom the last time they has anal sex with a male partner (UNGASS Indicator 19)

Not available. Current interventions do not cover MSM or male sex workers.

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse (UNGASS Indicator 20)

Of the IDUs reporting sexual intercourse in the last six months, 35 % or 237/ 548 of IDUs report using a condom.

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (UNGASS Indicator 21)

94 % (IBBS 2009). In three major cities of Kabul, Herat and Mazar, 94%, 86 % and 98% respectively used sterile needles in the last time they injected. There are no significant differences in age pattern across the cities in terms of sharing needles (18-24 and 25+).

Prevention in General Population:

In the context of Afghanistan, prevention in general population includes blood safety, Voluntary Counselling and Testing, advocacy and communication. Details are provided below:

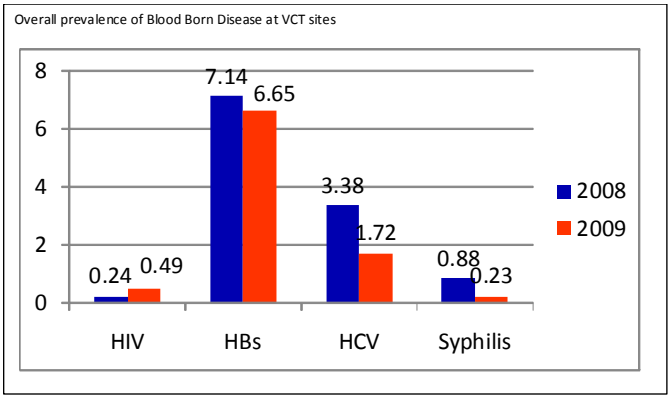
Blood Safety:

The MoPH has developed a comprehensive plan for strengthening access to safe blood in the country. As a result, the Blood Safety Program is currently supported through the French Cooperation. In 2008 and 2009, 31,239 units were collected from the public Blood Banks. Of this screening is happening in quality assured manner in 6 of the 12 blood banks.

In 2008, 12 provinces reported to central Blood Bank (Helmand, Herat, Nangrahar, Bamyan, Farah, Balkh, Jozjan, Kapisa, Kandahar, Faryab, Paktika, Kabul). However in in 2009 only six provinces reported (Helmand, Parwan, Faryab, Herat, Balkh and Nangrahar). Currently no quality monitoring of private blood banks exists. Blood donors in Afghanistan are usually relatives of the person needing blood units and a panel of relatives offering blood are tested and those with no known infections are then asked to provide blood. All of the units were screened for HIV, HBV, HCV and Syphilis.

Voluntary Counselling and Testing Centres:

By 2007, the MoPH had established 6 VCT centres – Kabul (2), Jalalabad, Mazar-i-Sharif, Faizalabad and Herat. In 2008 and 2009, another 5 more centres were added. During 2008-2009, 19,875 persons tested themselves for HIV, of which 42 % were women. Of those who tested, 69 tested positive (0.35 %). Of this the males who tested, 0.47 % were HIV +ve while in the case of female, it was 0.18 %. HBV cases are 7 %, HCV+ve 3 % and Syphilis 0.63 %. In all cases, men tested higher than women. 1618 family counselling sessions were conducted in addition to 27,000 group counselling and 16,955 individual sessions. [Source: MIS of NACP]



Life skills education (LSE):

In a country where only 43% of men and 13% of women are literate, it is a challenge to implement HIV awareness and prevention programmes. In addition, significantly high levels of school drop-outs make it more difficult to carry out HIV intervention programmes. According to UNICEF, the net primary school enrolment ratio for males is 66% while for females it is 40%. Overall, poor enrolment rates are aggravated by high drop-out rates.

In selected provinces, the MoPH has initiated reproductive health and HIV/ AIDS activities specifically for out-of-school youth by establishing youth information centres and youth-friendly services. HIV/AIDS agenda has been included in the national education curriculum for 4th-12th grade

Providing Life Skills Education is one of the priorities for the Programme. This is aimed at school children and adolescents. Currently, this programme is implemented through ARCS. In 2008, 81 schools were covered and in 2009 the numbers increased to 122 (of the total 12,000 schools in Afghanistan). Other than specific LSE, basic HIV knowledge related information has been mainstreamed into education curriculum.

Advocacy and Communication:

The NACP has developed a Communication and enabling environment strategy, which is expected to a. Raise awareness and advocates for HIV; b. Provide appropriate and accurate information; c. Influence the social norms in their communities, and d. Provide the necessary support for people to adopt behaviours which can prevent HIV transmission as well as help reduce stigma and discrimination associated with it.

The Programme has developed strong HIV prevention messages. Advocacy meetings were held and broadcast with the highest level of religious authorities in the nation, as well as with communities, media and service providers. Some anecdotal evidence of increased awareness and knowledge retention has been noticed. After repeated efforts since 2007-2008, the Opium Substitution Treatment (OST) policy under this component has been recently approved.

Through a separate contract with Futures Group International (FGI), the MoPH/NACP has additionally started advocacy and communication activities to mobilize high-level political support and interventions designed to reduce stigma and discrimination among Afghan drug users.

The HIV/AIDS Coordinating Committee of Afghanistan (HACCA) is a key link in developing high-level advocacy strategies and policy engagement. The HACCA comprises of representatives from government ministries, donors, UN, civil society, religious leaders and educational institutions and organizations. Futures Group International, additionally, has provided support and technical assistance to the HACCA secretariat (with funds from USAID) that works in close collaboration and coordination with the NACP team.

At the field level an Advocacy Training of Trainers (ToT) for harm reduction NGO implementers and relevant line ministries was conducted during March to April 2009.

Communications have focused on HIV prevention messages and risk reduction, creating a more enabling environment by challenging stigma and discrimination through media spots and events, developing culturally appropriate, up to date HIV information and disseminating global best practice among AHAAP partners. Some highlights of the communications strategy are listed below:

- World AIDS Day event December 2008 and December 2009.
- Technical round table on HIV and AIDS launched and broadcast.
- Short radio and TV clips were produced and broadcasted through radio and TV main channels during December 2008 and December 2009.
- HIV & AIDS stakeholder's directory developed in May 2009 and is updated regularly.
- 2,200 brochures, 380 posters and 500 red ribbon messages and slogans related to HIV and AIDS for stigma reduction, were developed and disseminated in 2008. In Dec 2009, 40000 leaflets, 12000 posters, 500 banners, 5000 brochures, 2000 magazines, 2000 pens carrying HIV messages were distributed in 8 major cities of the country including in Kabul city.

A significant achievement has been the progress made around fostering a more supportive environment among media practitioners including journalists who may not have a full understanding of the social and economic benefits that are associated with harm reduction programmes. Ongoing initiatives include:

- 60 media focal points (journalists) from different media agencies trained in HIV and AIDS in June 2009
- Media Monitoring: Afghanistan Media Watch initiated in January 2009 to assess how HIV and AIDS are being presented in Afghan Media.
- Annual HIV and AIDS Media Award programme was announced on April 26, 2009

The messaging needs to be further developed and some existing messages revised, with involvement of Most at Risk populations and further refinement is necessary and possible.

Given the security situation, the Programme has found it difficult to launch a household level survey or any other population based studies. Therefore several general populations' related indicators are not answered within this report.

Summary of indicators:

Percentage of donated blood units screened for HIV in a quality assured manner (UNGASS Indicator 3)
50 %. Quality assured screening is happening in six of the 12 blood banks. Currently no quality monitoring of private blood banks exists.

Percentage of women and men aged 15-49 who received an HIV Test in the last 12 months and who know their results (UNGASS Indicator 7)
0.16 %. 19,875 persons tested themselves for HIV in 2008-9, of which 0.35% tested positive. According to UN Population division, there are 12,212,000 Afghans in the age group of 15-49 years; 42 % of those tested were women and 0.18 % of the women tested HIV +ve compared to 0.47 % men.

Percentage of schools that provided life skills based HIV education in the last academic year (UNGASS indicator 11)
1 %. No. of schools covered by the LSE programme – 122 of the total 12,000 schools.

Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about the HIV transmission (UNGASS indicator 13)
Not available.

Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of fifteen (UNGASS Indicator 15)
Not available.

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (UNGASS Indicator 16)
Not available.

Percentage[3] of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse (UNGASS Indicator 17)
Not available.

[3] BSS

Care, Support and Treatment for People Living with HIV/AIDS (PLHA)

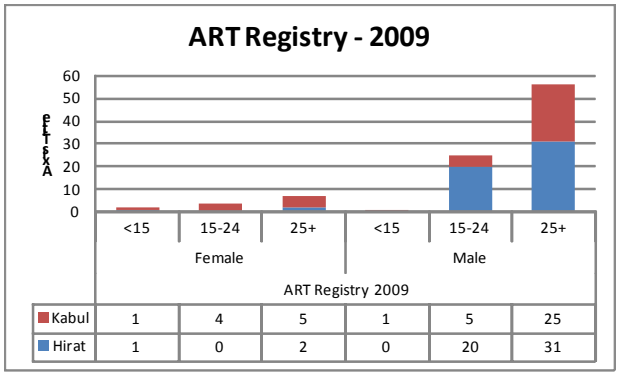
By end of 2009, cumulatively, 636 cases of HIV +ve were reported [source of information includes VCT, Blood Banks, HMIS, ICRC, and Afghanistan National Army (ANA)]. The quality assurance of testing is not up to the mark (except VCT sites) and there is a chance of double counting.

Currently ART is being provided by two ART clinics located in Kabul and Herat which have been established in April and Julne 2009 respectively. In all, about 95 Cases of HIV have been registered in 2009, of which 19 Persons are on ART. The Programme is in the process of acquiring CD4 count machine, which will provide more accurate metrics for ART programme monitoring.

An HIV-TB task force has been set up within the MoPH and recently, HIV patients have started being referred for testing for TB. Recently persons testing positive for TB and who have high risk behaviour are referred for HIV testing. In 2009, 394 TB positive cases where screened for HIV and about 4 were positive for HIV. The data currently reported is from routine reporting of facilities in 8 provinces. More reliable information could be arrived at through well established HIV surveillance and/ or conducting HIV sero-prevalence survey among TB patients.

During 2008-2009, 606 episodes of STI were treated in the 5 clinics; 1618 family counselling sessions were conducted in addition to 27,000 group counselling and 16,955 individual sessions.

The increased capacity of MoPH/NACP has resulted in the adoption of the Afghanistan HIV Code of Ethics, an important milestone for the support and protection of people living with HIV/AIDS in the country.



The services currently offered to IDUs include detoxification, counselling, life-skills and education opportunities. Additional therapies include music and therapeutic and participatory activities that were appreciated by clients. A total of 400 beds in residential centres are available throughout the country with the majority based in Kabul. Currently demand is far ahead of supply. The largest treatment centre in the country, Jangalak, is located in Kabul. The coordination of the centre is the joint responsibility of the MoPH and Ministry of Counter Narcotics.

Summary of indicators:

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (UNGASS Indicator 4)
Not available.

ART initiated and rolled out only in end of 2009. Currently 95 patients are registered in the ART clinics of Kabul and Herat including 13 are female, 3 are children (<15) and 29 from 18-24 years of age. There are no robust size estimations and therefore the denominator for this indicator is unavailable. In addition, without CD 4 count machine availability, advanced HIV infection is not tracked systematically.

Percentage of HIV infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission (UNGASS Indicator 5)
Not available. Given the low prevalence, the country does not have a PPTCT programme in place.

Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV (UNGASS Indicator 6)

1 %. In 2009, 394 TB positive cases where screened for HIV and about 4 were positive for HIV.

Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child (UNGASS indicator 12)
Not applicable

Institutional Strengthening and Capacity Building

Programme Management

The Programme Management capacities have significantly improved within the MoPH, through the support of partners. Some key examples:

a. The MoPH/NACP team is fully staffed with clearly laid out individual responsibilities. There are monthly working group meetings (harm reduction, advocacy and communication, M&E and surveillance) attended by MoPH/NACP, UN agencies and NGO implementers where overall programmatic issues and progress are discussed. In addition, a working group on Monitoring and Evaluation also exists.

b. MoCN has been coordinating joint activities of the MoPH and MoCN by establishing 3 working sub-groups (Prevention; Treatment, and Harm Reduction); and has been supporting Demand and Harm Reduction initiatives in the country in collaboration with UNODC and GTZ-IS.

c. A significant and important relationship has also been developed between MoPH/NACP and the Ministry of Counter Narcotics.

d. The MoPH/NACP team is also responsible for the development of a series of guidelines for implementation (harm reduction, TB & HIV, ART, STI, OST HIV Testing (VCT & PICT) along with a database for the analysis of individual implementer performance alongside overall programmatic performance.

e. Alongside the coordination and management of AHAPP, the MOPH/NACP is also the focal point for all HIV activities funded under GFATM and for the development of future HIV funding rounds.

f. The MoPH/NACP, supported by FGI, also coordinate and support the HACCA secretariat that has received $ 1 million from USAID for strengthening HACCA to increase its capacity to oversee HIV prevention, treatment and care programmes in Afghanistan.

g. NACP managers and staff have also regularly participated in regional and international consultations and trainings in 2008-2009 around such issues as Monitoring and Evaluation, Estimations, Surveillance and other substantive topics supported by UNAIDS, WHO, UNODC and other partners.

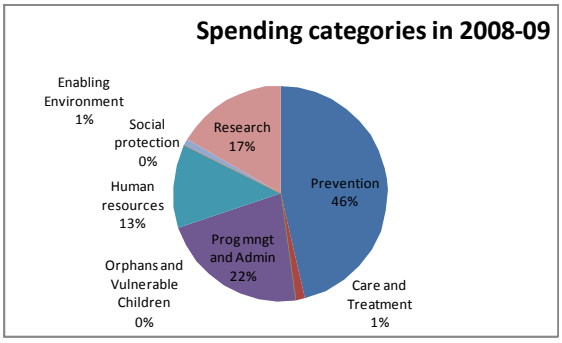
Capacity Building:

Several capacity building and training programmes covering harm reduction implementation and advocacy have been completed. For service delivery, the standard operating procedures and checklists have been developed and documented by MoPH/NACP which is responsible for monitoring quality of service and ensuring that NGO implementers are providing qualified staff with the necessary range of skills. Three NACP staff visited vulnerability reduction projects in India. NACP training officer received Management training in Indonesia for 2

months. The Ministry of Public Health had included HIV/AIDS in the Basic Package of Health Services (BPHS) and EPHS. The BPHS covers more than 80 percent of the population and is largely delivered by contracted NGOs. The MoPH has completed draft National Guidelines on VCT and trained one staff member on voluntary counselling in Iran; three lab technicians of the VCT centres have been trained in India. Twenty-two media workers have been provided training on HIV/AIDS in Kabul. One medical staff of Kabul ART received short course on ART (SCART) training for 3 weeks in Belgium.

Strategic information:

Strategic information includes Surveillance (biological and behavioural), a robust M&E system and research. The aim is to provide improved evidence for better programme design and make mid course corrections. Afghanistan's programme is still nascent and has been characterised by lack of good quality information. However in the last two years, there have been several research / studies commissioned, which have informed the programme. These have been carried out despite significant field level difficulties, due to the security situation.

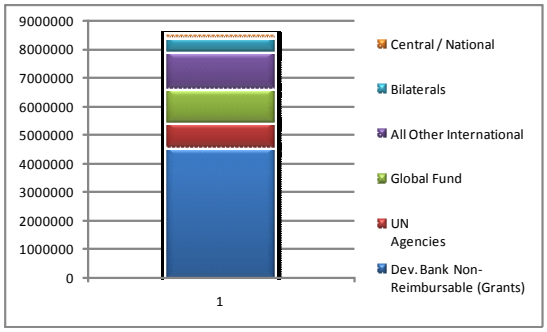


- The MoPH/NACP, through a contract with Johns Hopkins University (JHU), has just completed the first integrated biological and behavioural survey (started in 2009 with results available at the beginning of 2010).
- University of Manitoba (UoM) had completed a study in Kabul, Jalalabad, and Mazar-i-Sharif among high-risk groups (Social Mapping of High-Risk Groups) in 2006;
- MoPH had completed a study among TB patients (1,200 persons) in seven provinces, including HIV/AIDS testing.
- Research has been undertaken by Naz Foundation to study the context of same-sex contacts between men, including identifying different sub-populations of MSM through UNICEF support.

Financing and spending:

To fight HIV and AIDS, Afghanistan spent 8.5 million USD in the years 2008-09. The funds spent were from a variety of sources including the World Bank, UN Agencies, Global Fund, International NGOs, Bilateral and the National Government. While the contribution of the National Government is small, it is to be seen in the context of the conflict recovery process the current Government is seized with.

The major investors in HIV and AIDS in Afghanistan in terms of financial support include the World Bank (54 %), INGOs (15%), Global Fund (14%), UN Agencies (10%), bilateral(6%) and MoPH < 1%.



Prevention should be a top priority for Afghanistan; in terms of funding 46 % of funds were spent on this. Programme Management and Administration accounted for 22 %. The third major cost was research (17 %), as it was a priority to secure adequate evidence to mount a relevant response.

Domestic AIDS spending by categories and financing UNGASS (Indicator 1)
Afghanistan raised and spent 8.5 million USD in the years of 2008-09. Of this, 54 % was financed by World Bank, INGOs (15%), Global Fund (14 %) and UN agencies (10%). Highest allocation was for prevention (46 %), followed by Programme Management and Administration (22 %), Research (and Surveillance) accounting for 17 % and Human Resources 13 %.

Conclusion and outcome / impact of the Programme:

The Afghanistan AIDS Control Programme has suffered from lack of evidence which has been partly addressed recently (in 2009-10). Meanwhile, the Programme has made great strides in 2008-09, with the roll out picking up from 2009. In many senses, the Programme is young and is rapidly maturing by reaching scale and quality. The IBBS 2009 serves as one of the baselines for the Programme. Given the severe difficulties of data collection, the Programme has managed to gather evidence which is extremely useful, but has to be cautiously used, given limitations.

There is no robust information on the prevalence rates of HIV amongst the general population – there are neither HIV sentinel surveillance sites nor case reporting systems. The information available includes blood banks and VCT Centres. Quality assurance in these centres is still at initial stages. In 2009, 636 HIV-positive cases have been recorded, mostly through blood screened at the central blood bank and reported through HMIS. The number of deaths due to AIDS was reported less than 10 in 2009.

Prevalence information has been collected only from the Most at risk population – given the low level of the epidemic; this strategy is the most appropriate. Amongst the MARPs, the epidemic is very variable across the MARPs, only in the case of IDUs and Prison inmates; HIV is prevalent at this point. Prevalence amongst IDUs varies from 1 to 3 to 18 % in Mazar, Kabul and Herat respectively. In the two prisons where HIV Prevalence was measured, the prevalence ranged from 0.57 to 1.57%.

The IBBS also revealed risky behaviours among injecting drug users that could lead to spill-over to other high risk groups and from there to the general population. The new findings suggest that there should be an urgent scale-up of interventions for IDUs in the western provinces of the country. In addition, there is a need for providing comprehensive harm reduction services in prisons which is considered a major challenge.

ART has been rolled out in mid 2009. Much needs to be done in identifying positive persons; encouraging voluntary testing of high risk individuals to test and access services.

Given the evidence till date, the HIV epidemic is in its early stages - largely concentrated within the risk groups – particularly the IDUs and Prisoners. The potential for a rapid increase in these groups is very real. In addition, given the interaction between IDUs and FSWs (and MSMs of which very less is known), and given the low levels of knowledge and safe sex practices amongst FSWs, there is a likelihood of the prevalence rates increasing within FSWs, MSMs, Prisoners and Truckers – who currently are at 0 %. In addition, given the absence of research data, other potential aspects of risk and vulnerability related, for example, to mobility, consequences of conflict and gender should not be overlooked.

There was considerable progress during 2008 and 2009; however, the coverage of services is still a challenge and there is a need for expansion of services to most areas of the country.

Summary of indicators:

Percentage of most at risk populations who are HIV infected (UNGASS Indicator 23)
IDUs – ranges from 1 % in Mazar, 3 % in Kabul and 18 % in Herat.
FSWs – 0 %
MSMs – Not available
Prisoners - 0.57 to 1.57 %

Percentage of young women and men aged 15-24 who are HIV infected (UNGASS indicator 22)
Not available

Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (UNGASS Indicator 24)
Not available

V. BEST PRACTICES

With a nascent programme in Afghanistan, this section lists out some of the achievements and Best Practices.

a. Supportive policy environment:

The much awaited and critical Opioid Substitution Therapy (OST) Policy was technically approved during 2009 by the Consultation Group on Health and Nutrition (CGHN), the Technical Advisory Group (TAG) of the Ministry of Public Health (MoPH). This gives Afghanistan much needed impetus for harm reduction.

b. Expansion of care, treatment and/or support programmes:

The ART programme was initiated during this reporting period with 95 patients being registered. Two ART centres were set up in 2009- one in Kabul and another in Herat. The HIV and TB referral system was also initiated and already 394 TB patients have been tested for HIV.

c. Start up and expansion of prevention programmes:

Harm reduction programmes have been expanded to four more provinces during the reporting period, making a total of eight provinces that have harm reduction programmes. This is a significant achievement given the difficult security situation. VCT centres have also been expanded into four more provinces, making a total of eight provinces with VCTs. There is one specific VCT for female prisoners in Kabul.

d. Demand based, comprehensive packages

The Needle and Syringe Programme is a demand driven programme. There are no quotas or restrictions for IDUs to access the amount of sterile equipment they require. The Comprehensive Safe Injection Kit is a standard pack of 3 needles & syringes, a cooking spoon, tourniquet, cotton wool, 3 vials of clean water, 3 alcohol swipes, 3 plasters, IEC leaflet and registration card. Following the initial provision of the kit, IDUs are able to resupply further kits according to their needs (e.g. if they inject 5 times a day they will receive 5 needles & syringes, 5 alcohol wipes, 5 vials of clean water, cotton wool, and 5 plasters). Hygiene Kits are also distributed (soap, shampoo, anti-lice powder) and barbering/shaving services offered at outreach sites.

e. Monitoring and evaluation:

The programme's achievements to date are impressive. Mapping and size estimation have been conducted. Comprehensive integrated bio-behavioural surveillance (IBBS 2009) has been completed among priority populations of injecting drug users, prisoners, female sex workers and road transport workers. The geographic representativeness of the sample is commendable, given the severe security constraints. The sample sizes are sound, with acceptable sample sizes for each sub-population: injecting drug users (N=548, in Kabul, Mazar and Herat); prisoners (N=660, in Kabul and Herat); female sex workers (N=368, in Kabul); and road transport workers (N=365 in Torkham on the Pakistan border). The range of biological pathogens examined includes HIV, syphilis, herpes, HBV and HCV. Laboratory validation and quality assurance procedures are comprehensive and reflects international best practice. The IBBS round undertaken in 2009 will serve to establish a second generation surveillance system (Afghanistan: HIV/AIDS prevention project mid-term review mission, Feb 4-11, 2010).

f. Improved Coordination

The reporting period saw improved coordination and working between Civil Society and government through World AIDS Day events, technical working groups, the GFATM Country Coordinating Mechanism (CCM) and the HIV and AIDS Coordinating Committee of Afghanistan (HACCA). The HACCA of Afghanistan has been especially instrumental in getting the different line ministries, development partners and NGO implementers to

coordinate efforts. This reporting period has seen increased attendance and participation, robust discussions and actions on programme and policy.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

This is a section on some of the challenges within Afghanistan. Remedial actions against the challenges reported in the last UNGASS report are not applicable here, since this is the first UNGASS report.

g. The single biggest challenge for the Programme is the security situation. Despite this, the Programme has made strides.

h. Low-awareness on HIV and AIDS and stigma and discrimination are major challenges to implementing effective HIV interventions and accessing most at risk populations.

i. Behavioural surveillance data and knowledge, attitude, and practice (KAP) surveys are needed to develop a coherent plan which can be translated into effective action. Mapping of risk groups such as injecting drug users and sex workers was conducted in 2006-7 in Kabul, Jalalabad, and Mazar and different HIV prevalence studies have been conducted among IDUs. The recent IBBS conducted does provide substantial information. However, estimates of most at risk population are still not sufficient to set milestones. Assessments are also needed on other vulnerability factors to allow the expansion of programmes across populations and regions of the country.

j. As Illicit drug use is punishable by law, prison interventions that include harm reduction are difficult to implement. National and sectoral HIV policies and guidelines need to be developed. Although OST policy has been technically approved, effective implementation and scale-up to those most in need is still a challenge.

k. Although there is a referral system between HIV and TB, it still needs to be strengthened and thus to increase the possibility of detection of cases and appropriate treatment. Similarly, referral systems need to be strengthened between outreach, DIC, drug treatment, VCT and ART centres.

l. Effective Integration of HIV and AIDS services within the national health care system and ensuring government contribution to the program for sustainability purposes is a major challenge.

m. The government finance and procurement procedures are lengthy; therefore many times access to much needed supplies takes longer than expected. There is a shortage of CD4 counting machine, test kits, syphilis test kits, etc.

n. Quality of service provision and care is not yet optimal; however, steps are being taken towards filling this gap.

o. Since Afghanistan's national AIDS programme is largely donor driven in terms of financing, there are multiple reporting systems that increase the work load and possibly result in duplicate reporting.

p. Gender issues including needs of female drug users are not fully understood and addressed by the Programme at this stage.

q. Critically, scale up and quality is the key challenges for the programme. There is a need to quickly cover the most at risk populations to avoid an increase in prevalence rates.

VII. SUPPORT FROM COUNTRY'S DEVELOPMENT PARTNERS

Afghanistan's development partners work closely in support to the national response which is largely funded through donor resources. They include multi-laterals (i.e. WHO, UNODC, UNAIDS, UNICEF, UNFPA, World Bank, and GFATM), bi-laterals (e.g. USAID, GTZ, etc), International NGOs (e.g. International Federation of Red Cross and Red Crescent, etc), and others such as the Futures Group International.

The development partners have diverse sets of programmes and are major contributors within the National Strategic Framework. While financial support is crucial, the country's various development partners have a major role to play, with each partner having their respective areas of technical contribution within the ANSAF framework in the spirit of the 'Three Ones' principle. This kind of coherent support is critical for Afghanistan in meeting national and international targets.

The largest donors are the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and the World Bank. The GFATM (Round 7) has approved a proposal for US$ 11 million that finances Strengthening Provincial HIV Program (SPHP) in eight provinces of the country. The SPHP aims to reduce the spread of HIV, reduce morbidity and mortality of AIDS and mitigate the social impact of the epidemic in Afghanistan. The MoPH and Gesellchaft fur Technische Zusammenarbeit (GTZ-IS) are the principle recipients. World Bank has sanctioned US$ 10 million through the Afghan HIV and AIDS prevention project (AHAPP) for harm reduction services to at risk groups (IDUs, sex workers, prisoners, and truckers) in different cities (Kabul, Mazar, Jalalabad, Herat) as well as for strengthening biological and behavioural surveillance, advocacy and communication. USAID has provided US$ 1 million to support HIV and AIDS Coordination Committee of Afghanistan's (HACCA) Secretariat for better coordination of the multi-sectoral response to HIV in the country as well as to provide support for improving management of the HIV program. It will also fund one pilot MSM project.

WHO provides support to ARV treatment and other technical areas of the HIV response. Last year, they supported the NACP in the efforts to establish the first two ARV treatment centres which was a breakthrough. Treatment and care is currently being provided to over 100 persons and this number is likely to rise substantially over the coming years especially if the system of linkages with VCT centres, referral through outreach among at-risk populations, DIC for IDU and front-line health services in general are reinforced.

Through the Joint UN Team on AIDS established in 2009, UNAIDS provides capacity-building and technical support as well as helps mobilize commitment and resources for national governmental and civil society partners. In order to coordinate and pool efforts of the UN system, a Joint Support Plan is being elaborated. UNAIDS has provided support from 2006 initially to the development of the ANASF, including through the ASAP mechanism, and with UNODC to the GFATM Round 7 proposal development. In 2008-2009, resources were mobilized for emergency HIV prevention and relief support to drug users in Kabul implemented by UNODC and WHO. It also links the national AIDS response with global best practices on AIDS.

Among the UN agencies, UNODC has a significant role to play, given the extent of drug cultivation, trafficking, use and its consequences in the country. Their role includes support to demand reduction; research and programmes on IDU, harm reduction and OST; drug treatment; drug use among refugees, returnees and women.

In addition to the above partners, the Programme in Afghanistan is currently supported by the i) European nations for harm reduction within the drug demand reduction programme; ii) UNICEF support to NACP on a

communication strategy; iii) UNFPA support for VCT centres; iv) UNESCO, along with the NACP and other UN agencies is involved in HIV education and communication activities in the country; v) French AFD support for blood safety; and vi) NGO support for VCT testing. In addition, GFATM Round 2 supported laboratory assessment, TB sero-prevalence study, and HIV training. Multiple donors, including the Swedish support the Basic Package of Health Services (BPHS) provided by NGOs in all provinces and covers >85% of the population. The BPHS includes HIV testing and counselling at the comprehensive health centre level.

There are several implementing partners in Afghanistan consisting of International and Afghan NGOs. Some of the key ones which are involved with HIV response are listed here (involved in 2008-2009):

1. Medecins Du Monde (MDM)
2. Solidarity for Afghan Families (SAF)
3. Organization of Technical Cooperation for Community Development (OTCD)
4. Sanayee Development Organization (SDO)
5. Nejat Center
6. Afghanistan Family Guidance Association (AFGA)
7. Khateez Organization for Rehabilitation (KOR)
8. Agency for Assistance & Development of Afghanistan (AADA)
9. World Vision International (WVI)
10. Aide Médicale Internationale (AMI)
11. Health and Social Development Organization (SHDO)
12. Ibn-e-Sina
13. Shahamat Health & Rehabilitation Organization (SHRO)
14. Islamic Relief International (female IDU)
15. Actionaid
16. Just for Afghan Capacity & Knowledge (JACK)
17. John Hopkins University (JHU)
18. Futures Group International (FGI)
19. Relief International (RI)
20. Swedish committee of Afghanistan (SCA)
21. Afghan Red Crescent Society (ARCS)
22. Social Health and Development Program (SHDP)
23. Youth Health Development Organization(YHDO)

VIII. MONITORING AND EVALUATION ENVIRONMENT

The NACP as main coordinating body for HIV and AIDS activities at country level has the lead role in all HIV-related issues. All stakeholders involved in HIV and AIDS activities follow the framework of ANASF, the NACP and its M&E.

The NACP is gathering HIV and AIDS data from eight provinces through provincial HIV advisors, HMIS officers and various local and international NGOs. The NACP then analyzes, interprets and utilizes data for decision making, public awareness and other necessary purposes. The World Bank and GFATM Round 7 are also supporting the process of maintaining a standard and unified M&E system at national level. NACP standard tools have been distributed to NGOs to be used at each service delivery point. Reports, updates and other necessary information are widely shared with all stakeholders through HACCA, the CCM and HIV and AIDS quarterly reports.

The Surveillance Working Group (SWG) is providing technical support to the development and implementation of the M&E plan and integration within the wider MOPH M&E Strategy as well as with the CCM and multi sectoral ministries. Existing human resources for M&E include a Consultant and an Officer at national level. It is worth mentioning that, currently, only the M&E consultant is in place. He has been appointed to assist the implementation of M&E activities at national and provincial level as well as to provide support to national and international stakeholders involved in HIV and AIDS activities. In addition, the NACP may call on international technical assistance when necessary. The SWG consists of l M&E experts as well as donors, UN agencies and local and international NGOs to assist the NACP to apply its available resources and implement the M&E plan, organize capacity building for the NACP and its officers, ensure adequate surveillance, and timely reporting from all service providers.

In order to integrate NACP surveillance and monitoring data into existing MoPH data systems, the following data types are considered:

1) Special survey data (household surveys, surveys of hard to reach populations and service quality surveys of non BPHS/EPHS related services);
2) Routine monitoring data and health facility survey data from BPHS/EPHS facilities conducting NACP related activities (e.g. blood banks/transfusion sites, diagnostic HIV testing, TB screening, STI management);
3) Routine monitoring data from non-BPHS/EPHS facilities and targeted intervention implementation units; and,
4) Routine financial and human resources data maintained by the Health Economics and Finance Directorate (HEFD) and Human Resources database respectively.

- For the above-mentioned data category 1, where there are existing surveys being conducted by other ministries or agencies using appropriate sampling methods of the desired target population, NACP will request that the related national indicators be added to these instruments. Examples of such surveys include the National Risk and Vulnerability Assessment (NRVA), Multi-Index Cluster Survey (MICS), etc. Data and associated documentation of methodology and protocols from the special surveys commissioned by NACP will be shared with the responsible units, with the MOPH responsible for performance monitoring and surveillance. Where existing models for conducting surveys exist (e.g. balanced scorecard assessments through health facility surveys), conventions adopted by other units

with the MOPH will be followed where applicable. These surveys are financially supported by the GFATM Round 7, World Bank, UNODC, and USAID.

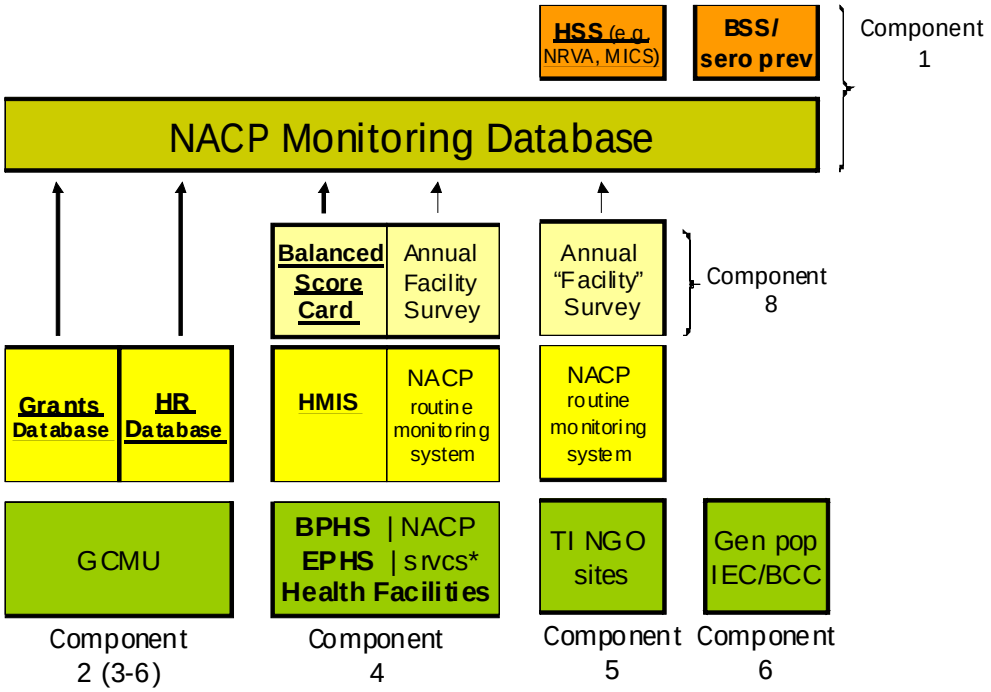
- For data category 2, NACP will participate in the ongoing HMIS stakeholders' meetings and working groups to update the formats used by the BPHS/EPHS facilities. Data for two indicators are being collected from BPHS/EPHS facilities at country level – i.e. total number of people tested for HIV and total number who are HIV positive. The normal channel for modifying formats involves adjustment to the respective strategy/guideline of the MOPH for each programme area to reflect changes in protocols and quality standards. NACP staff will be trained to access the HMIS, import the NACP related-data from the HMIS into a consolidated NACP data base and use the analysis tools provided by the HMIS to conduct routine analysis. NACP will obtain support from the HMIS team to develop a standard report for the NACP related indicators from BPHS.

- For data category 3, the NACP has developed modules for each additional programme area (VCT/Blood Banks, Prison-based HIV centres, Drop-in Centres, border site activities for returnees, outreach to access targeted interventions for at-risk and vulnerable populations). This data is flowing from provinces to the national level through implementing NGOs and provincial HIV advisors. The data is then transferred into excel based database in NACP. Analysis and report generation functions is similarly developed using the HMIS model and user interface (i.e. pivot tables in MS Excel). Using unified and standard M&E tools are crucial for proper data analysis, interpretation and decision making process.

- For data category 4, NACP is regularly importing information from the Economics and Finance Directorate (HEFD) on fund flow of different grants/contracts aggregated by POP component and responsible line ministries. The existing grants management tracking system used by BPHS will be the same mode of grant tracking for NACP activities. In addition, the human resources database established by the HEFD will be the source of data on the status of staffing within the ministries. The annual service quality assessments of non BPHS/EPHS sites will include a component on staffing and will provide the data for indicators on staffing by implementation unit.

For all data categories, to ensure the ability of MOPH to integrate analysis of NACP-related data with other sources of data, all NACP data will follow the standard coding conventions for geographic areas/administrative units and facilities used by other MOPH systems (e.g. HMIS).

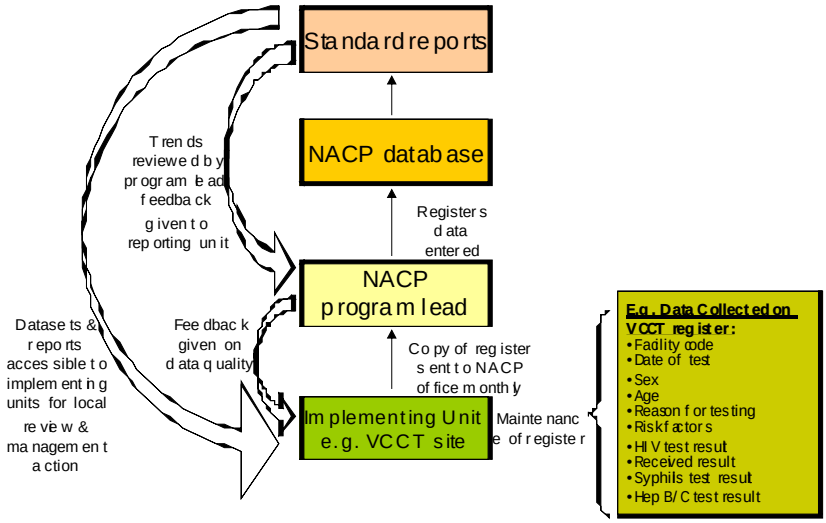
NACP data flow and components



Underlined text indicates reliance on existing systems, NACP will import a subset of the data
*includes VCT, TB/HIV, STD, Blood donation, Infection prevention

All implementing agencies prepare, based on requirements, monthly or quarterly reports that should be dispatched to the NACP. At provincial level, the data is checked and compiled by NGOs and sent to the provincial HIV advisor. After reviewing the report, the advisor will send a copy to the NACP for further analysis, interpretation and dissemination. NACP compiles all received data in a database and a dedicated M&E Officer is analyzing and interpretation the data. If there is any inconsistency of data or some data error, the M&E department of the NACP informs the facilities where the data came from. In case more clarifications are required, they are provided accordingly. After cleaning and editing the data, the standard report is generated and shared with program management, CCM, HACCA and other partners aiming to improve the quality of HIV services and making proper result based policies.

NACP Facility Based Services Schematic presentation



Coordination and Information Sharing:

The Government of Afghanistan views HIV as multi-sectoral and has established HACCA as an independent body to coordinate AIDS- related issues among government entities, international and national partners (i.e. donors, UN agencies, NGOs, private sector and civil society). This is a multi-sectoral structure which reflects the full commitment and priorities of the Government of Afghanistan and the development partners in responding to HIV and AIDS in line with the country's National Development Strategy (ANDS) and Millennium Development Goals (MDGs). At the same time, the CCM is also playing a major role in coordinating HIV, TB and Malaria related issues in the country. HIV and AIDS national and provincial reports, findings, issues, proposals and lessons learned are openly shared and discussed with members of these two bodies to take correct measures for disease response.

Furthermore, several mechanisms exist to communicate and widely disseminate HIV information to all who need it. This includes active information-sharing between the NACP and implementing partners, via reports, supervisory field visits and feedbacks mechanism on monthly and quarterly bases. The second channel is a wider approach between all stakeholders including government ministries, funding and UN agencies, well known religious leaders, parliamentarians, policy-makers, research institutions, NGOs and civil society. This leads to ensure advocacy and political commitment at state level to improve access and quality of services, and sustain HIV and AIDS activities in the country. The third level of beneficiaries are the community elders and various community groups, PLHIV, vulnerable and most at risk populations. This category is mainly targeted through mass media campaigns, VCTs, DICs, prison based programs and Blood Banks. Finally, the role of mass media to raise public awareness is the crucial part of the information dissemination aiming to prevent transmission, reduce stigma and discrimination in community and improve access to HIV services in Afghanistan.

In order to achieve the aforementioned assignments, NACP plans to further strengthen coordination and build the capacity of various stakeholders involved in the field of HIV. This includes ensuring the use of standardized and unified M&E and surveillance system at the country level and on quality reporting and through aforementioned assignments.

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Annex A – Description of Key Data Sources used

There are three kinds of data used in this report – Existing reports (which are quoted), MIS information of the NACP and IBBS-2009. While the first does not require description, the MIS of NACP is described in the Chapter VIII – M&E environment. Below is a description of the IBBS Process.

As part of a process to establish a surveillance system in Afghanistan, in 2009 Johns Hopkins University (JHU) conducted Integrated Biological and Behavioural Surveillance (IBBS) among four populations of interest to the Afghanistan National AIDS Control Program. The primary objectives of the study were to measure prevalence of HIV and related diseases, key risk behaviours, knowledge of HIV/AIDS, and utilization of HIV-related services. Subsequent rounds of IBBS are planned to monitor these indicators over time.

Previous studies showed fairly large numbers of injection drug users (IDU) in major Afghan cities, with key risk behaviours and some cases of HIV detected. Therefore, IBBS was conducted among IDU in the cities of Kabul, Herat and Mazar-e-sharif. IBBS among female sex workers (FSW) was conducted in Kabul since, according to mapping exercises, it has the largest numbers of FSW. The two largest prisons, Herat prison and Pul-e-charkhi, were studied, along with road transport workers (RTW) at the busiest border crossing along the Afghanistan – Pakistan border at Torkham. The RTW study included an equal number of drivers and driver assistants, based on informal accounts of risk behaviour in both groups.

For this initial round of IBBS, eligibility for the sex worker group was limited to females because there is little information on male sex work, no risk minimization programs and the issue of male-to-male sex is very sensitive in Afghanistan. Eligibility for all other groups was limited to males, based on information that road transport workers are typically male and that female injecting drug users and prisoners, who are relatively low in number, will be included in an upcoming study.

For the prisoners and road transport worker surveys, systematic random sampling was used. FSW and IDU, which are considered hidden populations, cannot be sampled using systematic random sampling. Therefore a method called Respondent-driven sampling (RDS) was used to approximate probability sampling. The samples for all groups and sites are listed below.

Samples of IDU, Prisoners, FSW, and RTW - 2009 IBBS

	Kabul	Herat	Mazar	Torkham
Injecting Drug Users	286	160	102	
Prisoners	352	318		
Female Sex Workers	368			
Road Transport Workers				365

Extensive formative research was done before the finalization of instruments and protocols. Fieldwork was implemented by two local Afghan NGOs, Ibn-Sina and Medical Management Research Courses Afghanistan (MMRCA), with technical support from JHU. The survey teams were trained by JHU and NGO staff over a period of about five days, and piloting preceded data collection. Particular emphasis was placed on confidentiality and privacy, as well as counselling and testing techniques and referral procedures for participants testing positive. To ensure confidentiality, no names or identifying information were collected.

Informed consent was taken before the behavioural interview and blood sample collection. Rapid testing was performed on site for five diseases: HIV, hepatitis B, hepatitis C, syphilis, and herpes simplex virus 2. For participants testing positive for HIV, a second and third rapid tests from different manufacturers were used for confirmation, according to national counselling and testing guidelines. Data collection took between 2 and 4 months for each group, as shown below. All data was brought to the JHU central office in Kabul for processing and storage.

2009 Data Collection

Survey Group	Site	May	June	July	Aug	Sep	Oct	Nov	Dec
IDU	Herat	X	X	X	X				
	Mazar		X	X	X				
	Kabul			X	X				
Road Transport Workers	Torkham	X	X	X					
Prisoners	Herat					X	X	X	
	Kabul							X	X
Female Sex Workers	Kabul					X	X	X	X

Annex B – Process of consultation

The NACP started to prepare for drafting the UNGASS country progress report in early December 2009. As a first step, relevant stakeholders were invited for a meeting on December 29, 2009 at the NACP (the meeting minutes are attached). The stakeholders who attended this meeting included representatives from the Government, Civil Society and academic institutions. The objectives for the meeting were as follow:

1. Briefing the stakeholders on the UNGASS country progress report 2008 - 2009 and National Composite Policy Index (NCPI).
2. Agree on establishing a committee for UNGASS report preparation.
3. Agree on the process for NCPI data gathering and validation.

At the meeting, a detailed discussion took place on the process for developing the UNGASS report. All partners expressed their interest and support to take active part. Following were the key decision of the meeting:

- The format for AIDS spending matrix (the first UNGASS indicator) is to be circulated to all partners working in HIV and AIDS and be asked to complete the forms and send the information for the years 2008 and 2009.

- Two focal points were appointed to complete the NCPI Part A and Part B.

- The people to be interviewed in government as well as in the civil society were selected.

- IBBS data was discussed and it was decided to speed up the process of completing the analysis of the collected IBBS data in order to be ready for submission through the UNGASS report.

- It was agreed that once the different pieces of the report are made ready, a final validation meeting was to be conducted, before final submission.

Following the first meeting, the two focal points for the NCPI conducted a desk review of the existing material on HIV and AIDS in the country. All the relevant materials were then uploaded to the NACP web-site in early January 2010 to be easily accessible for the relevant partners. The people to be interviewed in the government and the civil society sections were notified and briefed on the NCPI and were given enough time, as requested by the interviewees. A face-to-face meeting was then organized with interviewees where the relevant sections were discussed and the NCPI questionnaires were finalized at the individual levels.
The hard copy of the questionnaires were filled and used for analysis.

All the relevant partners working in HIV and AIDS in 2008 and 2009 were identified by the NACP and then the funding matrix template was circulated to them. In addition, the stakeholders were contacted separately and the funding matrix was explained to them. The forms were filled as they were received and made ready for final validation.

A brief report of IBBS was prepared by Johns Hopkins University in close coordination with the NACP. The NACP also collected other information on indicators to be ready for final validation.

Once good progress was made in compiling the relevant information, preparation was made for final validation of the information. Since it was the first professional attempt to prepare the UNGASS country progress report for Afghanistan, the NACP decided to involve expert consultants in finalization of the report for two reasons: first, to ensure that an independent evaluation of the situation in Afghanistan has been undertaken, and second that the NACP will get benefit of the best practice in compiling and finalization of the UNGASS progress report to be replicated in the coming years. Therefore, with the request of the NACP, UNAIDS provided support by sending its two consultants from 23rd of March 2010 for a period of 6 days to put the different pieces of the report together and help in the validation process. The consultants undertook a full desk review of the relevant documents as well as the collected information for the UNGASS report and prepared a draft copy of the report and other data for vetting by the NACP, development partners and civil society.

To validate the contents of the report, a national consultation meeting on the UNGASS Afghanistan Report 2010, was held on 27th March 2010. The meeting was well-attended by the NACP, UN Agencies, development partners and the civil society including two injecting drug users. The meeting started with validation of the NCPI and followed by validation of other indicators. Detailed discussions occurred over different parts and the inputs of the discussion were integrated into the report accordingly.

The NACP and the consultants then prepared the final draft of the report and presented it to the Ministry of Public Health (MoPH) and other partners for final review. The Acting Minister of the MoPH & Policy and Planning Deputy Minister and the Director General of Preventive Medicine & Primary Care Services was briefed over the final draft of the report and all incoming comments were incorporated accordingly. The Acting Minister signed off the report on March 30, 2010 and the NACP submitted the report electronically to the UNAIDS website on March 31, 2010.

Annex C – Sources of funds and expenditure

Agencies	Actionaid	JHU	Futures	OTCD	SAF	Jack	SDO	SHRO	NACP	UNODC	UNAIDS	UNFPA	UNICEF	WHO	GTZ/GF	MoPH/GF	MDM	ARCS	SIDA	USAID	Public	Total	%
Type of organisation	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	Dev. Bank Non-Reimbursable (e.g. Grants)	UN Agencies	UN Agencies	UN Agencies	UN Agencies	UN Agencies	Global Fund	Global Fund	All Other International	All Other International	Bilaterals	Bilaterals	Central / National		
Total	**427607**	**1336485**	**544500**	**565239**	**544736**	**158084**	**142960**	**285387**	**580000**	**446082**	**260000**	**20620**	**71847**	**89147**	**1030513**	**157470**	**1036377**	**243460**	**415110**	**121468**	**18000**	**8495092**	
Prevention	207940	0	228500	461843	13108	2877	142960	285387	0	369612	220000	20620	24843	0	378358	28895	1036377	243460	249066	14923	0	**3928769**	**46%**
Care and Treatment	0	0	0	96090.6	0	0	0	0	0	0		0	0	24340	0	0	0	0		0	0	**120431**	**1%**
Orphans and Vulnerable Children	0	0	0	0	0	854	0	0	0	0		0	0	0	0	0	0	0		0	0	**854**	**0%**
Program Management and Administration Strengthening	0	0	251500	0	249147	149288	0	0	580000	19955		0	182	24890	385754	51777	0	0	41511	106545	18000	**1878549**	**22%**
Human resources	161967	0	12500	5652.4	282481	5065	0	0	0	56515	40000	0	0	39917	266401	76798	0	0	124533	0	0	**1071830**	**13%**
Social Protection and Social Services excluding Orphans and Vulnerable Children	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0		0	0	**0**	**0%**
Enabling Environment	0		52000	1652.84	0	0	0	0	0	0		0	31642	0	0	0	0	0		0	0	**85295**	**1%**
Research	57700	1336485	0	0	0	0	0	0	0	0		0	15180	0	0	0	0	0		0	0	**1409365**	**17%**

All figures in USD. Where Afghani currencies were quoted, they have been converted to USD @ 50 Afghanis to the USD. Uploading of the file is not in the format provided by UNAIDS. However, the categories of funding and spending are retained. Details are available, however not through NASA or NHA, but collected from partners through email.

NCPI Part A : Annex D

1. Strategic Plan

1. Has the country developed a national multi-sectoral strategy/action framework to combat AIDS? (Multisectoral strategies should include, but are not limited to, those developed by Ministers such as the ones listed under 1.2)

Yes	**X**	Period covered :***2006-2010***	Not Applicable (N/A)		No	

***IF No or N/A, briefly explain**:*

IF YES, complete questions 1.1 through 1.10 ; otherwise, go to question 2.

1.1. How long has the country had a multi-sectoral strategy/action framework?

Number of Years: 4 Years

1.2. Which sectors are included in the multi-sectoral strategy / action framework with a specific HIV budget for their activities ?

Sectors included	Strategy/Action framework				Earmarked budget			
Health	Yes	**X**	No		Yes	**X**	No	
Education	Yes	**X**	No		Yes	**X**	No	
Labour	Yes		No	**X**	Yes		No	**X**
Transportation	Yes		No	**X**	Yes		No	**X**
Military / Police	Yes	**X**	No		Yes	**X**	No	
Women	Yes		No	**X**	Yes		No	**X**
Young people	Yes	**X**	No		Yes	**X**	No	

If No, earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV specific activities?

Since the NACP was established in 2003 and there was lack of strategic information, low HIV prevalence and existence of hidden populations, the strategic framework addressed and funded HIV surveillance, advocacy and communication, most at risk populations and capacity development. Based on new finding from HIV surveillance, we may come up with clear budget allocation.

1.3. Does the multi-sectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations				
a.Women and girls	Yes	**X**	No	

b.Young women / young men	Yes	**X**	No	
c. Injecting Drug Users	Yes	**X**	No	
d. Men Who have sex with Men	Yes		No	**X**
e. Sex Workers	Yes		No	**X**
f.Orphans and other vulnerable children	Yes		No	**X**
g. Other Specific Vulnerable populations	Yes	**X**	No	
Settings				
e.Workplace	Yes	**X**	No	
f.Schools	Yes	**X**	No	
g.Prisons	Yes	**X**	No	
Cross-cutting issues				
h.HIV,AIDS and poverty	Yes		No	**X**
i.Human rights protection	Yes	**X**	No	
j. PLHIV involvement	Yes	**X**	No	
k. Addressing stigma and discrimination	Yes	**X**	No	
l. Gender empowerment and/ or gender equality	Yes	**X**	No	

1.4. Were target populations identified through a process of a needs assessment or needs analysis ?

Yes	**X**	No	

IF YES**,** when was this need assessment / analysis conducted?
2006-2007

IF NO, how were target populations identified ?

1.5. What are the target populations in the country?

Injecting Drug Users, Female Sex Workers , Long distance transport worker and prisoners

1.6. Does the multi-sectoral strategy/action framework include an operational plan?

Yes	**X**	No	

1.7. Does the multi-sectoral strategy/action framework or operational plan include :

a. Formal programme goals?	Yes	**X**	No	
b. Clear targets and / or milestones?	Yes	**X**	No	
C. Detailed budget of costs per programmatic area?	Yes	**X**	No	
d. Indications of funding sources?	Yes	**X**	No	
E. Monitoring and Evaluation framework?	Yes	**X**	No	

1.8. Has the country ensured "Full involvement and participation" of civil society in the development of the multi-sectoral strategy/action framework?

Active involvement		Moderate involvement	**X**	No involvement	

If active involvement , briefly explain how this was done :

IF NO or MODERATE involvement , briefly explain : The program is new and the concept of HIV was unclear for many of the stakeholders. Afghanistan has been affected by internal war and conflicts and the environment and opportunities for civil societies working environment was not good. In the past two years involvement of civil society has increased though there is need for improvement. There is still limited involvement of PLWH, IDUs and other risk populations. Meetings and documents are in English making it difficult for some groups to meaningfully participate.

1.9. Has the multi-sectoral strategy/action framework been endorsed by most external Development Partners (bi-laterals ; multi-laterals) ?

Yes	**X**	No	

1.10. Have external Development Partners (bi-laterals ; multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multi-sectoral strategy/action framework?

Yes , all partners		Yes, some partners	**X**	No	

I F SOME or NO**,** briefly explain

2. Has the country integrated HIV and AIDS into its general development plans such as : a) National development Plans, b) Common country Assessments / United Nations Development Assistance Framework , c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?

Yes	**X**	No		N/A	

2.1. ***IF YES****,* in which development plans is policy support for HIV and AIDS integrated?

a. National Development Plan	**Yes**	No	N/A
b. Common Country Assessment/UN development Assistance Framework	**Yes**	No	N/A
c. Poverty Reduction Strategy	**Yes**	No	N/A
d. Sector Wide Approach	Yes	No	**N/A**
e. Other	Yes	No	N/A

2.2. ***IF YES,*** Which policy areas below are included in these development plans?

✓ Check for policy / strategy included

Policy Area				
HIV Prevention	Yes	X	No	
Treatment for opportunistic infections	Yes	X	No	
Antiretroviral therapy	Yes	X	No	
Care and support (including social security or other schemes)	Yes	X	No	
HIV impact alleviation	Yes	X	No	
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	X	No	
Reduction of income inequalities as they relate to HIV prevention/treatment, care and /or support	Yes		No	X
Reduction of stigma and discrimination	Yes	X	No	
Women's economic empowerment(e.g. access to credit, access to land, training)	Yes		No	X
Other : Strengthening of health systems	Yes		No	

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes?

Yes		No	**X**	N/A	

3.1. ***IF YES,*** to what extent has it informed resource allocation decisions?

LOW										HIGH
0		1		2		3		4		5	**X**

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?

Yes	**X**	No	

4.1. ***IF YES,*** Which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes	**X**	No	
Condom provision	Yes	X	No	

HIV testing and counselling *	Yes	**X**	No	
STI services	Yes	**X**	No	
Treatment	Yes	**X**	No	
Care and support	Yes	**X**	No	
Others: [write in]	Yes		No	

* ***What is the approach taken to HIV testing and counselling?*** Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain : It varies from setting to setting. E.g. in prisons the HIV testing is voluntary whereas in the military it is mandatory.

5. Does the country have non-discrimination laws or regulations which specify protections or most-at-risk populations or other vulnerable sub populations?

Yes		No	X

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	X	No	

6.1. If yes, for which sub populations

a. Women	Yes		No	X
b. Young People	Yes		No	X
c. Injecting Drug Users	Yes	**X**	No	
d. Men who have sex with men	Yes	**X**	No	
e. Sex Workers	Yes	**X**	No	
f. Prison inmates	Yes		No	X
g. Migrants/mobile populations	Yes		No	X

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes	**X**	No	

7.1. Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes	X	No	

7.2. Have the estimates of the size of the main target population sub-groups been updated?

Yes	X	No	

7.3. Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs		Estimates of current needs only	X	No	

7.4. Is HIV and AIDS programme coverage being monitored?

Yes	**X**	No	

7.4.1. ***IF YES***, is coverage monitored by sex (male, female)?

Yes	**X**	No	

7.4.2. ***IF YES***, is coverage monitored by population sub-groups?

Yes	**X**	No	

IF YES, which population Sub-groups?

IDU, FSW, prisoners and long distance transport workers

Briefly explain how this information works?

NACP had developed forms to keep records of information of different groups. Based on these forms, implementing agencies and the national programme monitor these programmes and plan for interventions.

7.4.3. ***IF YES,*** is coverage monitored by geographical area?

Yes	**X**	No	

IF YES, at which levels (provincial, district, other)? ***Provincial***

Briefly explain

All information collected from the field and is sent to the provincial level. At this stage, provincial dedicated persons analyze the information and take appropriate action. All provinces send their reports to the central level where it is compiled and analysed. This is used for policy formulation and design of interventions.

7.5. Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	**X**	No	

Overall, how would you rate the strategy planning efforts in HIV and AIDS programmes in 2009?																					
2009		Poor																		Good	
0		1		2		3		4		5		6		7	x	8		9		10	

Comments on progress made since 2007 :
Establishment of HIV/AIDS Coordination Council of Afghanistan (HACCA)
Accelerated implementation of the National Strategic Framework

What remaining challenges in this area:
Stigma and discrimination associated with HIV
Laws and regulations against most at risk populations
Insufficient funds
Shortage of capacities to manage and deliver services

2. Political support

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President / Head of government	Yes		No	**X**
Other High officials	Yes		No	X
Other officials in regions and / or districts	Yes		No	X

2. Does the country have an officially recognized national multi-sectoral AIDS management/coordination body? (National AIDS Council or equivalent)?

Yes	**X**	No	

IF NO, briefly explain :

2.1. ***IF YES***, when was it created? Year ***2007***

2.2. ***IF YES***, who is the Chair?
[write in name and title/function]

Deputy Minister for Technical Affairs, MoPH

2.3. ***IF YES***, does it :

Have terms of reference?	Yes	**X**	No	
Have active Government leadership and participation?	Yes	**X**	No	
Have a defined membership?	Yes	**X**	No	
If Yes , how many members	60			
Include civil society members?	Yes	**X**	No	
How many	24			
Include people living with HIV?	Yes		No	X
Have an action plan?	Yes	**X**	No	
Have a functional Secretariat?	Yes	**X**	No	
Meet at least quarterly?	Yes	X	No	

Review actions on policy decisions regularly?	Yes		No	X
Actively promote policy decisions?	Yes	**X**	No	
Provide opportunity for civil society to influence decision-makings?	Yes	**X**	No	
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	**X***	No	

** There is much scope for improving donor co-ordination and reducing parallel reporting. However there are mechanism in place now which should address these issues over time. Bilateral and multilateral co-ordination is reasonably good; however INGOs level co-ordination is still an issue.*

3. Does the country have a mechanism that promotes interaction between government, people living with HIV, **civil** society and the private sector for implementing HIV and AIDS strategies / programmes?

Yes	**X**	No	

3.1. ***IF YES***, does it include?

-Develop IEC materials
- Abrogate compulsory testing as pre-requisite for acquiring work permit for foreign workers
- agree on general reporting formats and forms

IF YES*,* What are the main challenges for the work of this body?
- Lack of an appropriate policy and legal environment for implementation of HIV/AIDS interventions

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?

Percentage : ***80%***

5. What kind of support does the NACO (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes	**X**	No	
Technical guidance / materials	Yes	X	No	
Drugs/supplies procurement and distribution	Yes		No	X
Coordination with other implementing partners	Yes	X	No	
Capacity-building	Yes	X	No	
Other: [write in]				

6. Has the country reviewed national policies and legislation to determine which, if any , are inconsistent with the National AIDS Control policies?

Yes		No	X

6.1. ***IF YES***, were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes		No	

6.2. ***IF YES****,* which policies and legislation were amended and when?

Policy/Law:		Year :	
Policy/Law:		Year:	
Policy/Law:		Year:	
Policy/Law:		Year:	
Policy/Law:		Year:	

[List as many as relevant]

Overall, how would you rate the political support for the HIV programmes in 2009?

2009	Poor																				Good
0		1		2		3	X	4		5		6		7		8		9		10	

Since 2007, what have been the achievements in this area?

-establishment of HACCA

- establishment of functional secretariat of HACCA

What are the remaining challenges in this area?

Much work is needed to gain high level political commitment for HIV interventions

There needs to be a review of laws and policies of the country

3. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes	**X**	No		N/A	

1.1. ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

Be sexually abstinent	
Delay sexual debut	
Be faithful	X
Reduce the number of sexual partners	
Use condoms consistently	X
Engage in safe (r) sex	X
Avoid commercial sex[4]	X
Abstain from injecting drugs	X
Use clean needles and syringes	X
Fight against violence against women	X
Greater acceptance ad involvement of people living with HIV	X
Greater involvement of men in reproductive health programmes	X
Other: HIV is responsibility of all Afghan citizens Use VCT services Stigma reduction among IDU HIV & Islam particularly Khotba	X

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes	X	No	

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	X	No	

[4] Messages are not specific to avoidance of commercial sex but in reference to "illegal sex" which includes commercial sex but in legal terms also includes sex outside of marriage and male to male sex

2.1. Is HIV education part of the curriculum in

Primary schools?	Yes		No	X
Secondary schools?	Yes	X	No	
Teacher training?	Yes		No	X

2.2. Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes		No	X

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes		No	X

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes	X	No	

IF NO, briefly explain :

3.1. ***IF YES***, which sub-populations and what elements of HIV prevention do the policy/strategy address?

✓ Check for policy/strategy included

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other Sub-populations [write in]
Targeted information on risk reduction and HIV education	X		X	X	X	Truck driver
Stigma & discrimination reduction	X				X	
Condom promotion	X		X	X	X	TD
HIV testing & counselling	X		X	X	X	TD
Reproductive health, including STI prevention & treatment						
Vulnerability reduction (e.g. income generation)	N/A	N/A	X	N/A	N/A	
Drug substitution therapy	X	N/A	N/A	N/A	N/A	
Needle & syringe exchange	X	N/A	N/A	N/A	N/A	

Overall, how would you rate policy efforts in support of HIV prevention in 2009?

2009	Poor																			Good
0		1		2		3	X	4		5		6		7		8	X	9		10

Since 2007, what have been key achievements in this area?

Drafting the OST policy

What are the remaining challenges in this area?

- Implementation of OST policy
- development of national and sectoral policies

4. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes	X	No	

IF NO, how is HIV prevention programmes being scaled-up?

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts * in need?

Conducting studies in 2005 and 2006 on size estimation of MARP, including studies conducted by Action Aid in 2006 and ORA international in April 2005; and University of Manitoba on social mapping in 2008 and IDUs in Kabul.

4.1 To what extent has HIV prevention been implemented?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	**The majority people in need have access**		
	Agree	**Don't Agree**	**N/A**
Blood safety		X	
Universal precautions in health care settings		X	
Prevention of mother-to-child			X

transmission of HIV			
IEC on stigma and discrimination reduction		X	
Condom promotion		X	
HIV testing & counselling	X*		
Harm reduction for injecting drug users	X*		
Risk reduction for men who have sex with men		X	
Risk reduction for sex workers		X	
Programmes for other vulnerable sub-populations	X		
Reproductive health services including STI prevention & treatment	X		
School-based AIDS education for young people		X	
Programmes for out-of-school young people		X	
HIV prevention in the workplace		X	
Other [write in]			

* Supply side initiatives have made tremendous strides. However, there is scope for improving access

Overall, how would you rate efforts in the implementation of HIV prevention programmes in 2009?

2009	Poor																			Good
0		1		2		3		4		5	X	6		7		8		9		10

Since 2007, what have been key achievements in this area?

- Expansion of HIV/AIDS prevention programme to 8 provinces
- Establishment of ART/DIC/VCTs
- Mass media campaigns

What are remaining challenges in this area:

Integrating and improvement of HIV prevention activities into BPHS /EPHS

4. Treatment, Care and Support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes	X	No	

1.1 ***IF YES***, does it give sufficient attention to barriers for women, children and most-at-risk population?

Yes	X	No	

2. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support service?

Yes		No		NA	
	X				

If yes how were these determined?

Based on studies and research

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented ?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support service	The majority of people in need have access		
	Agree	Disagree	N/A
Antiretroviral therapy	X		
Nutritional care		X	
Paediatric AIDS treatment			X
Sexually transmitted infection management	X		
Psychosocial support for people living with HIV and their families		X	
Home-based care		X	

Palliative care and treatment of common HIV-related infections	X		
HIV testing and counselling for TB patients		X	
TB screening for HIV-infected people	X		
TB preventive therapy for HIV-infected people	X		
TB infection control in HIV treatment and care facilities	X		
Cotrimoxazole prophylaxis in HIV-infected people	X		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		**X**	
HIV treatment services in the workplace or treatment referral systems through the workplace		X	
HIV care and support in the workplace (including alternative working arrangements)		X	
Other programmes: [write in]			

* Districts or equivalent de-centralized governmental level in urban and rural areas

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	X	No	

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?

Yes		No	**X**

Overall, how would you rate efforts in the implementation of HIV treatment care and support programmes in 2009?

2009	Poor																			Good
0		1		2		3		4		5	X	6		7		8		9		10

Since 2007, what have been key achievements in this area?

- ART specialists trained
- ART centres established in Kabul and Herat
- ART treatment guidelines
- Approval of GF Round 7

What are remaining challenges in this area:

Increasing ART centre in the country
Awareness raising and increasing demand
Training of staff
Acquiring laboratory equipment

5. Does the country have a policy or strategy to address the additional HIV-or AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes		No		NA	X

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes		No	

5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes		No	

5.3 ***IF YES,*** does the country have an estimate of OVC being reached by existing interventions?

Yes		No	

IF YES, what percentage of OVC is being reached?

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?
2009 Poor Good
0 1 2 3 ***4*** 5 6 7 8 9 10
Comments on progress made since 2005 :

5. Monitoring and evaluation

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes	X	Years covered: [write in]	2007-10	In progress		No	

1.1 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes	X	No	

1.2 ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	X	No	

No PLHIV

1.3 ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners		Yes, most partners	X	Yes, but only some partners		No	

2. Does the Monitoring and Evaluation plan include?

a data collection and analysis strategy	Yes	✔	No	
Behavioural surveillance	Yes	✔	No	
HIV surveillance	Yes	✔	No	
A well-defined standardized set of indicators	Yes	✔	No	
Guidelines on tools for data collection	Yes	✔	No	
A strategy for assessing quality and accuracy of data	Yes		No	✔
Data analysis strategy	Yes		No	✔
A data dissemination and use strategy	Yes	✔	No	

3. Is there a budget for the M&E plan?

Yes	✔	Years covered: [write in]		In progress		No	

If yes, what percentage of total HIV programme funding is budgeted for M and E activities? 10%

3.1 ***IF YES***, has full funding been secured?

Yes		No	✔

Despite of having 10% secured for M&E, still some indicators cannot be measured. In addition some of the most at risk populations are not fully addressed.

4. Are M and E priorities determined through national M and E system assessment?

Yes		No	✔

If no, briefly describe how priorities for M and E are determined?
Based on the National Strategic Framework, and through the surveillance working group the priorities have been set.

5. Is there a functional M&E Unit or Department?

Yes	✔	In progress		NA	

Currently staffed by one person; to be expanded

IF NO, what are the main obstacles to establishing a functional M&E Unit/Department?

5.1 ***IF YES***, is the M&E Unit/Department based

In the NAC (or equivalent)? (National AIDS Control Organization)	Yes		No	✔
In the Ministry of Health?	Yes	✔	No	
Elsewhere? [write in]				

5.2 ***IF YES***, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

There is a Monitoring, Evaluation and Research Division at NACO

Number of Permanent Staff: 1		
Position: M&E consultant	***Full time***	Since when?: 2007

Number of temporary staff:	0	
Position: [write in]	Full time/Part time?	Since when?:
Position: [write in]	Full time/Part time?	Since when?:
Position: [write in]	Full time/Part time?	Since when?:

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes	**X**	No	

IF YES, briefly describe the data sharing mechanism

In each quarter, implementing partners submit their progress report considering indicators. In addition, there is a quarterly review workshop for this purpose.

What are the major challenges?

- Insufficient staff
- Dealing with most at risk populations
- Lack of skilled local experts
- Security
- Government bureaucratic procedures

6. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No		Yes, but meets irregularly	X	Yes, meets regularly	

6.1 Does it include representation from civil society?

Yes	**X**	No	

7. Is there a central national database with HIV related data?

Yes	**X**	No	

7.1 If Yes, briefly describe the national database and who manages it

This is an excel based database and national M&E Consultant manages it

7.2 If yes, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementation organizations?

a. All of the above
b. Yes, but only some of the above
c. No none of the above

7.3 Is there a functional Health Information System?

At National level YES
At sub national level YES
If YES, what levels? Provincial disaggregated by facility

8. Does the country public at least once a year M and E report on HIV and one , including HIV surveillance data?

Yes	**X**	No	

9. To what extent are M & E data used?

9.1 LOW HIGH

0		1		2		3		4	x	5	

Provide a specific example:

We are going to use these data on revision of the National Strategic Framework. In addition the data has been used for reprogramming.

What are the main challenges:

Convincing policy / decision makers to set targets and interventions for MARP

9.2 For resource allocation

Low HIGH

0		1		2		3	x	4		5	

Example: Securing Global Fund Round 7

9.3 For program improvement

Low HIGH

0		1		2		3	x	4		5	

The need for revision of routines reporting and seeking alternatives to IBBS

Main challenges:

Piloting and use of tools by service providers.

10. Is there a plan for increasing human capacity in M&E at national, sub national and service-delivery levels?

    a. Yes at all levels
    b. Yes but only addressing some levels
    c. No

10.1 In the last year, was training in M&E conducted

At National level **YES**
If yes number trained- 4
At Sub national level **YES**
Number trained- 20
At service delivery level including civil society **NO**

10.2 What were other M&E capacity building activities conducted other than training? **NO**

Overall, how would you rate M&E efforts in the HIV programme in 2009?

2009	Poor																		Good
0		1		2		3		4		5	X	6		7		8		9		10	

Since 2007, what have been key achievements in this area?

- Developing routine data collection form
- Establishment of second generation surveillance system
- Development of national M&E plan and database

What are remaining challenges in this area:

Improvement of routines data collection form
Development of Access base database and regular data entry and analysis
Data use
Institutionalise Surveillance within the Department
Triangulation to IBBS

Annex E: National Composite Policy Index (Part B)

1. Human Rights

PLEASE ENTER "X" in the box, as appropriate.

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, healthcare etc.,)

Yes		No	X

IF YES, Specify:

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	X	No	

If YES, for which sub-populations?

Women	Yes	X	No	
Young people	Yes	x	No	
IDU	Yes		No	X
MSW	Yes		No	X
Sex Workers	Yes		No	X
Prison inmates	Yes		No	X
Migrants/mobile populations	Yes	x	No	

Other: (write in)

IF YES, Briefly explain what mechanisms are in place to ensure these laws are

Implemented:

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes	X	No	

3.1.1. **IF YES**, for which sub-populations?

Women	Yes	X	No	
Young people	Yes	X	No	
IDU	Yes	X	No	
MSW	Yes	X	No	
Sex Workers	Yes	X	No	
Prison inmates	Yes	X	No	
Migrants/mobile populations	Yes		No	

Other: (write in)

IF YES, briefly describe the content of these laws, regulations or policies and how they pose barriers:

4. Is the promotion and protection of human rights explicitly mentioned in any HIV Policy or strategy?

Yes	X	No	

Describe: Rights of PLHIV are mentioned in the National Strategic Framework

5. Is there a mechanism to record, document and address cases of discrimination Experienced by people living with HIV and/or most – at – risk populations?

Yes		No	X

IF YES, briefly describe this mechanism

6. Has the Government, through political and financial support, involved most – at – risk population in governmental HIV-policy design and programme implementation?

Yes		No	X

IF YES, describe some examples

7. Does the country have a policy of free services for the following:

HIV prevention services	Yes	X	No	
Anti-retroviral treatment	Yes	X	No	
HIV-related care and support interventions	Yes	X	No	

IF YES, given resource constraints, briefly describe what steps are in place to Implement these policies:

The services are not at a level to be accessed by all in need

8. Does the country have a policy to ensure equal access for women and men, to Prevention, treatment, care and support? In particular, to ensure access for Women outside the context of pregnancy and childbirth?

Yes	X	No	

9. Does the country have a policy to ensure equal access for most-risk populations To prevention, treatment, care and support?

The National Strategic Framework ensures equal access for the most at risk and vulnerable populations. The Afghanistan National HIV service code ethics deems it necessary for the country to provide equal access.

Yes	X	No	

9.1.1. Are there differences in approaches for difference most-at-risk populations?

Differences of approaches by cultural consideration, hidden or not, sensitivity, approach, services, confidentiality, specific, separate TIs

Yes	X	No	

IF YES, briefly explain the differences

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?

Yes		No	X

11. Does the country have a policy to ensure that AIDS research protocols involving Human subjects are reviewed and approved by a national/local ethical review committee?

Yes	X	No	

11.1.1. **IF YES,** does the ethical review committee include representatives of civil

Society and people living with HIV?

Civil society are represented, but not PLWH*

Yes		No	X

IF YES, describe the effectiveness of this review committee
Timelines of the IRB has improved

12. Does the country have the following human rights monitoring and enforcement Mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes		No	X

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes		No	X

- Performance indicators or benchmarks for

a) Compliance with human rights standards in the context of HIV efforts

Yes		No	X

IF YES, on any of the above questions, describes some examples:

13. Have members of the judiciary (including labour courts/employment tribunals) Been trained/sensitized to HIV and AIDS and human rights issues that may come up on the context of their work?

Yes		No	X

14. Are the following legal support services available in the country?

- Legal aid systems for HIV and AIDS case work

Yes		No	x

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes		No	X

- Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes		No	X

15. Are there programmes in place to reduce HIV related stigma and discrimination?

Yes	X	No	

IF YES, what types of programmes?

Media	Yes	X	No	
School education	Yes	X	No	
Personalities regularly speaking out	Yes		No	X

Other: (write in)

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2009?

2009	Poor																			Good
0		1		2	x	3		4		5		6		7		8		9		10

Comments on progress made since 2007 :

BPHS implementation guidelines contain non-discriminatory comments. Existence of code of ethics. Guidelines and checklist. There are still challenges in prisons, sex workers.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

2007	Poor																			Good
0		1		2		3		4		5	X	6		7		8		9		10

Comments on progress made since 2007 :

Several strong steps already taken to implement differential programmes.

2. Civil Society participation

1. To what extent has civil society contributed to strengthening the political Commitment of top leaders and national policy formulation?

LOW										HIGH
0		1		2		3	X	4		5	

Comments: many NGOs e.g. MDM, KOR, ARCS, AFGA, Action AID, KAF, SHDP are working together with MoPH, SAF, OTCD

2. To what extent have civil society representatives been involved in the planning And budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts)

LOW										HIGH
0		1		2		3		4	X	5	X

Many NGOs were involved in formulation of the strategic framework

3. To what extent are the services provided by civil society in areas of HIV Prevention, treatment, care and support included

3.2. In both the National Strategic plan?

LOW										HIGH
0		1		2		3		4	x	5	

3.3. In national budget?

LOW										HIGH
0		1		2		3	X	4		5	

3.4. In national AIDS report?

LOW										HIGH
0		1		2		3	X	4		5	

Majority of the NGO activities have been included in the National AIDS strategy. Many of these activities are not included in the national budget. There is no unified standard for of reporting.

6. To what extent is the civil society sector able to access
   a. Adequate financial support to support its HIV activities

LOW										HIGH
0		1		2		3		4	X	5	

b. Adequate technical support to finance its activities

LOW										HIGH
0		1		2		3		4	x	5	

1. To what extent is civil society able to access

   a. adequate financial support to implement its HIV activities?

LOW										HIGH
0		1		2		3		4	X	5	

   b. adequate technical support implements its HIV activities?

LOW										HIGH
0		1	X	2		3		4		5	

INGOs felt it was adequate but local NGOs felt not sufficient

What percentage of following HIV programmes is estimated to be provided by Civil society

Prevention for youth 51-75%
IDUs > 76%
MSM NA
Sex workers > 75%

Testing and counselling 25 to 50 %
Reduction of Sigma and discrimination 51- 75%
Clinical services <25%

Overall, how would you rate the effort to increase civil society participation in 2009 ?

2009	Poor																			Good
0		1		2		3		4		5		6		7		8	X	9		10	

Comments on progress made since 2007 :
Establishment of HACCA and Secretariat, establishment of HR, M&E surveillance and vulnerable populations.
Challenges:

Involvement of IDUs and other MARPS
Working with sec workers

3. Prevention

5. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?

Yes	X	No	

IF NO, how are HIV prevention programmes being scaled-up?:

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

✓ Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV prevention programmes	Majority people in need have access		
	Agree	**Don't Agree**	**N/A**
Blood safety		X	
Universal precautions in health care settings		x	
Prevention of mother-to-child transmission of HIV			X
IEC on risk reduction		X	
IEC on stigma and discrimination reduction		X	
Condom promotion		X	
HIV testing & counselling		X	
Harm reduction for injecting drug users		X	
Risk reduction for men who have sex with men		X	
Risk reduction for sex workers		X	
Programmes for other most-at-risk population		X	
Reproductive health services including STI prevention & treatment	**X**		
School-based AIDS education for young people		X	
Programmes for out-of-school young people		x	
HIV prevention in the workplace			X

Other programmes: (write in)

Overall, how would you rate the effort in the implementation of HIV prevention programmes in 2009?																					
2009	Poor																				Good
0		1		2		3		4		5		6		7	X	8		9		10	
Comments on progress made since 2007contracts issued : in spite of initial delays contracts were issued to NGOs and prevention interventions are now in place. In prison settings while interventions have started due to policy restrictions, these are limited in nature i.e. NSP, condoms and OST programmes are set to start in prisons. The World Bank, GFATM and to a lesser extent the UN are main contributors to the response. The programme is primarily being implemented by the NGOs and one of the major achievements has been the partnership between the NACP and the civil society partners Progress has been made on several policy initiatives such as harm reduction and OST. NACP has several working groups including those on harm reduction and IEC.																				

Challenges:
Capacity of NACP to manage and monitor the prevention programme is limited and needs to be built up. NGO staff capacity is limited and needs to be built. Information on MSM and concomitant programming is very limited. The gender aspect of the programme is weak. While prevention services are available in 8 provinces, the majority of the provinces are not yet covered. In addition, coverage of key populations will need to scaled up for e.g. of the estimated 19,000 IDUs in Afghanistan coverage with current programmes would be less than 20% by end of 2010.

4. Treatment, Care and Support

1. Has the country identified the districts (equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes	X	No	

IF yes, how were these specific needs determined?

Based on scarce epidemiological data, the NACP prioritised risk groups, among which re IDUs, sex workers, truckers, migrants and youth. MSM were also included

IF NO, how are HIV and AIDS treatment, care and support services being scaled-up?:

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

X Check the relevant implementation level for each activity or indicate N/A if not applicable

HIV and AIDS treatment, care and support service	Majority of people in need		
	Agreed	**Do not agree**	**NA**
Antiretroviral therapy		X	
Nutritional care		X	
Paediatric AIDS treatment		X	
Sexually transmitted infection management	**X**		
Psychosocial support for people living with HIV and their families		X	
HIV testing and counselling for TB patients		X	
TB screening for HIV-INFECTED PEOPLE		X	
TB preventive therapy for HIV-people		X	
TB infection control in HIV treatment and care facilities		X	
Cotrimoxazole prophylaxis in HIV infected people	**X**		

Post –exposure prophylaxis (e.g. occupational exposures to HIV, rape)		X	
HIV treatment services in the workplace or treatment referral systems through the workplace		X	
HIV care and support in the workplace (including alternative working arrangements)		X	

Other Programmes: (write in)

Overall, how would you rate the effort in the implementation of HIV treatment, care and support programmes in 2009?																					
2009	Poor																			Good	
0		1		2		3		4	x	5		6		7		8		9		10	

Since 2007, what have been the key achievements in this area:

- The first import of ART in the country, the opening of the first ART clinic, less than 50 PLWH receiving first line treatment
- Staff training in ART, established national ART working group and essential drugs list

Challenges:
Reaching more patients in need of treatment (officially more than 500 PLWH and less than 50 receive treatment), reduce stigma about HIV/AIDS, decentralisation of access to treatment in provinces (in 2009 only Kabul and Herat provideART). Import of 2nd line treatment.
Financial shortfall to cover treatment

*OI Opportunistic infection;
**OVC Orphans and other vulnerable children

2. Does the country have a policy or strategy to address the additional HIV-and AIDS- related needs of orphans and other vulnerable children(OVC)?

Yes		No	x	NA	

a. IF YES, is there an operational definition for OVC in the country?

Yes		No	X

b. IF YES, does the country have a national action plan specifically for OVC?

Yes		No	X

c. YES, does the country have an estimate of OVC being reached by existing interventions?

Yes		No	X

IF YES, what percentage of OVC is being reached? % (write in)