AFGHANISTAN NATIONAL HIV/AIDS STRATEGIC FRAMEWORK

2011-2015 (NSF II)

Kabul, Afghanistan

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ABBREVIATIONS & ACRONYMS

AHAPP Afghanistan HIV/AIDS Prevention Project
AIDS Acquired Immune Deficiency Syndrome
ANASF Afghanistan National Strategic Framework
ANBSTS Afghanistan National Blood Services and Transfusion Safety
ANP Afghanistan National Police
ART Anti-Retroviral Treatment
ARV Anti-Retroviral
ASAP AIDS Strategy and Action Plan
BBDs Blood Borne Diseases
BCC Behavioral Change Communication
BPHS Basic Package of Health Services
CBC Community-Based Care
CBO Community-Based Organization
CCM Country Coordinating Mechanism
CHABHA Children Affected by HIV/AIDS
CHCs Comprehensive Health Centers
DHS Demographic Health Survey
EPHS Essential Package of Hospital Services
FSWs Female Sex Workers
GDPM General Directorate of Preventive Medicine
GFATM Global Fund to fight AIDS, Tuberculosis and Malaria
GIZ Deutsche Gesellschaft fur Internationale Zusammenarbeit GmbH/International Services
GoA Government of Afghanistan
HACCA HIV/AIDS Coordination Committee for Afghanistan
HBV Hepatitis B Virus
HCV Hepatitis C Virus
HIV Human Immunodeficiency Virus
HMIS Heath Management Information System
HPRO Health Protection and Research Organization
HSV-2 Herpes Simplex Virus
IBBS Integrated Bio-Behavioral Surveillance
IDUs Injecting Drug Users
IEC Information, Education, and Communication
IPDs Internally Displaced Persons
JHU John Hopkins University
KABP Knowledge, Attitude, Behavior, and Practice
LSE Life Skills Education
MDM Medecins Du Monde
M&E Monitoring and Evaluation
MMT Methadone Maintenance Therapy
MoCN Ministry of Counter Narcotics
MoD Ministry of Defense
MoDM Ministry of Displaced and Martyred
MoE Ministry of Education
MoF Ministry of Finance
MoHE Ministry of High Education
MoHRA Ministry of Hadj and Religious Affairs
MoI Ministry of Interior
MoIYC Ministry of Information, Youth, and Culture
MoJ Ministry of Justice
MoLSA Ministry of Labor and Social Affairs
MoPH    Ministry of Public Health
MoRR    Ministry of Returnees and Refugees
MoWA    Ministry of Women Affairs
MSM     Men who Have Sex with Men
MTCT    Mother-To-Child-Transmission
NACP    National AIDS Control Program
NGO     Non-Governmental Organization
NSF     National Strategic Framework
NSEP    Needle Syringe Exchange Program
OIs     Opportunistic Infections
OST     Opioid Substitution Therapy
PMTCT   Prevention of Mother-to-Child Transmission
PPTCT   Prevention of Parent-to-Child Transmission
POP     Program Operational Plan
PLHIV   People Living with HIV
STI     Sexually Transmitted Infection
SWG     Surveillance Working Group
TB      Tuberculosis
ToT     Training of Trainers
UN      United Nations
UNAIDS  Joint United Nations Program on HIV/AIDS
UNESCO  United Nations Educational, Scientific, and Cultural Organization
UNFPA   United Nations Population Fund
UNGASS United Nations General Assembly Special Session on HIV/AIDS
UNHCR   Office of the United Nations High Commissioner for Refugees
UNICEF  United Nations Children’s Fund
UNIFEM  United Nations Development Fund for Women
UNODC   United Nations Office on Drugs and Crime
USAID   United States Agency for International Development
VCT     Voluntary Counseling and Testing
WB      World Bank
WHO     World Health Organization
FOREWORD
The first Human Immunodeficiency Virus (HIV) case was reported in Afghanistan in 1989. Since then, the Government of Afghanistan (GoA) has taken important steps in halting the HIV epidemic that is now concentrated (more than 5% HIV prevalence) among one of the Key Affected Populations (KAPs) i.e. Injecting Drug Users (IDUs). Other KAPs include prisoners, Female Sex Workers (FSWs), and Men who have Sex with Men (MSM). The number of People Living with HIV (PLHIV) is reported at 1250 persons till end of 2010, while the Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimates between 2,000 to 3,000 PLHIV in the country in the same year. Although, Afghanistan is a country of low HIV prevalence with under 0.05 percent among the general population, it exhibits a wide spectrum of risks and vulnerability factors of various segments of the population that call for immediate action. These factors include certain economic, social, demographic, and behavioral determinants that, if not addressed effectively, may fuel the spread of HIV.

The National AIDS Control Program (NACP) was established in 2003 which, under the leadership of the Ministry of Public Health (MoPH), plays a coordination and management role. Since then, the national response has focused on provision of targeted services for KAPs, vulnerable populations, and general population. With the support of key international donors and development agencies, the country has taken a multi-sectoral approach to the HIV response in order to arrest HIV transmission from further spread in the community. In spite of the progress made, the sustainability and effectiveness of the HIV response is undermined by a number of serious challenges that include political instability and insecurity, poverty and unemployment, mass out-migration, deterioration of basic health and education services, as well as gender imbalances, high illiteracy, and stigma and discrimination against PLHIV. Nevertheless, the GoA is confirming its commitment to continue an effective and sustainable HIV response that is based on multi-sectoral collaboration of key ministries; MoPH, Ministry of Interior (MoI), Ministry of Justice (MoJ), Ministry of Haj and Religious Affairs (MoHRA), as well as wide participation of Non-Governmental Organizations (NGOs) and civil societies, KAPs and PLHIV.

The second HIV National Strategic Framework (NSF II) has been formulated as a guiding policy document for the GoA to launch, monitor and evaluate its HIV interventions as a continuation of the previous strategy, Afghanistan National AIDS Strategic Framework (ANASF I). The NSF II puts forward key strategic directions for Afghanistan that will help accelerate the scaling-up of the HIV interventions based on the principle of universal access to prevention, treatment, care and support services, as well as the UNAIDS vision of Zero new HIV infections, Zero discrimination, and Zero AIDS-related deaths.

The NSF II will be implemented by NACP under the technical guidance and oversight of General Directorate of Preventive Medicine (GDPM) and Primary Health Care and Communicable Disease Control (CDC) Directorate – to ensure successful execution and monitoring of the national HIV response. Implementation of this strategy will be sustained with further technical and financial support of the development and donor community and the high-level political leadership of Afghanistan.

Best wishes,

Suraya Dalil, MD, MPH
Minister of Public Health, Islamic Republic of Afghanistan
ACKNOWLEDGEMENTS

This Strategy has been prepared as a joint undertaking of the Afghanistan NACP, the UN Joint Team on HIV/AIDS (Joint Team), the World Bank (WB) AIDS Strategy and Action Plan (ASAP), and the UNAIDS. This has been done as a part of continuous technical support provided by the UNAIDS and the WB to NACP and the MoPH aimed to strengthen institutional capacity of NACP for the design and implementation of its NSF II that will provide strategic guidance for the sustained HIV/AIDS national response for the next five years - 2011-2015.

A number of key national, international and regional agencies provided extensive support and technical expertise for the preparation of this document throughout its various stages. The core team composed for the purposes of the NSF II formulation included the management and key staff of NACP, the UN and donor communities such as United Nations Office on Drugs and Crime (UNODC), WHO, United Nations Educational, Scientific, and Cultural Organization (UNESCO), United Nations Children’s Fund (UNICEF), as well as Office of the United Nations High Commissioner for Refugees (UNHCR), United States Agency for International Development (USAID), United Nations Population Fund (UNFPA) and the WB.

Technical guidance and overall supervision was provided by General Directorate of Policy & Planning (GDPP) and GDPM of the MoPH and HIV/AIDS Coordinating Committee for Afghanistan (HACCA). In addition, a number of line ministries participated in stakeholder consultations that helped shape the content and direction of the NSF II. Specifically, those included the Ministry of Counter Narcotics (MoCN), MoI, MoJ, Ministry of Returnees, Refugees, and Displaced Populations (MoRRD), MoHRA. Also, the Ministry of Education (MoE), Ministry of Women Affairs (MoWA), Ministry of Labor, Social Affairs, Martyred & Disabled (MoLSAMD), and Ministry of Information, Culture & Youth (MoICY) were also consulted. At the same time, a large number of local and international NGOs such as Futures Group International, Medicines de Monde (MDM), World Vision International, Nejat,, AFGA, AADA, YHDO, SHDP, ARSC, JACK, KOR, HSDO. bn-Seena, ANSA, SDO, SAF, WADAN, CHA, OTCD were part of the series of discussions for the purposes of NSF II design. Also, GIZ-IIS provided technical inputs for the NSF II. Finally, operations research agencies such as John Hopkins University (JHU), ActionAid, and Health Protection and Research Organization (HPRO) participated in the preparation of this document, as well as involvement of PLHIV and KAPs.
EXECUTIVE SUMMARY

This NSF-II has elaborated in continuity of the ANASF-I goal to achieve universal access to HIV prevention, treatment, care, and support for KAPs, vulnerable populations and PLHIV. Drawing from the situation and response analysis, key priorities for the NSF-II are defined through four key priority or thematic areas:

Priority area 1: Increase coverage, quality, and effectiveness of HIV prevention interventions among KAPs, vulnerable populations, and general population,

Priority area 2: Increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families,

Priority area 3: Ensure availability and use of strategic information for decision-making, and

Priority area 4: Create supportive and enabling environment for a sustained and effective national response to HIV and AIDS.

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

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

In all above thematic areas, special attention will be given to a progressive expansion in the scope, geographical scale and the enhanced quality of services over the next five years in order to ensure effective HIV response. Services include, but are not limited to, HIV prevention interventions to all populations at-risk of acquiring/transmitting HIV, Voluntary Counseling and Testing (VCT), Anti-retroviral Treatment (ART) for PLHIV and Prevention of Mother-to-Child Transmission (PMTCT) of HIV. As mentioned before, HIV services will start in the key urban areas of the country, the Western provinces, as well as in other selected provinces. Further expansion of services in the provinces will be guided by national Integrated Bio-Behavioral Surveillance (IBBS) rounds conducted every two years to discern emerging HIV epidemiological patterns in a phased approach.

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

1. The need for effective and efficient implementation of current resources and increased scope and quality of HIV prevention, treatment, care, and support services,

2. Involvement of KAPs, vulnerable populations and PLHIV in the design of programs and in service delivery,

3. Ensure an equity in access to services for all populations at risk of HIV infection and in need of services, including a focus on addressing gender differences;

4. Deliver services through partnership between public and private sectors, and thereby increase efficiency and effectiveness, and
5. Adopting **integrated approaches** that link services in a continuum from community outreach to service provision through health services.

**National Strategic Results Framework**

This section describes the objectives and expected results/outcomes and strategies necessary to achieve the objectives of the NSF-II:

**Thematic area 1:** Increase coverage of prevention interventions for KAPs and their partners, vulnerable populations, as well as among general population.

*Objective 1:* To maintain HIV prevalence to <5% among KAPs by 2015  
*Objective 2:* To decrease HIV risk factors among vulnerable populations by 2015  
*Objective 3:* To reduce risk of HIV transmission among general population by 2015

**Thematic area 2:** Increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families.

*Objective 1:* To reduce stigma and eliminate discrimination associated with PLHIV by 2015

**Thematic area 3:** Ensure availability and use of strategic information for decision-making.

*Objective 1:* To generate reliable evidence to support HIV decision-making by 2015.

**Thematic area 4:** Create supportive and enabling environment for a sustained and effective national response to HIV and AIDS.

*Objective 1:* To reduce stigma and eliminate discrimination associated with PLHIV by 2015

**Strategic directions for the NSF-II**

Strategic Directions for IDUs.  
Strategic Directions for FSW and MSM Interventions.  
Strategic Directions for Prison Interventions.  
Strategic Directions for Interventions for General Population.  
Strategic Directions for Interventions in Health Settings.  
Strategic Directions for Interventions to Ensure Blood Safety.  
Strategic Directions for Universal Precautions in Health Facilities.  
Strategic Directions for Interventions in Institutional Enabling Environment.  
Strategic Directions in Multi-Sectoral Coordination.  
Strategic Directions for Resource Mobilization.
Strategic Directions in Reducing Stigma and Discrimination.

Strategic Directions in Strategic Information and Operations Research.

Strategic Directions for Monitoring and Evaluation (M&E) and Integration of HIV in Health Management Information System (HMIS).

Strategic Directions in Interventions for Treatment, Care and Support.

Strategic Directions for Interventions in Treatment.

Strategic Directions for Intervention in Care and Support.

**NSF II Risks and Mitigation**

Drawing from the experiences of the last five years of the HIV response in Afghanistan, the current NSF-II five-year plan faces numerous and diverse risks that could adversely affect the pace and extent of implementation and, subsequently, the desired Impact Results. Primarily, overall security and political developments in the country could result in interruption of program activities. Secondly, policy environment central to the AIDS response, such as government, development partners and specific sector policies on: drug control and prevention within the larger context of the ‘war on drugs’, prison reforms as well as public opinion vis-à-vis socio-cultural issues related to sensitive behavioral and life-style aspects. The above can directly impact on the ability to propose policy changes and to undertake activities in relation to scaling-up Harm Reduction and, in particular, OST in the community and prisons; to ameliorate health and day-to-day conditions in prisons and detention centers; to get law enforcement agreement to address sex work which is currently criminalized; and to ensure community and public opinion leaders’ acceptance of a ‘public health’ rationale to reach ‘hidden’ and marginalized populations.

Another set of risk factors are related to government structures and continuity in program leadership. At any one point of time, a small but critical mass of partners needs to be in place with competences and know-how to address the HIV response. In addition to government allocation of human resources, the position of the NACP within the architecture of the MoPH, provision of office premises and resources, and pursuing the effective integration of HIV activities within the health system, there is need for continuity in funding through the WB, The Global Fund and other multi and bi-lateral sources. Lastly, currently the consensus on priorities and the identification of strategies reflected in the NSF-II relies on a very limited evidence base.

Mitigating measures to address the above-mentioned risks are largely already encompassed within the NSF-II strategies. Notwithstanding that some of the risks are ‘external’ environmental ones (e.g. overall security and within specific provinces), the following mitigation measures can be highlighted:

- Decentralizing and reinforcing staffing and capacity of the AIDS program and services at provincial level in the priority areas to ensure continuous reach of the communities in need;
- Maintaining a targeted and sustained ‘Evidence-based Advocacy and Communication Strategy’ through the NSF-II with key sectors such as Public Health, Counter Narcotics, Prison Authorities, Interior, Police, Haj and Religious Affairs, to influence critical policy decisions;
- Developing adapted local models and, at times, ‘indirect’ approaches to HIV prevention service-provision to at-risk groups, in particular for sex work and men who have sex with men;
• Reinforcing capacity and the number of implementing public and private sector partners;

• Pursuing the existing policy of integration of certain HIV/AIDS services within primary health care service provision;

• Rolling-out a ‘Resource Mobilization Strategy’ with continued emphasis on demonstrating results and allocative efficiency, where the majority of resources are invested in programs that will have the largest impact on HIV epidemic, i.e. programs for IDUs and partners, and proposal formulation for the Global Fund, WB and other donors;

• Implement a mid-term review to measure progress towards the outputs and outcomes and make the necessary adjustments; and

• Placing priority emphasis on generating additional strategic evidence and on an improved M&E.

• Thus, the successful undertaking of at least some of the above proposed measures will contribute towards effective implementation of the NSF-II operational plans.
INTRODUCTION

The NSF II aims to provide strategic guidance for the HIV/AIDS national response for 2011-2015 that will strengthen (i) an enabling policy and institutional environment, (ii) improve management and technical capacity of the NACP and its implementing partners to launch the HIV/AIDS interventions, and (iii) further support the design of targeted interventions for key affected populations through comprehensive services of prevention, treatment, care and support. The NSF II will help facilitate a successful execution of HIV/AIDS interventions formulated under the previous national HIV strategy (ANASF I), promote consistency and transparency in the areas of procurement, disbursement, financial reporting, and M&E of the effectiveness of the HIV/AIDS response.

The NSF II has been formulated by utilizing Results-Based Strategic Planning Methodology of the ASAP which was discussed and agreed on in a series of meetings with the Core Group. This also included a review of the ANASF 2006-2010; the Program Operational Plan (POP 2007), the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS 2009 Country Report, the Afghanistan HIV/AIDS Prevention Project (AHAPP) documents, and the Global Fund Round 7 Proposal to ensure sustainability of the current HIV response and build on the existing institutional and operational capacity of the NACP, relevant departments of the MoPH, key participating ministries (e.g. MoCN), implementing NGOs, and technical expertise and coordination provided by the key UN agencies (e.g. UNODC, WHO, UNESCO), and international and national operations research agencies (e.g. JHU, HPRO). Additionally, the preparation of the NSF II also relied on a review of relevant program, policy, and strategic documents of key sectors (e.g. health, justice, interior, counter narcotics, education, social and women affairs, economic development).

The NSF II consists of five parts. Part 1 gives a general background on Afghanistan including key findings of the country’s HIV epidemiological situation and the status of the national response. Part 2 describes guiding principles, rationale, strategic approaches and overall NSF II strategic framework for each selected priority area for the next five years (2011-2015). An outline on the implementation strategy and steps are found in Part 3. M&E framework is detailed in Part 4 of the document followed by estimated costing of the NSF II (Part 5).
PART ONE: SITUATION AND RESPONSE ANALYSIS

I. Situation Analysis

Country Context

Thirty years of protracted war, foreign invasion and civil unrest made Afghanistan, a country of 29 million people, fall to 181 out of 182 countries with regard to the Human Development Indicators and be classified as among the poorest nations in the world.\(^1\) Mass out-migration and displacement due to conflict as well as lack of income-generating opportunities resulted in high mobility of populations, including significant exodus to urban areas and long-term migration to Pakistan, Iran, and the countries of the Arab Gulf.\(^2\) Consequently, today Afghanistan faces a variety of political, security, economic, social and human development challenges among which the HIV/AIDS epidemic poses an emerging threat. For the most part, this is associated with the increasing dependency of a growing segment of the population on regular use of a wide range of opiates, including opium and heroin, coupled with high prevalence of Tuberculosis (TB) and Sexually Transmitted Infections (STIs) in the context of severe deterioration of access to basic social, education and health services. Among other underlying factors, poor HIV knowledge and limited access to sex and reproductive education, low literacy rate (27 percent) and high stigma and discrimination against PLHIV, as well the KAPs, including IDUs, FSWs, MSM, and prisoners, are most apparent.

Drug Use

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

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\(^2\) UNHCR, Afghanistan Operational Update, 2007

\(^3\) Afghanistan Drug Use Survey, 2005, UNODC and Ministry of Counter Narcotics (MoCN) of the Islamic Republic of Afghanistan


\(^5\) UNODC, MoCN 2009 Drug Survey Executive Summary
areas where the drugs are produced (Northern and Southern regions), as well as the Central region, mainly Kabul.6

**Injecting Drug Use**

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

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

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

6 UNODC, MoCN 2009 presented the price of heroin to be at 2.2 USD, followed by opium at 1.6 USD and other opiate at 1.5 USD per day and an overall estimate of 300 million spent by all IDUs annually in the country to maintain their habit.
7 Data provided by the MoCN, 2006
common use of other substances, such as hashish, alcohol (61 percent and 65 percent, respectively) and most disturbingly, transitioning from smoking to injecting of heroin among 98 percent of IDUs.¹⁴

Other determinants of HIV epidemic in Afghanistan

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

HIV Epidemiological Situation

Afghanistan is among the countries of Central Asia and South Asia of low HIV prevalence and a concentrated epidemic that are confronted with growing risk of HIV/AIDS, mainly due to the high incidence of injecting drug use that partially intersects with sex work.¹⁹ Latest UNAIDS data indicate that the epidemic presently remains under 0.05 percent among the general population, yet has the potential to grow quickly from a small base of IDUs to their sexual partners and thus to heterosexual men and women unless effective,

¹⁶ The World Bank, HIV in Afghanistan Data, 2010
¹⁷ Studies on female sex workers (ORA International, 2006), men who have sex with men (Action Aid, 2006), and vulnerable children UNICEF (2009) cumulatively suggest that transactional sex and sexual exploitation of women, girls and children became more prevalent as the result of increased poverty in the last decade. Also, information collected from drop-in-centers (DIC) of MDM (Wilson, John Hopkins, 2010) reveals that young IDU boys, as well female IDUs are sold for sex by some policemen in Kabul.
¹⁸ Andrea Wilson, HIV in Afghanistan: A Review of Literature and Evidence of Disease Burden Among Vulnerable Populations, John Hopkins University, 2010
¹⁹ AIDS in South Asia: Understanding and Responding to a Heterogeneous Epidemic, The World Bank, 2006
vigorous, and sustained action is taken early. In early 2007, the officially reported number of HIV cases was 71, including 18 women and 53 men, detected only at three health services in two locations of the country - the Kabul City Central Blood Bank, Kabul and Herat VCT centers - cumulatively between 1989-2007. The UNAIDS and WHO, however, estimated a higher number of people living with HIV ranging from at least 2,000 to 3,000. It was known only that 24 out of the 71 HIV-positive individuals were IDUs, while no information was available about the remaining cases. In August 2007, GoA reported 245 cases. And the most recently available data indicated 1250 HIV-positive cases reported in 2010, and the number of deaths due to AIDS was estimated under 11 cases (NACP, 2011).

Despite this low prevalence, high rates of HIV prevalence (7.1 percent) are reported among IDUs, one of the KAPs, with a soaring regional variation of up to 18 percent in one urban center (Herat). HIV prevalence rate of 1.6 percent is reported among prisoners (mostly IDU prisoners). Although HIV prevalence rates among FSWs are presently known to be at 0 percent and no data is available for MSM population, high risk behavior factors such as unsafe sexual practices (e.g. low condom use, multiple sexual partners), poor knowledge and/or misconceptions about HIV transmission and STIs, drug and alcohol consumption, and, most importantly, close interaction between these populations present the danger of the epidemic spilling over to these populations and potentially to other segments of the wider population.

Key Affected Populations – IDUs, FSWs, MSM and Prisoners

Injecting Drug Users (IDUs)

There are up to 23,000 IDUs in Afghanistan. A 2008 University of Manitoba mapping assessment estimated 159, 55, and 1,251 IDUs in the three cities of Mazar-i-Sharif, Jalalabad, and Kabul, respectively. The study revealed that injecting drug is largely street based and clustered within urban districts, with Kabul having the largest number of IDUs per cluster (half of all 177 IDU clusters with at least 5 IDUs). While size estimation of rural IDUs is yet to be launched, some sources point at the existence of injecting drug use outside of urban areas. Unsafe Injecting drug use is considered the key mode of HIV transmission in Afghanistan as IDUs report the highest HIV prevalence rates in the country largely due to unsafe injecting practices such as sharing of needles and syringes (47 percent) and unsafe sexual behavior. The 2009 IBBS reported HIV prevalence rates among IDUs ranging between 1 percent in Mazar-i-Sharif, 3.2 percent in Kabul to 18.2 percent in Herat which, overall, corresponds with previously obtained rate of 3 percent among Kabul IDUs. Additionally, data collected from Opioid Substitution Therapy (OST) patients confirmed HIV prevalence rate of 3 percent among IDUs in Jalalabad. However, alarmingly MDM indicated 15 percent HIV prevalence among a small sample its OST patients in 2010 in Kabul thus demonstrating extremely high rates among IDUs. The 2009 IBBS also reported that IDUs exhibit a range of high HIV risk behaviors. The majority of sexually active IDUs surveyed in all three cities (up to 64 percent) reported paying for sex with a FSW and up to 25 percent of them having sex with a man or a boy. Almost one third of all interviewed IDUs shared

21 NACP data, 2007
22 Afghanistan Epidemiological Fact Sheets on HIV/AIDS and STIs, UNAIDS, 2011
28 Opioid Substitution Therapy: First Results and Way Forward. Presentation to the World Bank, Medicines de Monde (MDM), April 2011
needles or syringes and only 32 percent of all IDUs used a condom during their last sexual encounter. In
addition, IDUs reported to be highly mobile with 80 percent changing their residence at least once and
almost 90 percent of all having lived outside of the country for the past 10 years, including up to 80 percent
of those living in Iran and up to 50 percent in Pakistan.

Female Sex Workers (FSWs)
According to the Mapping and Situation Assessment conducted by University of Manitoba in 2007, there
were an estimated 1,160 FSWs in three major cities of Afghanistan (Kabul, Mazar-i-Sharif, and alalabad) in
2007 with the largest absolute number (898) being in Kabul and the highest numbers of FSWs per capita
were in Mazar-i-Sharif with approximately 2.8 FSWs per 1,000 adult women (aged 15-49). Overall, there
were an estimated 1.9 FSWs per 1,000 women across all three cities. In spite commercial sex being available
in urban areas – in Kabul and primarily in brothels during pre-Soviet era, since the Taliban’s criminalization
of sex work, today it is believed to be largely home-based and hidden. The best available information
indicates HIV prevalence among FSWs currently to be at 0 percent. Although IDUs have the largest
potential to introduce HIV into a population, as research indicates, FSWs arguably could have the largest
impact on the extent of the spread of HIV through their interactions both with clientele and regular sex
partners. A Knowledge, Attitude, Behavior, and Practice (KABP) study conducted by ActionAid in 2006
(Knowledge, Attitude, Behavior and Practice in High Risk and Vulnerable Groups in Afghanistan) revealed
that 84 percent of FSWs had 1-2 clients per day and the rest had 3 clients and more per day.

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

30 Mapping and Situation Assessment of High Risk Populations in Three Cities of Afghanistan, University of Manitoba, 2008
31 Andrea Wilson, 2010 Ibid
35 Knowledge, Attitude, Behavior and Practice in High Risk and Vulnerable Groups in Afghanistan, Action Aid, 2006
37 Bazgar, F and Young, A. Survey of Groups of High Risk of Contracting Sexually Transmitted Infections and HIV/AIDS in Kabul, ORA
Men Who Have Sex with Men (MSM)

As no robust estimates or behavioral or biological measures are present for MSM, no data is available on HIV prevalence among MSM. Recently, 1 out of 150 tested MSM was found positive for HIV infection. Although little is known about the extent of MSM behavior or the size of the MSM population in the country due to a tradition of sexual relationships of adult men with younger men and boys on one hand, including sexual exploitation of the latter, and high stigma and discrimination and hidden nature of this population on the other hand, sources however suggest that male-to-male sexual contact may play a large role in HIV transmission than previously assumed. The 2007 mapping assessment revealed a close interaction of MSM with female partners (spouses) and young males, and reliance on drugs. In addition, available information indicates that many MSM include those who engage in sex for money and goods, largely unprotected. The assessment revealed that many of those interviewed in Kabul and Mazar-i-Sharif MSM were actively involved in commercial sex work and had multiple sex partners. It also demonstrated that in one study location, the MSM had between 12-60 male sex partners per month from a total network of 100-200 MSM which could total to 86,000 to 144,000 sexual contacts per year for this network. Similarly, the 2009 Naz Foundation International study shed some light on sexual behavior, knowledge and attitudes of MSM in Kabul and Mazar-i-Sharif pointing to alarmingly risky behavior. Over 60 percent of the interviewed MSM reported sexual debut by the age of 19, including 25 percent of those who experienced it by force. Majority (89 percent) of the MSM received goods or money for sex while 26 percent the MSM interviewed in Kabul reported having more than 6 sexual partners in the last month preceding the study, including regular partners, strangers and paid partners of various occupations, and largely police and military. The study also highlighted that MSM had high incidence of having sex with females, especially in Mazar-i-Sharif (both paid and unpaid) and STI symptoms while reporting a low condom use, including during the last sexual encounter with a male. Finally, the study findings suggested that some MSM may include those who perceived male-to-male sex to be somewhat “contextual” given delayed marriage due to its high cost, ban on sexual relationship with women outside marriage, sex with men is considered “safe” (not leading to pregnancy) and less expensive than with FSWs.

PRISONERS

As of November 2009, there were 18,260 prisoners and detainees, including 17,660 male and 600 female prisoners (as well as 200 children with their mothers among them) in 34 prisons and 203 detention centers in Afghanistan. At the current rate of incarceration, UNODC projects that by 2015 the prison population will rise up to 30,000 persons related to the high level of drug use and readily available drugs in the country. The lack of drug treatment programs and the punitive policies reflected in the Counter Narcotics Law provide requisite conditions for a dramatic increase in country’s prison population, with the potential risks of spread of HIV and TB infections. The 2006 study among Kabul IDUs, that included prison IDUs, indicated that over 30 percent of prisoners were injecting heroin. HIV prevalence among prisoners in the country is believed to be growing and is associated with injecting drug use, including regional variation of 0.6 percent of HIV prevalence rate among surveyed prisoners in Kabul and 1.6 percent in Herat in 2009. However, data obtained in 2008 indicated a prevalence of 11 percent among a small sample of Herat male prison IDUs. The 2009 IBBS conducted in Kabul and Herat prisons, a home to the country’s largest number of the incarcerated (4,500 prisoners in Kabul and 1,200 prisoners in Herat) - revealed that majority of the

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38 NACP 2011 data
40 University of Manitoba, 2008
41 University of Manitoba, 2008
42 Rapid Assessment of Male Vulnerabilities to HIV and Sexual Exploitation, Naz Foundation International, 2009
43 UNODC 2010 data
45 IBBS, 2009
interviewed male prisoners in Herat (70 percent) were young – between 18-30 years old, married (65 percent), could not write or read (61 percent) and were in prison for more than a year (60 percent). By contrast, only half of Kabul prisoners were between 18-30 years old and 40 percent could not read or write, while the majority (80 percent) spent more than one year in prison. The IBBS 2009 provided first ever information on risk behaviors, including sexual behavior of the prisoners. The majority of the interviewed prisoners (up to 84 percent) reported having sex, including a small number (5 percent) of those who had multiple partners in the last 12 months preceding the study. Over a third of Herat and Kabul prisoners also reported ever buying sex from a FSW, including 12 percent of them doing so in the last 12 months while only 2 percent in Herat and none in Kabul reported condom use with a FSW. When asked if they ever had used a condom, between 12 and 18 percent of prisoners reported using condom. Over 10 percent of all prisoners (in both locations) reported having sex with a male (an adult or a boy) coupled with a significant number of them (75 percent in Herat and 53 percent in Kabul) used drugs, including 25 percent and 10 percent of them using while incarcerated – in Herat and Kabul prisons respectively. Currently, no information is available on sexual behavior of female prisoners, including female IDU prisoners.

Possible Intersections among KAPs and links to other populations

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

Data collected in 2003 and 2006 in Kabul City showed that almost all surveyed IDUs share needles and/or syringes with multiple and concurrent users, almost never use condoms and frequently have sex with FSWs, as well as MSM - primarily young men and boys - either for money or drugs. The findings of IBBS 2009 also confirmed previously obtained information revealing that between 55 and 70 percent of IDUs have ever bought sex from a FSW, while 12 percent of them bought sex in the last six months only 17-32 percent used condom during their last sexual encounter; about 3 percent of IDUs had sex with men. The University of Manitoba 2008 study also indicated high frequency of sexual partners among MSM who were engaged in commercial sex work, i.e. having three clients per day, mostly home-based. The UNODC/MoCN 2009 Survey suggests that a considerable number of IDUs obtain drugs or pay for drugs in exchange for sex and have at least 2 sexual partners in the month prior to the study. There are also indications of a number of female IDUs, particularly among the FSWs, thus pointing to the intersection of drug use and sex work that has serious implications for further spread of HIV infection mainly to the clients of FSWs and sexual partners of the IDUs. The former include long-distance truck drivers, migrant workers, students, police, and military.

Women, youth, and children also represent significant segments of the population that are potentially prone to infection as they are in direct contact with KAPs and vulnerable groups (IDUs, FSWs, MSM, truckers,

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48 Community Drug Profile #5, An Assessment of Problem Drug Use in the Kabul City, UNODC, 2003, Prevalence of HIV, Viral Hepatitis, Syphilis, and Risk Behaviour among Injecting Drug Users in Kabul, Afghanistan, University of California, San-Diego (UCSD) 2006
migrant workers, police and the military) and thus are potentially on the “receiving end” of the HIV transmission without having knowledge of such risks. Consequently, the possibility of single and multiple intersections within risk groups and further out to the vulnerable populations increases the odds of HIV infection among these populations.

Vulnerable Populations – Long-Distance Truck Drivers, Returnees, Refugees and IDPs, Uniformed Services personnel, Migrant Workers, Youth and Street Children

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

**LONG-DISTANCE TRUCK DRIVERS**

Existing data (IBBS 2009) report the HIV prevalence among long distance truck drivers to be presently at zero percent. However, recent information indicated 3 out of 2,272 tested truck drivers to be HIV positive. This group is high mobile including prolonged length of time (up to 30 days at once) and distance travel across the country and to neighboring Iran and Pakistan, countries of higher HIV prevalence rates. Afghanistan relies on road transport routes for international trade over 13 international border crossings and immediate connections to its five neighboring countries (Pakistan, Iran, Turkmenistan, Tajikistan, Uzbekistan, and China). This translates into a large portion of male population engaging in long-distance transport work that is prone to high risk behavior, including exposure to commercial sex, male-to-male sex, and use of alcohol and drugs. At the same time, the wives and other sexual partners may also become vulnerable to risk, especially due to their being largely unaware of the sexual behavior of their spouses while absent from home resulting from the taboo around sex as well as cultural expectations that prevent women from discussing or negotiating safe sex. The IBBS 2009 noted that long-distance truck drivers estimated at 60,000, including 6,000 of those working in and out of the country represent a vulnerable group to HIV transmission due to their risky sexual behavior. The IBBS 2009 results pointed at a number of startling contributing risk factors found among this group such as low literacy level (50 percent), high level of drug use (17 percent) and incarceration (up to 38 percent), high levels of buying sex with FSWs (19 percent) and engaging in sex with men and boys (11 percent) while being married (80 percent) and majority (97 percent) reporting having multiple sex partners.

**IDPs, RETURNEES AND REFUGEES**

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

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50 NACP 2011 data  
52 Presentation by Ministry of Refugees and Returnees at HACCA meeting, Kabul, 20 April 2010  
53 According to figures provided by the Islamic Republic of Iran and Pakistan, more than one million Afghan economic immigrants who are un-registered live in Iran and more than 300,000 in Pakistan. The Ministry of Refugees and Returnees reported that since 2002 around 6 million people have returned to Afghanistan of which 4.4 have been re-located to their original places. However, there are still 3 million Afghans who live in Iran and Pakistan and elsewhere.  
54 Particular focus is needed on cross-border mobility with Pakistan and Iran, including refugees, those involved in economic activities and Afghan residents in neighboring countries. In the case of Pakistan, for example, a large population of Afghans resides in the main cities of this country, with the majority in the Province of Khyber Pakhtunkhwa (KPK) and the Federally Administered Tribal
deprivation can seriously contribute to increasing odds of their HIV risks. At the moment, available information, e.g. The 2006 World Food Program study of PLHIV in Afghanistan – indicates that 40 percent of all PLHIV surveyed were either not currently living in their place of origin and or just returned from abroad.\textsuperscript{55} Recently, UNODC and MoPH conducted a Drug and HIV Vulnerability Assessment and Mapping carried in 5 provinces (Kabul, Parwan, Herat, Nangahar, Jawzjan and Baghlan). \textsuperscript{56} It estimated 28,000 recent heroin users among the refugee population and around 7,700 IDUs. Drug users in this sample were more likely to have engaged in risky behavior for HIV transmission, including regular reliance on a commercial sex work. Condom use was 30-40 percent amongst those who have had sexual contact with a non-regular partner, a proportion which was the same amongst drug users and non-users.

**UNIFORMED SERVICES PERSONNEL:**
Currently, there is no data on HIV prevalence among the uniformed services personnel, including police. However, information available indicates evidence of high risk behavior among this group including drug use, use of commercial sex and sex with men and boys. For instance, a police interventions project under the Integrated Drug Prevention, Treatment and Rehabilitation Project in Afghanistan, launched in July-September 2008 revealed that 249 out of the 828 police staff tested were positive for using drugs. Similarly tests carried out from October-November 2008 revealed that out of the 725 police staff tested, 167 were using drugs.\textsuperscript{57} In addition, Columbia University and HPRO conducted a KABP study among 4,750 national army recruits with the study findings being reviewed by the MoPH.\textsuperscript{58}

**MIGRANT WORKERS:**
No systematic data is presently available on HIV status of Afghan migrant workers. However, the HIV risks among this group are apparent as South Asia supplies the majority of migrant workers to the Gulf countries that in many cases routinely test migrant workers for HIV and deport those found positive, including Afghan male seasonal migrants. Lack of access to health care and discrimination of this population limits their access to HIV counseling, who consequently often return home without knowledge of their HIV status and associated risk behaviors. For example, in the neighboring Pakistan’s North Western Frontier Province of Pakistan 70 percent of HIV positive individuals were Pakistanis who had been deported from migrant work in the Middle East. As Afghanistan’s economic out-migration is increasing with hundreds of thousands Afghans migrating either permanently or seasonally to Iran, Pakistan, and the Gulf countries annually, high risk behavior, including demand for commercial sex and injecting drugs increases as men spend longer time away from home.\textsuperscript{59}

**YOUTH AND STREET CHILDREN:** Almost 63 percent of Afghanistan’s population is below the age of 25, growing up in a challenging and complex environment, marked by poverty and increasing insecurity, lack of access to quality education, and violence.\textsuperscript{60} The presence of a large number of street children (estimated at 50,000 persons), including drug users among them, is particularly alarming.\textsuperscript{61} While there are no statistics available of how many children in total are living in orphanages in different parts of Afghanistan, UNICEF has

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\textsuperscript{55} Survey to Determine the Impact of Food Assistance Programmes on PLWHA, World Food Program, MoPH, 2006
\textsuperscript{56} Drug and HIV Vulnerability Assessment and Mapping among Returnees and Deportees, UNODC, MoPH, 2011 (unpublished)
\textsuperscript{57} GIZ IS, IP IP Report, 2009
\textsuperscript{58} Knowledge, Attitude, and Practice and Sero-prevalence Assessment of HIV, Syphilis, Hepatitis B and C Among Afghan National Army Recruits in Afghanistan, Columbia University and HPRO, 2011 (draft)
\textsuperscript{59} Understanding HIV Epidemic in Afghanistan,
\textsuperscript{60} Youth literacy rates are low with 50 percent for boys and 18 percent for girls; secondary school enrolments are respectively 23 percent and 7 percent, and less than 1 percent of the Afghan population obtaining higher education
\textsuperscript{61} Best Estimates of Social Indicators for Children in Afghanistan, 2003
estimated that 12 percent of children in Afghanistan are orphans for various reasons. The situation of Afghan girls is of particular concern - under traditional pressures they enter early marriage and early pregnancy, and have limited freedom to escape the norms and traditions that dictate females’ lives in many communities around the country. Information on abuse and dependence of children and adolescents on substances indicates that children and adolescents are often involved at a very young age and become familiar with opiate drugs because of drug use at home. Another area of serious concern is related to sexual abuse of male adolescents and children in the country. A 2009 study on male vulnerabilities to HIV and sexual exploitation in Afghanistan highlighted the evidence of sexual exploitation of male adolescents by older males. As the study revealed, almost 61 percent of the interviewed adult males (a purposive sample of 100 persons) had sex with other males, reporting sexual debut by 15 years-old and almost 89 percent of them had been involved in transactional sex. Similarly, women and girls in the country are also prone to violence, including sexual violence in some instances, as well as at detention facilities, or as they become victims of traditional practices to resolve feuds within the family and community, such as forced marriage. In addition, larger numbers of child marriages (43 percent of 20-24 years old women) reported marriage below 18 years of age. Thus, these factors make children, adolescents, and youth particularly prone to HIV-related risks.

In addition to the likelihood of being infected by HIV, Children Affected By HIV/AIDS (CHABHA) also face the consequences of becoming orphaned due to AIDS or forced into poverty and deprived of basic services due to the illness of their parents. CHABHA are those who are living in or coming from a family where one or more parents or caregivers are HIV positive, children who have lost one or both parents or primary caregivers due to AIDS or children / young people (under 18 years) who are HIV positive themselves. As Afghanistan has over 600 positive cases while approximately 2,000 cases are foreseen to be present. Considering the definition of CHABHA and taking into account the average size of family in Afghanistan (5 members per family) and estimated HIV cases, it is predictable that the number of CHABHA in the country will be around 1,800. Thus, HIV prevention, treatment, care, and support services to CHABHA should be indispensable part of the NSF II and national policies to be implemented.

**HIV Knowledge**

Until recently, no systematic evidence existed on knowledge, perceptions and attitudes of KAPs and other populations with regard to HIV. Data obtained lately from various studies has made it possible to identify some of the important perceptual trends summarized in this section. One of the first studies conducted among male IDUs (2005) determined that 43 percent of them in Kabul and Herat had heard of HIV/AIDS, 83 percent of whom reported willingness to use condoms to avoid contracting HIV infection. However, the 2006 KABP study reported that almost 70 percent of IDUs in Mazar-i-Sharif and Jalalabad did not know where to go for an HIV test and 40 percent did not know that sharing needles may lead to HIV infection. The 2009 UNODC/MoCN Drug Survey, the 2009 IBBS, and the 2010 cohort study provided new information among IDUs with some striking differences across findings, although with some indication that contacts with programs were improving knowledge scores. If the UNODC data pointed at relatively low awareness and knowledge about HIV prevention among the surveyed IDUs, both IBBS and the cohort study indicated significantly higher levels of HIV knowledge. The IDUs study by UNODC reported that many of IDUs who

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63 In some regions of the country, parents provide opium to their children to calm them down to numb their hunger
64 Rapid Assessment of Male Vulnerabilities to HIV and Sexual Exploitation in Afghanistan, NACP, Naz Foundation International and UNICEF, 2009
65 Silence is Violence, UNAMA & OHCHR, 2009
67 Study on Knowledge, Attitude, Behavior and Practice in High Risk and Vulnerable Groups in Afghanistan, Action Aid Afghanistan, 2006
heard of HIV did not know about HIV modes of transmission or means of its prevention. Also, the majority of the studied IDUs never used condoms during sex in the last month of the survey and only a small number mentioned occasionally using condoms. Conversely, most IDUs that participated in the 2010 cohort study (88 percent) were aware of HIV with fairly high accurate knowledge of HIV (63 percent), likely to be associated with the large presence of harm reduction interventions in Kabul compared to other regions. Similarly, the IDUs who participated in IBBS 2009 also reported having heard of HIV with 83 percent in Mazar-i-Sharif, 93 percent in Kabul, 96 percent in Herat respectively, including almost all (up to 99 percent in all three cities) identifying needle sharing as a method of transmitting HIV and high condom awareness (between 80–99 percent) among all surveyed IDUs in all three cities.

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

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

The 2006 ActionAid study that included a small-scale survey of truckers on the Uzbekistan border and within Kandahar tucking routes provided information on knowledge of HIV among long-distance truckers demonstrating that approximately 34 percent had heard of HIV/AIDS and 7 percent had paid for sex in the previous year, out of which only one quarter had used condoms. Additionally, in a 2005 survey conducted in Kabul by ORA International, none of the truckers reported using a condom during sex with FSWs. The 2009 IBBS revealed that while reporting high level of knowledge about HIV and transmission modes (up to 80 percent) and other STIs (60 percent), only 22 percent reported adequate knowledge about condom use as a preventive measure and only 1 percent knew of HIV prevention services. The 2007 study of refugees in Kabul, Herat, Mazar, and Kandahar found that 53 percent of returnees from Iran and 29 percent from Pakistan had heard of HIV/AIDS.

The first ever qualitative study among policy makers on HIV knowledge conducted in 2010 revealed that the majority of the interviewed were aware of HIV and AIDS, however lacked correct knowledge of modes of transmission. Stigma and discrimination against KAPs were high among this group, while showing strong respect for the opinions of the country’s religious leadership. Another study that also highlighted the perceptions and attitudes of policy makers and health professionals towards the disease and KAPs (i.e. IDUs) demonstrated similar stigma against IDUs and the need of advocacy for involvement of religious leadership.

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69 Mapping and Situation Assessment of High Risk Key Populations in Three Cities of Afghanistan, University of Manitoba, 2007
70 Bazgar, F and Young, 2005, Ibid
73 HIV-Related Knowledge, Attitudes and Beliefs of HIV Policy Makers & Persons who Influence HIV Policy in Afghanistan, John Hopkins University, 2010
as well as providing awareness to communities and law enforcement.\textsuperscript{74} As far as the general population, no data on knowledge, behavior, attitudes is available as no household based KABP surveys have been launched in the country.

In 2005 ActionAid conducted a KABPPassessment that shed some light among HIV knowledge among the Afghan youth\textsuperscript{75}. The study was conducted among university students from Kabul, Mazar, Kandahar and Heart. Only 6 percent could identify that it is transmitted by a virus, 5 percent knew that it is transmitted through sexual intercourse and 4 percent through infected blood. Over a third (36 percent) of the interviewed students believed that students had sexual partners and 95 percent perceived HIV/AIDS as a serious health issue for Afghanistan. The study also revealed that the majority (91 percent) was aware of HIV but only 28 percent had a good level of HIV knowledge. Around one-third had positive attitudes toward PLHIV. However, approximately 30 percent reported risky behavior. Females were statistically more knowledgeable than males, and high-risk behaviors were significantly more prevalent among males. However, general awareness, and attitude were not statistically different between genders. A considerable proportion of students (15 percent) were sexually active while only 35 percent of them were married.\textsuperscript{76}

\section*{Prevalence of STI and TB}

\subsection*{STI PREVALENCE}

Although systematic and rigorous data on STIs is currently unavailable, information collected to-date suggests high prevalence of STIs in certain populations. The IBBS 2009 also provided sero-prevalence data on infections other than HIV, such as HBV, HCV, Herpes Simplex Virus (HSV-2), and syphilis among the IDUs, FSWs, prisoners and long-distance truckers pointing to potential rapid spread of HCV and HSV-2 especially among IDUs. Thus, the lowest levels of HCV were reported among the FSWs (less than 1 percent) while IDUs reported the highest average rate of 58 percent (across the cities, it ranged from 25.5 percent in Mazari-i-Sharif, 37.5 percent in Kabul to 58 percent in Herat). Surprisingly, truckers, thought to be a sexually active group, demonstrated somewhat lower prevalence rates of 8.2 percent for HBV, 6.6 percent of HCV and 1 percent for Syphilis, and less than 1 percent for HSV-2. Prisoners also reported a relatively lower prevalence across all tested infections ranging from 1 to 4 percent. The HSV-2 highest rates were also found among IDUs – 20 percent in Mazar-i-Sharif, 16 percent in Kabul and 4.4 percent in Herat, followed by 10 percent among FSWs. For other infections, the FSWs also reported lower rates of 3.5 percent of HBV and 5.4 percent for Syphilis.

\subsection*{TUBERCULOSIS (TB)}

Afghanistan has one of the highest TB prevalence rates in Central Asia and it tops the list of 22 high-burden TB countries in the world. According to the WHO’s TB Global Report, approximately 51,000 new TB cases occur annually in Afghanistan, and 11,000 people died from TB in 2007 in the country.\textsuperscript{77} TB cases have been disproportionately high among the female population who are infected more than twice than men with 64 percent of the notified cases are women. TB and Gender Study is currently underway aimed to assess the situation. Annual new cases of TB per 100,000 people are 189 per and new Sputum Smear (ss+) cases pare 79 per 100,000. The HIV incidence among TB cases is calculated at 0.02 percent.

\begin{flushleft}
\textsuperscript{74} Todd, C. et al, 2010, \textit{Ibid}
\textsuperscript{75} A Study on Knowledge, Attitudes, Behavior and Practices in High Risk and Vulnerable Groups in Afghanistan, Action Aid, 2005
\textsuperscript{76} Gender Difference in KAP related to HIV among Freshmen Students in Afghan Universities.
\textsuperscript{77} World Health Organization’s (WHO’s) Global Tuberculosis Control Report, 2009
\end{flushleft}
II. National Response

Institutional Framework

Since 2005-2006, the GoA has taken numerous steps towards a comprehensive multi-sectoral HIV response with the financial support of international donors and technical assistance of development partners, involvement of public and private sector stakeholders, and participation of local and international NGOs. In particular, the Afghanistan National Development Strategy had been developed to identify priority policy and program areas for seventeen sectors to achieve the Millennium Development Goals, including setting a five-year target to maintain low prevalence (<0.05 percent) of HIV and to reduce mortality and morbidity associated with HIV/AIDS by the end of 2010 (Jaddi 1389). Consequently, in October 2006, the GoA approved ANASF for 2006-2010, and thus to move ‘Towards Universal Access for Prevention, Care and Treatment, and Mitigation of the HIV/AIDS epidemic’. Subsequently, within the implementation of ANASF 2006-2010, a number of important achievements have been made by the GoA, namely under the leadership of MoPH and NACP that covered areas of: (a) policy, planning, and institutional development; (b) HIV/AIDS programming for KAPs; (c) Information, Education and Communication (IEC) campaigns; (d) provision of STI services; (e) establishing linkages between the National TB Program and Reproductive Health; (f) setting up of VCT centers; (g) launching blood safety; and (h) harm reduction programs. The GoA has also encouraged a multi-sector response to HIV translated into commitments made from other relevant ministries, including MoCN, MoI, MoJ, and MoHRA) among others. Efforts have also been made to achieve better coordination of implementation at various levels, including integrating HIV/AIDS into the national health system where relevant and as a part of the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Eight of the 34 provinces have HIV advisors who facilitate coordination and integration at the provincial level. Many provincial governmental directorates, such as those of Women Affairs, Prisons, Culture and Youth Affairs, and Religious Affairs, are involved in the HIV response at national and provincial levels.

Policy, Strategy and Guidelines Development

As a part of the implementation activities of the ANASF 2006-2010, several policies and guidelines have been developed and approved in the country. One of the important achievements includes adoption of the Harm Reduction Strategy for IDUs and HIV/AIDS Prevention in 2005 of the MoCN and MoPH, National Drug Control Strategy by the MoCN in 2006 and National OST Policy in 2010, developed to provide further policy support for implementing a full package of services for drug-related harm reduction in Afghanistan. HIV/AIDS concerns were addressed in a number of strategies, including the National Health Policy 2005-2009 and the National Health Communications Policy and Strategy 2004-2007 that have an objective on HIV/AIDS. In 2007, a Communication Strategy for Building an Enabling Environment for Targeted Interventions was developed. The National Strategic Plan for TB Control 2006-2010 was formulated in 2005.

79 The ANASF 2006-2010 put forward 6 objectives, including: (i) Strengthening Strategic Information to Guide Policy Formation, Program Planning and Implementation; (ii) Gaining Political Commitment and Mobilization of Resources necessary to Implement the National HIV/AIDS Strategy; (iii) Ensuring Development and Coordination of a Multi-Sectoral HIV/AIDS Response and Developing Institutional Capacity of All Sectors Involved; (iv) Raising Public Awareness on HIV/AIDS and STI Prevention and Control, and Ensure Universal Access to Behavior Change Communication on HIV/AIDS, Especially Through Targeting High-Risk Groups and Vulnerable Populations; (v) Ensuring Access to Prevention, Treatment and Care Services for High-Risk Groups and Vulnerable Populations; (vi) Strengthening the Health Sector Capacity to Implement an Essential Package for HIV/AIDS (EPHA) within the Framework of BPHS and Essential Package of Hospital Services EPHS.
80 NACP was established in 2003
followed by the National TB and HIV Policy, Strategy and Guidelines prepared in 2007. In addition, a National Reproductive Health Strategy 2011-2015 has integrated HIV/AIDS into its programming. A number of other health-related guidelines have been formulated and approved, including the National Drug Treatment Guidelines of the MoCN and MoPH in 2006, the National HIV Testing and Counselling Guidelines in 2007, the Basic Package of Health Services and the Essential Package of Hospital Services both developed and became active in 2005 and included an HIV/AIDS component. In 2007, the MoPH also has completed the draft National Guidelines on VCT and, in 2008 it approved the Blood Transfusion Policy, which aims to strengthen transfusion safety, including quality testing of blood for HIV and other blood-borne diseases. The MoPH has also developed a comprehensive plan for strengthening access to safe blood formulated through the Blood Safety Program currently underway. In 2007, the National Strategy Plan for the M&E of the MoPH has been developed. In 2007 as well an HIV Communication Strategy has been drafted followed by the M&E Plan for HIV Prevention, Treatment, Care, and Support in Afghanistan formulated in 2009. Finally, the National HIV/AIDS Policy has been developed in 2010 and has been approval by the MoPH.

Coordination Mechanism

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

Operational Response

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

Programmatic Response: Prevention, Treatment, Care and Support, Strategic Information, and M&E

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

HIV Prevention among KAPs

**IDUs:** Interventions targeting IDUs have been provided in line with global recommendations on the comprehensive package of services required for HIV prevention, treatment and care among IDUs and notable achievements have been made in the provision of first ever: (a) harm reduction as well as (b) drug treatment services in the country.\(^\text{82}\) **Harm reduction** activities for IDUs include the distribution of safe injecting kits, collection of used needles and syringes, syndromic management of STIs, counseling for Blood Borne Diseases (BBDs) including VCT for HIV, HCV and HBV testing, condom promotion, primary health care and abscess management, overdose management, referral for TB services, referral to ART, as well as social services like hygiene kits and nutrition. In terms of target groups and programmatic area coverage, the WB and the GFATM fund most interventions in this area, while UNODC, UNAIDS, and WHO additionally focused on support to: (a) female drug users, (b) drug use among returnees and refugees, (c) advocacy and policy dialogue, particularly on OST, and (d) social and night shelter support to street-based and homeless drug users.

UN agencies and the donors also assist NACP in strengthening of its institutional capacity, as well as that of implementing NGOs. However, some serious challenges are present, including limited geographic coverage to achieve targets for IDUs (Table 1). After several years of policy dialogue and logistical challenges, OST is now available on a pilot basis in a center run by MDM in Kabul, where by November 2010, 71 person were receiving Methadone Maintenance Therapy (MMT) while there is need to reach a much large number of the total population of IDUs in the coming years and across the key urban centers. The status of the HIV epidemic among IDUs is also unknown in several urban localities, such as in Jalalabad, as the IBBS 2009 did not cover this city while it is believed to be prone to greater HIV risks than previously assumed.\(^\text{83}\)

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\(^{83}\) UNGASS, 2010
Table (1): Coverage Gap of Prevention Services among IDUs

<table>
<thead>
<tr>
<th>Details</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of IDUs in Afghanistan(^{84})</td>
<td>20,000</td>
</tr>
<tr>
<td>Estimated number of IDUs in Kabul(^{85})</td>
<td>1,261</td>
</tr>
<tr>
<td>Estimated planned coverage of Needle Syringe Programs (NSEP) in the country (2011)(^{86})</td>
<td>5,560</td>
</tr>
<tr>
<td>Estimated planned coverage of OST (2011)(^{87})</td>
<td>200</td>
</tr>
</tbody>
</table>

In terms of drug treatment, there are a total of 46 treatment centers across 21 provinces supported mainly by the MoCN and the Colombo Plan as well as a range of residential and community-based drug treatment centers operated by international and local NGO\(^{88}\). Services to the community are free of charge and usually include detoxification treatment, counseling, HIV awareness education, residential rehabilitation, after-care, and/or referral.

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

**FSWs**: Until mid-2011, there were 2 programs available for FSWs in Kabul and Mazar-i-Sharif with a target of 400 FSWs in total with the one in Mazar-i-Sharif closing its operation. Services include syndromic case management of STIs, promotion of knowledge and consistent condom use, information about Mother-to-Child Transmission (MTCT) of HIV, as well as VCT are made available. These services need to be reinforced in terms of range of interventions as well as geographic coverage in order to cover key urban areas.

**MSM**: Two health centers catering for MSM and others are functional in Kabul and Mazar-i-Sharif. Due to the high stigma associated with MSM, these centers are designed as ‘male health clinics’. Services include syndromic case management of STIs, promotion of knowledge and consistent condom use, as well as increasing awareness. In addition, BBDs tests, HBV vaccines and general primary health care are made available. Currently, Afghanistan is one of seven country recipients of the GFATM Round 9 Regional Proposal on Reducing the Impact of HIV on MSM and Transgender Populations in South Asia, including countries such as Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka. The proposal aims to support a five-year program starting in 2011 that will lead to the development and strengthening of Community-Based Organizations (CBOs) and adapted systems to address risk and vulnerabilities of MSM to HIV by improving the provision of comprehensive HIV prevention, treatment, care and support to them. The program will also help build engagement in policy development and advocacy, address stigma and discrimination, as well as undertake operations research on issues related to MSM\(^{89}\).

**PRISONERS**: Harm and risk reduction activities for prisoners target primarily IDU prisoners, including in 8 cities: Herat, Ghazni, Kabul, Kandahar, Mazar-i-Sharif, Kunduz, Jalalabad, and Faizabad under the WB and GFATM supported nationally implemented projects. In addition, UNODC is supporting interventions in female prisons in Herat, Kabul, Charikar, Mazar-i-Sharif, Jalalabad, and Faizabad. However, the harm

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\(^{84}\) National Drug Use Survey, UNODC, MoCN, 2009

\(^{85}\) This estimate has been made by the Mapping and Situation Assessment of High Risk Key Populations in Three Cities of Afghanistan, University of Manitoba, 2007

\(^{86}\) These figures are based on targets

\(^{87}\) This is the target for the community based OST in Kabul implemented by Medecins du Monde (MDM).

\(^{88}\) The Colombo Plan for Cooperative Economic and Social Development in Asia and the Pacific is an inter-governmental regional organization to strengthen economic and social development of member countries in the Asia-Pacific Region

\(^{89}\) GFATM Round 9 Regional Proposal on Reducing the Impact of HIV on MSM and Transgender Populations in South Asia, 2010
reduction response in prisons remains limited and condoms, MMT and NSEP are not yet permitted in prison settings despite ongoing policy dialogue. Institutionally, while MoI is responsible for the management and operations of provincial prisons and district detention centers, MoPH is responsible for provision of health services to the prison population formulated through its Prison Health Strategy which is expected to be rolled out via BPHS and EPHS financed by the WB, the European Committee (EC) and the Government of the USA.\(^9^0\)

**HIV Prevention among Vulnerable Populations**

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

**Uniformed Services Personnel:** Training of Trainers (TOT) curriculum has been developed for the police to provide essential information on HIV and other blood borne diseases, as well as sensitization on substance abuse as well as discrimination against the rights of drug users. Accordingly, most recently a total of 200 police personnel received training in 5 provinces (Ghazni, Nangarhar, Kunduz, Badakshan, Herat and Kabul) in November 2010.\(^9^1\)

**Refugees, Returnees and IDPs:** Through GFATM Round 7 support as part of ‘Strengthening Provincial HIV and AIDS Program’ (SPHP), activities are being implemented in four border passage sites in Yorkham in Nangarhar, Sherkan Bandar in Kunduz, Islam Qala in Herat, and Daman district in Kandahar. Basic education on HIV and STI is provided on site and informative leaflets are distributed containing contacts of key personnel in HIV and AIDS centers in the 8 provinces. In terms of regional cooperation, regular tripartite meetings between Afghanistan, host countries and UNHCR are held to address general issues associated with Afghan immigrants and refugees.\(^9^2\) NGOs have also been selected, in consultation with the NACP, and mobile outreach units have been established in Herat and Nangarhar, and harm reduction services are being provided to Afghan returnee drug users since February 2010. An assessment of the HIV and drug use situation and a mapping of services among returnees/deportees in Afghanistan are being carried out in Kabul, Parwan, Baghlan, Jawzjan, and Herat. A directory of services for returnees is also being developed. Finally, UNAIDS supported a programmatic and service-providers exchange between NACP Afghanistan and the government and NGO counterparts that provide services to reach Afghans in Pakistan, including on continuum of care, ART, and PMTCT. Starting in 2011, regular coordination will be established between the NACPs in both countries, including between ART centers given that PLHIV among the Afghan populations are followed up in health services in cities such as Peshawar in Pakistan as well as in Kabul.

**Migrant Workers:** Up to now, there is no specific intervention addressing HIV and AIDS among this vulnerable group.

**Youth and Street Children:** Numerous activities have been initiated jointly by NACP, HACCA and UNICEF in collaboration with the Youth Department of Ministry of Information, Youth, and Culture (MoIYC), including (a) HIV awareness among youth in Kabul, Herat, Nangarhar, and Mazar-e-Sharif between September 2009 and June 2010 targeting over 30,000 young people (equal number of male and female youth) through 475

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\(^9^0\) Components of the Prison Health Strategy (PHS) include Prevention, Epidemiological Surveillance, Curative Care, Specialized Medical Care, Communicable Disease Control and Treatment, Mental Health, Drug User Services, Disability, Detention-Specific issues, Antenatal and Postnatal Care, Child Health and Immunization, and Essential Drug Supply.

\(^9^1\) Information provided by NACP, November 2010

\(^9^2\) Tripartite agreements with Iran, Pakistan and other countries have been signed. In Kabul Airport, a supervisory unit supported by International Organization on Migration and the Ministry of Refugees and Returnees operates, where medical services are provided and support is provided in transportation and re-location of returnees. In addition, UNODC and UNHCR are carrying out a joint regional project (2009-11). It involves the Governments of Afghanistan, Iran and Pakistan and provides comprehensive HIV prevention and care services to Afghan refugee drug users in Iran and Pakistan and returnees in Afghanistan.
sessions in these provinces; (b) delivery of the IEC/Behavioral Change Communication (BCC) materials such as posters, leaflets, magazines, as well as copies of TV and radio skits; and (c) a three-day TOT workshop was held in May 2010 at the Kabul Youth Center. In addition, the HIV/AIDS issues have been included in the national education curriculum for grades 4 to 12. In selected provinces, MoPH has initiated reproductive health and HIV/AIDS activities specifically for out-of-school youth by establishing youth information centers and youth-friendly services. Since 2007, UNICEF provides technical, financial and material support to MoIYC to increase opportunities for youth development and participation through the establishment of Youth Information Contact Centers (YICCs). YICCs have conducted training workshops on different areas, including HIV/AIDS, peace-building, child rights, elimination of discrimination against women, drug abuse, dangers of mine and unexploded materials, etc. In 2010, sensitization and awareness workshops were also conducted for 1,471 youth members from these training centers. Life Skills Education and HIV program developed by MoE and MoPH aims at school children and adolescents and is implemented by an NGO (ARSC). As a result, in 2008 and 2009, LSE program coverage reached over 122 schools. MoPH has launched a number of reproductive health and HIV activities for out-of-school youth via youth information centers and youth-friendly services. Lastly, HIV has been included in the new national education curriculum for grades 4-12.

HIV Prevention in the General Population

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

**TB/HIV Collaborative Activities:** In 1997, Afghanistan’s National TB Control Program adopted the DOTS (Directly Observed Therapy Short-Term) - the internationally recommended strategy for TB control - that has resulted in a significant leap in the program’s population coverage to 97 percent in 2007 and a case detection of 64 percent. This has been achieved through BPHS BPHS and EPHS delivery systems, currently technically supported through WHO and implemented by international and national NGOs, and due to the increased international donor support, improved inter-country coordination, and greater collaboration between public, private sector providers and communities. TB control services are implemented largely by NGOs. However, the treatment success rate fell below 85 percent after four years of being above this target. Moreover, the management of multi-drug-resistant TB, extensively drug-resistant TB and diagnostic capacity are extremely limited in the country. In terms of TB/HIV collaborative activities, some of the key achievements up to September 2010 include the development of the TB/HIV Guidelines and Curriculum. In order to enable coordination at the national and provincial levels, TB/HIV Task Force committees have been established at both levels and a referral system between TB and HIV programs has also been established. So far, around 140 PLHIV have been screened for TB and around 3,177 TB patients have received HIV counseling and testing. So far, 7 persons who are HIV positive and are TB patients have been referred to the ART centre for care and support services during TB treatment.

**Management of STIs:** As the NACP has initiated provision of STI services as a prevention strategy for HIV, STI clinical services have been providing an important point of access to KAPs, vulnerable and general populations. The WHO standard STI, Reproductive Tract Infection (RTI) and syndromic management guidelines were adopted, translated, printed and disseminated to service providers. In addition, an STI component has been integrated into the Reproductive Health Strategy 2011-2015. STI services are also

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93 USAID, Infectious Diseases, Afghanistan, 2009
available to general population through VCT centers. However, there is very minimal staff capacity, shortage of medicines and lack of a standard unique treatment protocol.

**PMTCT:** There is currently no data available on the extent of mother-to-child transmission of HIV though a few cases were reported in 2010. However, there is alarming evidence on Afghan women’s vulnerability to HIV with respect to their reproductive health. Maternal mortality in Afghanistan is among the highest in the world and stands at 1,400 per 100,000 live births. Nearly one in three pregnant women (32 per cent) only is provided care during pregnancy by a skilled health workers and nearly 24 per cent deliver with a skilled attendant. In terms of infant feeding practices, the exclusive breast-feeding rate of children between 0 and 5 months of age is 83 per cent (Afghanistan Health Survey, MoPH and JHU, 2006) However, some progress has been noted in this area. A working group on the Prevention of Parent-to-Child Transmission (PPTCT) or PMTCT has been established and the orientation training of hospital focal points from five regional hospitals has been completed on PPTCT. Operational guidelines, monthly reporting formats and monitoring checklists have been prepared which have been drafted by the PPTCT Working Group in December 2010 with services to be initiated in 2011. In addition, one national NGO (AFGA) has integrated PPTCT services in its reproductive health programme in 10 centers across Afghanistan. In the year 2010, out of the 93,075 women the services have reached out to, 64 were provided with HIV pre-test and post-test counseling and testing services.

**VCT:** VCT centers have been established at 3 different service points across Afghanistan. The first are the stand-alone VCT centers. By 2007, the MoPH had established 6 VCT centers, including two in Kabul and one each in Jalalabad, Mazar-i-Sharif, Faizabad, and Herat. In 2008 and 2009, 5 more centers were added. The second point is the incorporation of VCT at the community level up to the level of the Comprehensive Health Centers (CHCs) under the BPHS. However data is not available on the level of integration of VCT in BPHS. The third point is the integration of VCT in all the targeted intervention programs for IDUs, sex workers, MSM and truckers. As a result, a total of 22,844 (15,063 male and 7,675 female) persons were tested for HIV from January to December 2010 and currently know their status.94

**Advocacy and Communication:** Interventions for advocacy and communication is marked by development of an HIV Communication Strategy in 2009 that outlined NACP’s approach to communicating HIV messages and increasing awareness and commitment to HIV among key stakeholders, including religious leaders, communities, mass media, and service providers.95 In 2009, advocacy TOT was conducted for NGOs working on harm reduction. As for the general population, MoPH has been launching HIV/AIDS awareness campaigns via health workers, religious leaders, and community elders in a form of short radio and TV clips and skits in 2008-2009, brochures, posters and other visuals were distributed in 8 major urban areas. Finally, the World AIDS Day had been observed nation-wide since 2003 (annually) and HIV and AIDS Media Award Program is announced since 2009.

**HIV Treatment, Care and Support of PLHIV**

**HIV Treatment:** One of the main recent achievements of the national response has been the establishment of ART and development of the Adult ART Guidelines in the country. Currently, MoPH provides HIV treatment services through two ART Centers established in 2009 in the Infectious Diseases Hospital in Kabul and in the Public Health Hospital in Herat. By December 2010, 164 PLVIH have been registered at these centers. There are a total of 114 PLHIV who are currently on ART, of whom, 110 on first line treatment, and seven are children. The main services available in the centers are ART services, treatment of Opportunistic Infections (OIs) and TB diagnosis. Currently, the ART centers also provide hemoglobin determination, full blood count with differentials as well as CD4 count.

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94 Afghanistan Universal Access, 2010)
95 For example, 60 journalists were trained on HIV and Afghanistan Media Watch have been initiated in 2000
CARE TO PLHIV: Interventions to prevent various common OIs among HIV infected individuals are available at the 2 ART centers of the country. These include that screening to detect common diseases such TB, Hepatitis, pneumonia, diarrhea and other conditions in children or adults living with HIV are available, and interventions include the provision of Cotrimoxazole for HIV registered cases in ART centers to prevent Pneumocystis Pneumonia (PCP) and Toxoplasmosis in adults and children living with HIV.

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

Strategic Information and M&E

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

M&E: With regard to the M&E of the HIV response, the NACP has taken the role of ensuring the use of standardized and unified M&E and surveillance system at the country level and in quality reporting. At the moment, the NACP is gathering HIV and AIDS data from eight provinces through provincial HIV advisors, HMIS officers and various local and international NGOs. The NACP is then analyzing and interpreting data and utilizing it for decision making, public awareness and other purposes. The WB and GFATM Round 7 are also supporting this process of keeping a standard and unified M&E system at the national level. NACP standard tools have been distributed to NGOs to be used at each service delivery point. Reports, updates and other necessary information are widely shared with all stakeholders through HACCA, CCM and HIV/AIDS quarterly reports. The Surveillance Working Group (SWG) has been established in 2007 to provide (a) technical support the development and implementation of an HIV M&E Plan (prepared in 2008) and (b) to ensure its integration with the M&E Strategy of the MoPH. The SWG was able to develop a routine...

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SWG consists of World Bank, UNODC, WHO, JHU, UNICEF, and GIZ and it assists the NACP to apply its available resources and implement the M&E Plan, organize capacity-building for the NACP, ensure adequate surveillance, and timely reporting from all service providers.
reporting format for harm reduction services, vulnerable populations and VCT. However, existing human resources for M&E are limited as the NACP includes only one M&E Consultant (national level) responsible to assist the implementation of M&E activities at national and provincial level. However, the SWG has not met since 2010

Health Systems Strengthening

**Health Systems**: Efforts have been made to strengthen health system capacity to provide better HIV services. Currently, HIV services are integrated within the BPHS and EPHS which is a significant milestone. The BPHS is implemented in districts where 85 percent of the country’s population resides. The BPHS provide services starting from the health post level. Community health workers include HIV messages in their health promotion activities in the community and referral of clients. CHCs and the district hospitals include testing and counseling for HIV and also onward referrals. The EPHS also delivers VCT although little is known on the extent and quality of their service provision. The specialized services for the prevention and treatment of HIV, including harm reduction and ART, will continue to be implemented through a more vertical program with services available in key urban centers across the country until the financial and technical capacity within the national health system is improved. Some examples of progress made includes GFATM Round 7 funding providing training for 700 health care providers of BPHS implementers in 8 provinces conducted by Action Aid. In addition, HIV guidelines were developed by the NACP to 48 NGOs implementing the BPHS in 8 provinces.

Current Financing of the National Response

Up to November 2010, it is estimated that USD 12 million had been spent on HIV response in Afghanistan in recent years. As prevention remains a top priority, to-date 46 percent of all funding was for this area, while program management and administration accounted for 22 percent. The third major cost was on research (17 percent), as it remained a priority to secure adequate evidence to mount a relevant response (Figure 1). As reflected in Table 2, key donors and development agencies that provide financial support include the GFATM, WB, bi-laterals, and the UN.
Table 2: Inventory of Funding Per Program, 2009-2011

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Funding Source</th>
<th>Amount USD MLN</th>
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98 UNGASS, 2009, *Ibid* and data from the Finance Department of the NACP, MoPH
PART TWO: NSF II RESULTS-BASED STRATEGIC FRAMEWORK

Strategic Goal
Maintain HIV prevalence less than 0.05% in general population and less than 5% among KAPs (7.1% in IDUs, 0% FSW and 0% in Truckers) and to have National HIV Response effectively sustained to reduce HIV Related Morbidity and Mortality and to improve quality of life for PLHIV by 2015.

Strategic Objectives
- Provision of preventive Services KAPs (IDUs and their partners, FSWs, MSM and Prisoners).
- Prevention services for vulnerable populations (Truckers, IDPs, R&R, and Uniformed populations).
- HIV awareness and prevention in general population through Strengthening STI management and blood screening.
- Strengthen national capacity for Universal Access to prevention, treatment, care and Support.
- Strategic information and expansion of researches, strengthen M&E and to be aligned with HMIS.
- Reduce stigma and discrimination against PLHIV and KAPs.
- Strengthen institutional capacity of NACP to lead national HIV responses, enhance coordination and strengthening multi sectoral response.

Key Priorities
The NSF-II is elaborated in continuity of the ANASF-I goal to achieve universal access to HIV prevention, treatment, care and support for key affected populations (KAPs), vulnerable populations and PLHIV. Drawing from the situation and response analysis in Part 1 of this document, key priorities for the NSF-II are defined through four priority areas:

- **Priority area 1**: increase coverage, quality, and effectiveness of HIV prevention interventions among KAPs, vulnerable populations, and general population,
- **Priority area 2**: increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families,
- **Priority area 3**: ensure availability and use of strategic information for decision-making, and
- **Priority area 4**: create supportive and enabling environment for a sustained and effective national response to HIV and AIDS.

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

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

Addressing Intersection of Risky Behaviors, including unsafe injection of drugs with unsafe sex, warrants particular attention in the NSF-II given the potential for onward HIV transmission from IDUs to their sexual partners.
Available evidence also indicates that HIV prevalence is currently 0 percent among female sex workers and is unknown among men who have sex with men, but high rates of STIs and risk behaviors exist coupled with pervasive socio-legal stigma and discrimination. Thus, investment in the development of programs will be undertaken at appropriate scale to maintain these populations free of HIV infection and improve their access to services.

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

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

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

In all above thematic areas, special attention will be given to a progressive expansion in the scope, geographical scale and the enhanced quality of services, including prevention with at-risk populations, voluntary counseling and testing, treatment and prevention of mother-to-child transmission over the next five years to ensure effective coverage of populations beginning in the key urban areas of the country, the Western provinces as well as in other selected provinces. Further expansion of services in the provinces will be guided by national IBBS rounds conducted every two years to discern emerging epidemiological patterns in a phased approach.

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

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

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

1. The need for effective and efficient implementation of current resources and increased scope and quality of HIV prevention, treatment, care and support services;

2. Involvement of KAPs, vulnerable populations and PLHIV in the design of programs and in service delivery;

3. Ensure an equity in access to services for all populations at risk and in need of services, including a focus on addressing gender differences;

Annexes 3 and 4 summarize the details of a series of discussions held to identify the gaps (Annex 3) and propose recommendations (Annex 4) for the NSF-II by the Core Team in between November 2010 and March 2011.
4. Deliver services through partnership between public and private sectors, and thereby increase efficiency and effectiveness.

5. Adopting integrated approaches that link services in a continuum from community outreach to service provision through health services.

National Strategic Results Framework

This section describes the four priority areas and expected results/outcomes and strategies necessary to achieve the objectives of the NSF-II:

**Priority area 1: increase coverage, quality, and effectiveness of HIV prevention interventions among KAPs, vulnerable populations, and general population**

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

**Priority area 2: increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families.**

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

**Priority area 3: ensure availability and use of strategic information for decision-making.**

This will be achieved by reinforcing strategic information through targeted bio-behavioral studies and surveys among KAPs, vulnerable populations, and general population. Also, assessing ongoing prevention, treatment, care, and support of PLHIV will be a source of strategic information to guide further improvements of targeted service provision. In addition, conduct population size estimation for different populations of interest will be made available during the coming 5 years. Of equal importance, to strengthen HIV surveillance system and M&E in the country through building capacity on second surveillance surveys, sentinel sites surveillance, and activation of a one M&E framework.

**Priority area 4: create supportive and enabling environment for a sustained and effective national response to HIV and AIDS.**

This will be achieved through strengthening of the enabling institutional and policy frameworks via a range of strategies, including reinforcement of the capacity of the NACP, an improved multi-sector response, resource mobilization, addressing stigma and discrimination.
**Priority area 1**: Increase coverage, quality, and effectiveness of HIV prevention interventions among KAPs, vulnerable populations, and general population.

**Objective 1**: To maintain HIV prevalence to <5% among KAPs by 2015

**Outcome 1.1**: Reduced HIV risk behaviors among IDUs including prisoners by 50% from the base line

**Output 1.1.1**: Scaled-up comprehensive prevention services for IDUs

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

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

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

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

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

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

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

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

- Implementation of service delivery will be designed and undertaken through community-based outreach (including peer driven approaches) and include increased access to VCT linked with referral to ART for IDUs and partners, as well as STI services
Targeted IEC materials for IDUs and their sexual partners, coupled with condom distribution and referral to STI services, will be improved, using multiple channels of communications. As condom distribution remains a highly sensitive matter in the country, it will be made available through outreach, peer-educators and social networks facilitated by NGOs working with IDUs.

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

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

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

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

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

Output 1.1.2: Scaled-up comprehensive harm reduction interventions targeting prisoners

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

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

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

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

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

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

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

Prevention services should be integrated with the primary health care provided in prisons, and delivered through a network of peer educators essential to BCC and provision of referrals.
Outcome 1.2: Reduced HIV risk behaviors among FSWs and MSM by 50% from the baseline.

Output 1.2.1: Scaled-up focused HIV and STI prevention programs for FSWs.

Output 1.2.2: HIV and STI prevention interventions targeting MSM are in place.

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

Strategic Directions: Thus, the priority focus of the NSF-II for these two populations will be on HIV prevention in the main urban areas aiming to:

- Further map and assess these populations’ risks behaviors and HIV epidemiology; and
- Expand implementation and coverage of prevention programs adapted to the context of Afghanistan.

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

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

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

Objective 2: To decrease HIV risk factors among vulnerable populations by 2015

Outcome 2.1: Increased safe behavior among vulnerable populations by 50% from the baseline.
**Output 2.1.1: Prevention services reinforced targeting vulnerable populations - truckers, IDPs, refugees and returnees, and uniformed services personnel**

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

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

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

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

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

- **Integrate HIV prevention into humanitarian assistance for IDPs, refugees and returnees.**

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

**Objective 3: To reduce risk of HIV transmission among general population by 2015**

**Outcome 3.1: Increased access to quality HIV prevention services among general population**

**Output 3.1.1: Increased HIV awareness among general population**

A combination of high rates of illiteracy, limited access to information particularly among women and young people, isolation of certain regions and other pressing daily concerns, account for what is believed to be very low levels of awareness of the general population on HIV and AIDS in the absence of general population surveys. Limited visibility and stigma related to the very nature of transmission of HIV increases stigma to the HIV and hampers the implementation of targeted prevention programs to most at risk and vulnerable populations.
Strategic Directions: To this effect, through diverse communication and service-delivery channels, the NSF-II will pursue a focused effort to increase awareness among the general population and reduce stigma through the following:

- Effective prevention messages and adapted material developed and delivered through collaboration with mass and local media, health community workers, community and religious leadership. These will be specific to the varying needs of the general population and their level of education, gender, ethnic background and occupation – including for women, the illiterate, out-of-school youths, ethnic minorities, etc.

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

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

Output 3.1.2: Strengthened STI management

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

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

- Make available STI guidelines for effective management in health clinics.

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

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

- Develop and implement effective procurement and supply chain management systems for STI drugs.

- Develop STI surveillance.

Output 3.1.3: Universal screening of blood achieved

This strategy aims to ensure universal screening for all blood units for HIV and other transfusion-transmissible infections in order to meet needs. Only recently, efforts have been stepped up to ensure that all Blood Units undergo systematic screening for HIV in the country. There is, however, a need to monitor that universal screening actually does take place, including by ensuring the availability of screening equipment and trained personnel at provincial, district and community levels.

Strategic Directions:

- National Blood Safety Policy will be established to regulate the steps and procedures of universal screening on an annual basis, ensure supervision of central and regional blood banks. As an interim step, provisions will be made to ensure coverage in all urban areas.
National Blood Safety Unit will be established at the MoPH to implement the ‘National Blood Safety Policy’
Increase the number of Blood Banks in the country with attention paid to border areas and strengthen their capacity (training of staff and provision of equipment) to screen blood and blood products to ensure 100% blood safe

**Output 3.1.4: Universal precautions are implemented in 100% of health facilities.**

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

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

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

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

**Priority area 2: Increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families.**

**Objective 1: To improve quality of life of PLHIV by 2015**

**Outcome 2.1: Lives of PLHIV improved through access to health care and support**

**Output 2.1.1: strengthened national capacity for provision of universal access to treatment for PLHIV**

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

**Strategic Directions:**

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

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

**Output 2.1.2: the number of PLHIV on ART increased from 70 to around 1,000**

Presently, there are 636 PLHIV in Afghanistan. However, only 70 persons are receiving ART available at the two sites. It is important to scale up coverage of ART that it becomes available to all PLHIV that meet the clinical criteria for treatment. Some of the challenges of doing so may be the low level of VCT available
Strategic Directions:

- Prioritize ART sites expansion to selected new sites.
- Provide existing and new ART sites with adequate human resources, equipment and supplies.
- Integrate referral to ART services within BPHS, EPHS and TB services.
- Develop and implement a communication strategy for expanded ART, and establishment of a referral system between VCT, outreach and drop-in centers, as well as private health care services.
- Strengthen HIV-TB Collaborative activities.
- Improve supply chain protocols and procedures for better access and continuous availability of ARVs and OIs drugs.
- Improve linkages between HIV and Management of STIs, Hepatitis B and C, including provision of vaccines for PLHIV.

Output 2.1.3: ART services are provided in a quality assured manner to all PLHIV in need to treatment

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

Strategic Directions:

- Finalize and make available guidelines on clinical management, treatment, care and support for PLHIV to relevant health services.
- Establish an implement ART Quality Assurance System.
- Strengthen the national capacity and site-specific capacity of ART programs to provide quality services.
- Establish ART Working Group (AR-WG).

Outcome 2.2: Care and support for PLHIV are provided in a quality assured manner

Output 2.1.1: Effective community and home-based care interventions for PLHIV and their families are developed
Currently, there is no care and support system available for PLHIV and their families in Afghanistan. The NSF-II will support development of strategies that will establish an effective and a comprehensive system of care and support for PLHIV and their families. This will include providing access to psycho-social counseling, early detection and treatment of OIs and TB, as well as nutritional and food support. Protocols of home-based care and community-based care (CBC) will be developed and approved by 2012. PLHIV will be encouraged to establish support groups and national and local networks to enhance their empowerment. NGOs will be selected and trained in the provision of HBC and CBC.

**Strategic Directions:**

- Scale-up referral and early detection and treatment of OIs for PLHIV.
- Scale-up early detection of TB among PLHIV under chronic care and treatment.
- Integrate nutrition and food support into ART and PMTCT guidelines and NGO-based Community and Home-based Care.
- Provide nutritional and food Supplements through ART and PMTCT sites as well as NGOs.
- Establish PLHIV Support Groups and Associations facilitated by NGOs.

**Output 2.1.2: support income generating opportunities for PLHIV are in place from 2012 onwards**

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

**Strategic Directions:**

- Improve vocational and entrepreneurial skills for PLHIV and those affected.
- Support PLHIV to establish income-generating projects.

**Priority area 3: Create supportive and enabling environment for a sustained and effective national response to HIV and AIDS by 2015.**

- Objective 1: To reduce stigma and eliminate discrimination associated with PLHIV by 2015

**Strategic Directions:**

- Development of policy and legal measures that promote the provision of Universal Access to HIV Services of PLHIV and KAPs, including formulation of an Act to counter stigmatization and discrimination.
- Facilitation of greater Involvement of PLHIV and KAPs in program design and implementation
- Finalize the HIV Advocacy and Communication Strategy to accompany the implementation of NSF-II.
Expand sensitization of policy makers, community and religious Leaders, health care professionals, Journalists, educators, police, and the Judiciary.

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

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

Outcome 3.1: Enabling Institutional and policy frameworks in place

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

Output 3.1.1: Strengthened institutional capacity of NACP to lead national HIV response

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

**Strategic Directions:**

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

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

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

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

Output 3.1.2: Strengthened capacity of coordinated multi-sectoral HIV response

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

**Strategic Directions:**

- Renewing agreement with key ministries on their thematic areas of contribution and on policy and technical-level representation in HACCA.
Strengthening political commitment to AIDS across sectors for a sustainable national HIV Response, through an ‘Advocacy Communication Campaign’ launched at central, provincial and community levels, including on the annual occasion of World AIDS Day and other events.

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

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

Output 3.1.3: Resources for HIV response implementation sustained

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

Strategic Directions:

- Conducting a financial gap analysis of the HIV response;
- Ensure that external and internal funding is increased and allocated to the priorities of the NSF;
- Improved routine assessment of the disbursement of funds per individual programs

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

Priority area 4: Ensure availability and use of strategic information for decision-making.

Objective 1: to generate reliable evidence to support HIV decision-making by 2015.

Outcome 4.1: HIV strategic information and operations research expanded

Output 4.1.1: research capacity reinforced and evidence on HIV interventions available

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

- Strengthening capacities of NACP and local researchers for generating and disseminating strategic information and operations research.
- Establishing clearer mechanisms of collaboration between international research groups and the NACP.
- Needs assessment for expansion of OST and other services undertaken across the country, especially in the Western Provinces of Herat, Nimroz and Farah.
- Strengthening national 2nd Generation Surveillance (SGS) via expansion of surveillance of all KAPs and selected vulnerable groups.
- Mapping and size estimation studies of KAPs and vulnerable groups, and developing national estimations on number of PLHIV, mortality rates and number in need of treatment.
- Conducting an assessment of effectiveness of 1st line HAART in Afghanistan.
- Conducting policy assessments among policy makers.
- Qualitative situation assessments of risks and vulnerability undertaken in new geographic locations.
- Through national M&E framework, establishing mechanisms of dissemination of findings of studies to policy makers and Implementers.

Output 4.1.2: M&E system strengthened and aligned with HMIS

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

Strategic Directions:

- Finalize M&E Plan for 2011-2015 to align programme Indicators with UNGASS and National Health Indicators.
- Enhance capacity of Implementing Partners (NGOs) on M&E.
- Improve mechanisms of information dissemination at central, provincial and community Levels via an information dissemination plan.
- Integrate HIV data collection, analysis and dissemination into the overall HMIS.
NSF II Risks and Mitigation

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

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

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

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

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

Mitigating measures to address the above-mentioned risks are largely already encompassed within the NSF-II strategies. Notwithstanding that some of the risks are ‘external’ environmental ones (e.g. overall security and within specific provinces), the following mitigation measures can be highlighted:

- Decentralizing and reinforcing staffing and capacity of the AIDS program and services at provincial level in the priority areas to ensure continuous reach of the communities in need;

- Maintaining a targeted and sustained ‘Evidence-based Advocacy and Communication Strategy’ through the NSF-II with key sectors such as Public Health, Counter Narcotics, Prison Authorities, Interior, Police, Haj and Religious Affairs, to influence critical policy decisions;
Developing adapted local models and, at times, ‘indirect’ approaches to HIV prevention service-provision to at-risk groups, in particular for sex work and men who have sex with men;

Reinforcing capacity and the number of implementing public and private sector partners;

Pursuing the existing policy of integration of certain HIV/AIDS services within primary health care service provision;

Rolling-out a ‘Resource Mobilization Strategy’ with continued emphasis on demonstrating results and allocative efficiency, where the majority of resources are invested in programs that will have the largest impact on HIV epidemic, i.e programs for IDUs and partners, and proposal formulation for the Global Fund, WB and other donors;

Implement a mid-term review to measure progress towards the outputs and outcomes and make the necessary adjustments; and

Placing priority emphasis on generating additional strategic evidence and on an improved M&E.

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

NSF II implementation will include a number of steps and functions that would allow: (a) overall supervision, coordination and strategic oversight; (b) daily management and operational planning; (c) activities that will be designed and guided by Program Operational Plan (POP), (d) financial management, and (e) M&E.

Oversight and Supervision of NSF II Implementation

The primary implementing role for the NSF II will be given to the NACP that will include strategic leadership and oversight. In particular, the NACP role will include central and provincial level oversight and supervision as presented below.

At the central level:
NACP will have the overall responsibility for oversight and supervision. The NACP Director will have responsibility for the NSF II implementation and will be the focal point for coordination of NSF related activities. The HIV/AIDS Coordinating Committee for Afghanistan (HACCA) will provide assistance to the NACP for the effective implementation of the HIV/AIDS interventions within the framework of the NSF II. Chaired by the Deputy Minister for Technical Affairs of the MoPH, and represented by a wide range of local and international stakeholders, HACCA remain to serve as a broad-based and effective mechanism of technical oversight to NACP. HACCA would ensure involvement of representatives of all provinces by facilitating information and knowledge sharing, coordination and partnership among all stakeholders. HACCA will provide inputs to the NACP by reviewing the NSF II implementation on a routine basis (semi-annually and annually), providing assistance for the formulation of a national HIV/AIDS policy, facilitate resource mobilization and alignment, foster HIV/AIDS advocacy within the government’s structures, as well as among development partners and the donor community.

At the provincial level:
NACP regional coordinators (8 persons) and provincial officers (27 persons) will be responsible for ensuring coordination and monitoring of the specific Program activities.

Responsibilities of Implementing Agencies and Partners

Multi-Sectoral Responsibilities
A number of line ministries will participate in the implementation of the NSF II that will be formulated in a Program Operational Plan (POP) such as MoCN, Ministry of Hajj and Religious Affairs (MoHRA), Ministry of Interior (MoI), and Ministry of Justice (MoJ) – as key implementing partners. Other ministries such as Ministry of Defense, Ministry of Women Affairs (MoWA), Ministry of Social and Labor Affairs (MoSLA), Ministry of Returnees and Refugees (MoRR), MoE, and Ministry of Higher Education (MoHE), Ministry of Finance (MoF), Ministry of Information, Culture and Youth Affairs (MoICYA) will participated as participating partners. Several departments of the MoPH will also participate in the implementation of the NSF II, including: Department of Drug Demand Reduction, Department of Information, Education and Communication, Department of Reproductive Health, Department of Youth Health, Grant Contract Management Unit, and M&E Department.

Other participating agencies
The roles and responsibilities of each of the participating ministries and departments will be defined according to agreements to be reached between the NACP/MoPH and those ministries and formulated in respective memorandums of understanding (MoUs). The scope of work for each ministry and/or
department will be determined according to proposals prepared by each of the ministries, submitted to the NACP/MoPH and approved by the MoPH.

While a number of policy and institutional enabling activities will be implemented for the public sector, local and international NGOs, community-based and religious organizations will participate in the implementation of the activities proposed under the NSF II as sub-contractors, according to Terms of Reference defined for each of the activities. MoPH has a good track record of implementing interventions through NGOs working through BHPS and EBHS. Consequently, the NACP/MoPH will initiate a competitive selection process (call for proposals) that will include review of (a) technical and financial proposals of candidates; and (b) relevance of their qualifications. The contract will be awarded to those candidates whose technical and financial proposals will meet the criteria set by the NACP.

**Public-private partnership**

Through coordination and collaboration, this strategy will ensure that the private sector’s role in HIV response is strengthened in terms of capacity and technical aspects. Private sector should be updated with the HIV testing algorithm as well as their input in the HIV reporting system should be established.

**Role of KAPS, vulnerable populations, and PLHIV**

As key beneficiaries of HIV response, KAPS, PLHIV should be involved in developing, designing, and provision of HIV services, as well as in advocacy and communication part of HIV response.

**Financial Management**

The NSF II financial management will be led by the NACP in collaboration with the Department of Finance of the MoPH. Financial reporting to NSF II donors will be coordinated and managed by the NACP Finance Team according to annual procurement plans drafted per donor and GoA regulations to support contract management and procurement. NSF II will be audited internally and externally according to the requirements of the donors and the GoA.
PART FOUR: M&E FRAMEWORK

The NSF II will seek to reinforce the overall national M&E capacity and framework, and further align the latter with the HMIS of the MoPH. Following the reinforcement of the M&E team in the NACP in 2011, the national M&E framework on AIDS will be made operational. At the same time, M&E undertaken by participating ministries and implementing partners (NGOs) on HIV response, will also be aligned within this broader framework.

The Results Framework of the NSF II will guide data collection with the frequency of surveys to measure progress on outcomes carried out around every 2-3 years and the review of program data to monitor the delivery of outputs on annual basis. The mid-term review of the entire results framework and the progress made on indicators will lead to necessary adjustments to the chain of results and targets set. At the conclusion of five years of implementation, a final comprehensive review will be undertaken of the entire Results Framework.

The key data collection instruments to be drawn on for M&E, includes: IBBS; specific KABP; surveys and records from health care settings; review of program, financial and disbursement records; the Demographic Health Survey (DHS) or other comparable instruments administered in the general population; and data from the HMIS of the MoPH. UNGASS indicators are included into the framework to provide measures on globally adopted indicators.

Table 3 below gives an example of some outcome indicators according to each priority area described before. A full list of program indicators at different levels will be detailed in the PoP of this strategy.
### Table 3: Example of outcome indicators for each priority area

<table>
<thead>
<tr>
<th>Priority area 1: Increase coverage, quality, and effectiveness of HIV prevention interventions among KAPs, vulnerable populations, and general population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1:</strong> To maintain HIV prevalence to &lt;5% among KAPs by 2015</td>
</tr>
<tr>
<td><strong>Outcome 1.1:</strong> Reduced HIV risk behaviors among IDUs including prisoners by 50% from the baseline</td>
</tr>
<tr>
<td>Indicator 1.1.1: % of IDU who report using sterile injecting equipment the last time they injected [disaggregated by age, sex and location]</td>
</tr>
<tr>
<td>Indicator 1.1.2: % of IDU who reported the use of a condom at last sexual intercourse</td>
</tr>
<tr>
<td>Indicator 1.1.3: % of IDUs who both correctly identify ways of preventing sexual transmission and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td><strong>Outcome 1.2:</strong> Reduced HIV risk behaviors among FSWs and MSM by 50% from the baseline.</td>
</tr>
<tr>
<td>Indicator 2.1.1: % of FSWs reporting the use of a condom with their most recent client</td>
</tr>
<tr>
<td>Indicator 2.1.2: % of FSW who both correctly identify ways of preventing sexual transmission and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>Indicator 2.1.3: % of MSM who both correctly identify ways of preventing sexual transmission and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>Indicator 2.1.4: % of MSM reporting the use of condoms in anal sex</td>
</tr>
<tr>
<td>Indicator 2.1.5: % of Prisoners who both correctly identify ways of preventing sexual transmission and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td><strong>Objective 2:</strong> To decrease HIV risk factors among vulnerable populations by 2015</td>
</tr>
<tr>
<td><strong>Outcome 2.1:</strong> Increased safe behavior among vulnerable populations by 50% from the baseline.</td>
</tr>
<tr>
<td>Indicator 2.1.1: % of Truck Drivers reporting condom use in their last sexual contact</td>
</tr>
<tr>
<td>Indicator 2.1.2: % of Law Enforcement personnel [Police/Military] who both correctly identify ways of preventing sexual transmission and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td>Indicator 2.1.3: % of young women and men aged 15–24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
</tr>
<tr>
<td><strong>Objective 3:</strong> To reduce risk of HIV transmission among general population by 2015</td>
</tr>
<tr>
<td><strong>Outcome 3.1:</strong> Increased access to quality HIV prevention services among general population</td>
</tr>
<tr>
<td>Indicator 3.1.1: % of young women and men aged 15–24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
</tr>
</tbody>
</table>
Priority area 2: Increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families.

<table>
<thead>
<tr>
<th>Objective 1: To improve quality of life of PLHIV by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2.1: Lives of PLHIV improved through access to health care and support</td>
</tr>
<tr>
<td>Indicator 2.1.1: % of eligible adults and children currently receiving antiretroviral therapy</td>
</tr>
<tr>
<td>Outcome 2.2: Care and support for PLHIV are provided in a quality assured manner</td>
</tr>
<tr>
<td>Indicator 2.2.1: Number of Support Groups for PLHIV and Key Affected Populations in place</td>
</tr>
<tr>
<td>Indicator 2.2.2: Number of PLHIV and their families sensitized about their rights</td>
</tr>
</tbody>
</table>

Priority area 3: Create supportive and enabling environment for a sustained and effective national response to HIV and AIDS by 2015

<table>
<thead>
<tr>
<th>Objective 1: To reduce stigma and eliminate discrimination associated with PLHIV by 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 3.1: Enabling Institutional and policy frameworks in place</td>
</tr>
<tr>
<td>Indicator 3.1.1: Coordination Capacity of NACP reinforced at national and provincial levels</td>
</tr>
</tbody>
</table>

Priority area 4: Ensure availability and use of strategic information for decision-making.

<table>
<thead>
<tr>
<th>Objective 1: to generate reliable evidence to support HIV decision-making by 2015.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 4.1: HIV strategic information and operations research expanded</td>
</tr>
<tr>
<td>Indicator 4.1.1: Evidence-informed HIV programs in place</td>
</tr>
</tbody>
</table>
PART FIVE: NSF II INDICATIVE COST

The costing of the NSF II has been carried out to estimate the indicative cost of NSF II implementation for the next 5 years – 2011-2015 based on the financial cycle of the GoA. It was based on basic aggregation of costing data available from (a) AHAPP, (b) GFMAT, and partially 2007 POP. This included program and activities costs of all existing contracts with the NACP. The data has been reviewed, compared and utilized to estimate merely indicative costs of each strategic area formulated within this NSF II.

It was agreed that a detailed costing of the NSF II will be conducted at a later stage (Aug-Sept 2011) as a part of the preparation of the next Program Operational Plan (PO), as well as Round 11 GFMAT Proposal (also Aug 2011). Annex 1 presents suggested formats for the detailed costing.

As a result, the total resource required for the HIV interventions outlined by the NSF II is in a range of 30,540,000 USD (see table 4 below).
### TABLE 4: INDICATIVE COST OF AFGHANISTAN NSF II 2011-2015 (5 years) – In USD

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>37,124,450</td>
<td>12,000,000</td>
<td>939,453</td>
<td>31,860,000</td>
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</tr>
<tr>
<td><strong>STRATEGIC INFORMATION &amp; OPERATIONS RESEARCH</strong></td>
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<td></td>
</tr>
<tr>
<td>Sero-Biological Surveillance</td>
<td>3,000,000</td>
<td>3,015,212</td>
<td>1 IBBS + 3 size estimation studies</td>
<td>5,500,000</td>
<td></td>
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<tr>
<td>Behavioral, Mapping, Needs Assessments - KABPs</td>
<td>500,000</td>
<td>3,015,212</td>
<td>5 KABP studies</td>
<td>1,000,000</td>
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</tr>
<tr>
<td><strong>sub-total</strong></td>
<td>3,500,000</td>
<td>3,015,212</td>
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<td>6,500,000</td>
<td></td>
</tr>
<tr>
<td><strong>ADVOCACY &amp; POLICY DEVELOPMENT</strong></td>
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<td></td>
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</tr>
<tr>
<td>Raising HIV/AIDS Awareness at the Top Political, Religious and Military Leadership</td>
<td>500,000</td>
<td></td>
<td></td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Assistance of the HACCA</td>
<td>1,000,000</td>
<td></td>
<td></td>
<td>1,000,000</td>
<td></td>
</tr>
<tr>
<td>Developing of Key Policy Documents</td>
<td>200,000</td>
<td>10,000</td>
<td></td>
<td>200,000</td>
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<tr>
<td><strong>sub-total</strong></td>
<td>1,700,000</td>
<td>1,063,200</td>
<td></td>
<td>1,300,000</td>
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</tr>
<tr>
<td><strong>INSTITUTIONAL &amp; POLICY STRENGTHENING</strong></td>
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</tr>
<tr>
<td>Institutional Capacity Building - NACP</td>
<td>1,700,000</td>
<td>699,494</td>
<td>4 key ministries MoCN, MoI, MoJ, MoHRA</td>
<td>800,000</td>
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</tr>
<tr>
<td>Strengthening Institutional Capacity of Public, Private Sector, Civil Society via HIV Mainstreaming</td>
<td>800,000</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>sub-total</strong></td>
<td>2,500,000</td>
<td>699,494</td>
<td></td>
<td>2,800,000</td>
<td></td>
</tr>
<tr>
<td><strong>BLOOD SAFETY</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Blood Banks</td>
<td>10,000,000</td>
<td>60,000</td>
<td></td>
<td>240,000</td>
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</tr>
<tr>
<td>Raising Public Awareness on Blood Safety, Infection Prevention</td>
<td>100,000</td>
<td></td>
<td></td>
<td>100,000</td>
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<tr>
<td>Building National Clinical Expertise on HIV/AIDS/STI</td>
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<td></td>
<td></td>
<td>200,000</td>
<td></td>
</tr>
<tr>
<td>Development and Expansion of National Capacity for Quality HIV Testing</td>
<td>800,000</td>
<td></td>
<td></td>
<td>800,000</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS/STI and TB Joint Interventions</td>
<td>3,500,000</td>
<td></td>
<td></td>
<td>3,500,000</td>
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</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td></td>
<td></td>
<td>4,840,000</td>
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</tr>
<tr>
<td><strong>PREVENTION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Key affected populations (KAPs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IDUs and their Partners</td>
<td>4,560,000</td>
<td>5,196,000</td>
<td>1,000 IDUs</td>
<td>6,500,000</td>
<td></td>
</tr>
<tr>
<td>FSWs and their Clients</td>
<td>2,800,000</td>
<td>427,162</td>
<td></td>
<td>800,000</td>
<td></td>
</tr>
<tr>
<td>MSM and their Clients</td>
<td>2,800,000</td>
<td></td>
<td></td>
<td>800,000</td>
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</tr>
<tr>
<td>Prisoners</td>
<td>3,000,000</td>
<td>429,986</td>
<td></td>
<td>800,000</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td></td>
<td></td>
<td>8,900,000</td>
<td></td>
</tr>
<tr>
<td><strong>Vulnerable Populations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Long-Distance Truck Drivers</td>
<td>200,000</td>
<td>496,078</td>
<td></td>
<td>800,000</td>
<td></td>
</tr>
<tr>
<td>IDPs, Refugees, Returnees</td>
<td>200,000</td>
<td></td>
<td></td>
<td>200,000</td>
<td></td>
</tr>
<tr>
<td>Uniformed Personnel (Police and Military)</td>
<td>200,000</td>
<td>71,249</td>
<td></td>
<td>100,000</td>
<td></td>
</tr>
<tr>
<td>Migrant Workers</td>
<td>200,000</td>
<td></td>
<td></td>
<td>200,000</td>
<td></td>
</tr>
<tr>
<td>Youth and Street Children</td>
<td>200,000</td>
<td></td>
<td></td>
<td>200,000</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
<td></td>
<td></td>
<td>1,500,000</td>
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</tr>
<tr>
<td><strong>General Population</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV AWARENESS - communities, religious leadership</td>
<td>200,000</td>
<td></td>
<td></td>
<td>200,000</td>
<td></td>
</tr>
<tr>
<td><strong>ANTI-STIGMA &amp; DISCRIMINATION</strong> – communities, religious leadership</td>
<td>100,000</td>
<td></td>
<td>100,000</td>
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<tr>
<td><strong>ANTI-STIGMA &amp; DISCRIMINATION</strong> – private sector, civil society</td>
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<td><strong>Sub-total</strong></td>
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<td><strong>STI MANAGEMENT</strong></td>
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<tr>
<td><strong>TB-HIV</strong></td>
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<td><strong>HIV-HB,HC</strong></td>
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<td><strong>ART Management</strong></td>
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<td><strong>Support to PLHIV</strong></td>
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