



ISLAMIC REPUBLIC OF AFGHANISTAN



Country Progress Report 2014

AFGHANISTAN

National AIDS Control Program (NACP)

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List of Abbreviation

AHAPP	Afghanistan HIV Prevention Project
AIDS	Acquired Immuno Deficiency Syndrome
BBD	Blood Borne Diseases
BPHS	Basic Package of Health Service
CI	Confidential Interval
DDR	Drug Demand Reduction
EPHS	Essential Package of Health Service
FSW	Female Sex Worker
GA	Government of Afghanistan
GF	Global Fund
HIV	Human Immuno-deficiency Virus
HACCA	HIV and AIDS Coordinating Committee of Afghanistan
HLM	High Level Meeting
HMIS	Health Management Information System
IBBS	Integrated Biological Behavioral Survey
KAP	Key Affected Population
MSM	Men who have Sex with Men
MoCN	Ministry of Counter Narcotic
MoPH	Ministry of Public Health
NACP	National AIDS Control Program
NCPI	National Commitment and Policy Instrument
NSP	Needle and Syringe Program
OST	Opioid Substitution Therapy
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People who Inject Drugs
SEHAT	System Enhancement for Health Action in Transition
SHARP	Strengthening Health Activities for the Rural Poor
TFM	Transition Funding Mechanism
UN	United Nations
UNAIDS	Joint United Nation Program on HIV and AIDS
UNFPA	United Nation Population's Fund
UNICEF	United Nation Children's Fund
UNODC	United Nation Office on Drugs and Crime
WHO	World Health Organization



Islamic Republic of Afghanistan

Ministry of Public Health

March 31st, 2014

Foreword

The Ministry of Public Health of Islamic Republic of Afghanistan is happy to submit its third Global AIDS Response Progress Report (GARPR) on HIV and AIDS to add to the richness of global strategic information and response to HIV and AIDS.

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

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

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

Despite being young program, Afghanistan National AIDS Control Program has had good progress, especially, in the past few years. However, this program is yet to tackle many issues associated with effective implementation of the HIV services in the country.

Afghanistan Ministry of Public Health is strongly committed to delivering the health services in the country according to national standards and international best practices.

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

Sincerely,

Dr. Ahmad Jan Naeem

Deputy Minister, Ministry of Public Health, Kabul Afghanistan

I. Status at a Glance

A. Report Writing Process

Afghanistan reporting process was initiated in the late February. The first preparation meeting conducted on 25th of February 2014 in which all the stakeholders including line ministries, UN families, bilateral colleagues, civil society organization and National AIDS Control Program (NACP) implementers participated. At the meeting all the indicators were reviewed and all participants agreed upon the relevant indicators to report on, the timeline and process of data collection, analysis, validation and report-writing.

A consultant was hired for NCPI part with the support of UNAIDS, to conduct desk review and interview, analysis of the data and prepared a report on NCPI. NACP committed to collect the data and prepare the narrative report. The key informants were nominated through technical working group created for this purpose. A validation workshop took place on March 25th separately for parts A and B by which all the data on NCPI was validated

The second validation workshop took place on the March 30th where all the data and final draft of the narrative report were validated to be submitted in the system. The data entry process was started in the middle of March.

B. The Status of the Epidemic

HIV epidemic in Afghanistan is determined to be low and associated with injection drug use. Integrated Biological Behavioral Survey (IBBS) 2012, found HIV prevalence among PWID as average 4.4% (95% CI: 3.3-5.8) in 5 cities with the range from 0.3% in Mazar to 13.3% in Hirat provinces. The survey also revealed HIV prevalence among other key population such as 0.4% among MSM and 0.3% among FSW.

The survey also conducted among prisoners in Kabul and Hirat and Road Transport Workers (RTW) in one border site between Afghanistan and Pakistan where most of the transitions are taking place. HIV prevalence among prisoner in both cities is found 0.7% (95% CI: 0.2-1.6) and 0% among RTW.

C. The Policy and Programmatic Response

The Government of Afghanistan (GoA) with the support of partners has developed several policies and guidelines to date. One of the important achievements during the reporting period is the revision of Harm reduction guideline based on the new strategy of harm reduction developed by Drug Demand Reduction (DDR) department in MoCN. This guideline will intend to assist in the implementation of a comprehensive package of services especially OST implementation and scaling up to other provinces. The guideline is presented to the drug regulation committee in the MoCN and waiting for high commission consist of 9 deputy ministers' approval.

Two other ART and PMTCT guidelines are in the process of revision based on the new recommendations of WHO and UNICEF. The cutting point of CD4 from 350 will be increased to 500 as well as the co-infections and pregnancy will be included in the ART guideline. The option B+ will be incorporate in PMTCT guideline. Both of the guidelines will facilitate target 4 (reaching 15 million people living with HIV with ARV).

Strategic interventions in the area of HIV prevention have been reinforced since 2006-2007 and focused on: (a) key affected populations (PWID, FSWs and MSM), (b) vulnerable populations (migrant workers, police and the military) and (c) the general population, implemented with assistance from 10 international and national NGOs or implementing partners (IPs) which financed through the Global Fund (Round 7 and Transition Funding Mechanism (TFM)), the World Bank (Afghanistan HIV Prevention Project (AHAPP), Strengthening Health Activities for the Rural Poor (SHARP) and System Enhancement for Health Action in Transition (SEHAT)), and partially, through UN agencies (UNODC, UNAIDS, WHO, UNICEF, UNFPA, etc.) across nine provinces of the country – Kabul, Herat, Mazar-e-Sharif, Ghazni, Badakhshan, Kunduz, Kandahar, Jalalabad and Parwan.

However, coverage of harm reduction and, in particular, of Needle Syringe Programs (NSP) remains low (30% of total PWIDs estimated by UNODC in 2012) and insufficient to have an impact on the epidemic. UNODC, WHO and UNAIDS guidelines recommend that 60% coverage of NSP is required to prevent further epidemic spread. Similarly, the geographical coverage of existing programs is limited to eight provinces and needs to be progressively expanded.

Harm and risk reduction activities for prisoners target primarily those who inject drugs in eight provinces: Kabul, Herat, Ghazni, Kandahar, Balkh, Kunduz, Nangarhar, and Badakhshan under the World Bank and GFATM supported nationally implemented projects. In addition, UNODC is supporting interventions for female prisoners in Kabul, Herat, Balkh, Nangarhar, and Parwan. However, the harm reduction response in prisons remains limited in scope as NSP and OST are not yet permitted in prison settings despite the on-going policy dialogue.

D. Indicator data

Population	Indicator		GARPR 2012	GARPR 2014	Source
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015					
General Population	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Not relevant	The indicator is relevant but data is not available	
	1.2	Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	Not relevant	20-24 year=17%, 15-19 year=6%	NAVA 2011-12
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in last 12 months	Not relevant	Relevant but data is not available	
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	Not relevant	Relevant but data is not available	
	1.5	Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results	Not relevant	Relevant but data is not available	
	1.6	Percentage of young people aged 15–24 who are living with HIV	Relevant but data is not available	Not relevant (Generalized Epidemic)	
Sex Worker	1.7	Percentage of sex workers reached with HIV prevention programs	All FSW=6.3% <25years=5.2% 25year above=7.0%	All FSW=14.44% <25=13.64% 25+=14.89%	IBBS 2012
	1.8	Percentage of sex workers reporting the use of a condom with their most Recent client	All FSW=58.0% <25years=60.0% 25year above=56.0%	All FSW=51.5% <25years=52.9% 25year above=50.6%	IBBS 2012

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	1.9	Percentage of sex workers who have received an HIV test in the past 12 Months and know their results	All FSW=4% <25years=4% 25year above=4%	All FSW=54% <25years=53.3% 25year above=54.2%	IBBS 2012
	1.10	Percentage of sex workers who are living with HIV	The indicator is relevant but data is not available	All FSW=0.3% <25years=0.3% 25year above=0.3%	IBBS 2012
MSM	1.11	Percentage of men who have sex with men reached with HIV prevention programs	The indicator is relevant but data is not available	All=6.76% <25years=7.0% 25year above=6.54%	IBBS 2012
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partners	The indicator is relevant but data is not available	All=17.4% <25years=17.0% 25year above=17.8%	IBBS 2012
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	The indicator is relevant but data is not available	All=73.47% <25years=72.73% 25year above=74.07%	IBBS 2012
	1.14	Percentage of men who have sex with men who are living with HIV	The indicator is relevant but data is not available	All=0.48% <25years=0.0% 25year above=0.93%	IBBS 2012
Testing Service	1.16	HIV testing and counseling in women and men aged 15 and older	New indicator	All test 15+ =266534 Positive=137	IBBS 2012
Sexual Transmitted Infections/Diseases	1.17.1	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis	New indicator	The indicator is relevant but data is not available	
	1.17.2	Percentage of antenatal care attendees who were positive for syphilis	New indicator	The indicator is relevant but data is not available	
	1.17.3	Percentage of antenatal care attendees positive for syphilis who received treatment	New indicator	The indicator is relevant but data is not available	
	1.17.4	Percentage of sex workers with active syphilis	New indicator	FSW=1%	IBBS 2012
	1.17.5	Percentage of men who have sex with men with active syphilis	New indicator	MSM=10%	IBBS 2012
	1.17.6	number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	New indicator	59757	Routine data
	1.17.7	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	New indicator	The indicator is relevant but data is not available	
	1.17.8	Number of men reported with gonorrhoea in the past 12 months	New indicator	The indicator is relevant but data is not available	
	1.17.9	Number of men reported with urethral discharge in the past 12 months	New indicator	The indicator is relevant but data is not available	
	1.17.10	Number of adults reported with genital ulcer disease in the past 12 months	New indicator	The indicator is relevant but data is not available	
Target 2: Reduce transmission of HIV among people who inject drug by 2015					
PWIDs	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	80 syringe per PWID per year	92.2 syringe per PWID per year	Routine data
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	All PWID=35.0% <25years=42.59% 25year above=32.79%	PWID=23.37%	IBBS 2012

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	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	All PWID=94% <25years=94% 25year above=94%	All PWID=78.16% <25years=64.26% 25year above=83.73%	IBBS 2012
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	All PWID=22% <25years=25% 25year above=22%	All PWID=78.9% <25years=78.5% 25year above=79.1%	IBBS 2012
	2.5	Percentage of people who inject drugs who are living with HIV	All PWID=7.1% <25years=7.64% 25year above=6.95%	All PWID=4.4% <25years=2.7% 25year above=5.1%	IBBS 2012
	2.6	Estimated number of opiate users (Injecting and non-injectors)	New indicator	940,000 persons 15-65 years of age	Drug Survey 2009
	2.7	Percentage of people who inject drugs who are living with HIV	New indicator	35	Routine data
Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths					
PMTCT	3.1.	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother to child transmission	The indicator is relevant but data is not available	7.50%	Routine data
	3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	The indicator is relevant but data is not available	4.30%	Routine data
	3.2	Percentage of infants born to HIV-positive women receiving a biological test for HIV within 2 months of birth	The indicator is relevant but data is not available	100%	
	3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	The indicator is relevant but data is not available	The indicator is relevant but data is not available	
	3.4	Percentage of pregnant women who know their HIV status	The indicator is relevant but data is not available	404 pregnant women tested for HIV	Routine data
	3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	The indicator is relevant but data is not available	The indicator is relevant but data is not available	
	3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	The indicator is relevant but data is not available	100%	Routine data
	3.7	Percentage of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother to child transmission in the first 6 weeks	The indicator is relevant but data is not available	33.30%	Routine data
	3.9	Percentage of infants born to HIV-infected women started on co-trimoxazol (CTX) prophylaxis within two months of birth	The indicator is relevant but data is not available	0%	Routine data
	3.10	Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit	The indicator is relevant but data is not available	The indicator is relevant but data is not available	
	3.11	Number of pregnant women attending ANC at least once during the reporting period	The indicator is relevant but data is not available	The indicator is relevant but data is not available	
Target 4: Have more 4,000 people living with HIV on antiretroviral treatment by 2015					
ART	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	90.70%	All=4.2% Male=4.5% Female=3.7%	Routine data
	4.2a	HIV treatment: 12 months retention	New indicator	All=96.2% Male=93.9% Female=100%	Routine data
	4.2b	HIV treatment: 24 months retention	New indicator	All=95% Male=92.9% Female=100%	Routine data

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	4.2c	HIV treatment: 60 months retention	New indicator	All=74.8% Male=70.6% Female=85.2%	Routine data
	4.3a	Health facilities that offer antiretroviral therapy	2 Facilities	2 Facilities	
	4.3.b	Health facilities that offer pediatric antiretroviral therapy	2 Facilities	2 Facilities	
	4.4	ART stock outs	New indicator	0%	
	4.6	HIV care	New indicator	The indicator is relevant but data is not available	
	4.7a	Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	New indicator	The indicator is relevant but data is not available	
	4.7b	Percentage of people on ART tested for viral load (VL) with VL level <1000 copies/ml after 12 months of therapy	New indicator	The indicator is relevant but data is not available	
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015					
TB/HIV	5.1	Co-management of tuberculosis and HIV treatment	0.01%	2%	Routine data
	5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	New indicator	All=13.2% Male=9.1% Female=20.0%	Routine data
	5.3	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	New indicator	100%	Routine data
	5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	New indicator	73%	Routine data
Target 6: Reach a significant level of annual global expenditure					
HIV/AIDS Expenditure	6.1	Domestic and international AIDS spending by categories and financing sources	Complete matrix submitted	The amount of money spent by public and international source on HIV and AIDS during reporting period is 5.3 million USD	
Target 7: Eliminating gender inequalities					
Gender	7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months the past 12 months	The indicator is relevant but data is not available	The indicator is relevant but data is not available	
Target 8: Eliminating stigma and discrimination					
Stigma and Discrimination	8.1	Discriminatory attitudes towards people living with HIV	The indicator is relevant but data is not available	The indicator is relevant but data is not available	
Target 9: Eliminate travel restrictions					
Travel Restriction	9.1	Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed	No	No	
Target 10: Strengthening HIV integration					
HIV integration	10.1	Current school attendance among orphans and non-orphans aged 10-14	The indicator is not relevant	The indicator is not relevant	
	10.2	Proportion of the poorest households who received external economic support in the last 3 months	The indicator is not relevant	The indicator is not relevant	

II. Overview of the AIDS Epidemic

A. People Living with HIV

Based on available data HIV epidemic in Afghanistan seems to be low and step to concentrated, this means that HIV affected mainly PWIDs among key population at higher risk of contracting HIV. The recent Integrated Biological Behavioral Surveillance Survey (IBBS) in 2012 shows an overall 4.4% of HIV prevalence among PWIDs. This prevalence is varied from minimum 0.3% among PWIDs in Mazar city to maximum up to 13.3 percent in Herat city.¹ The study also found 0.3%, 0.4% and 0.7% among Female Sex Worker (FSW), Men who have Sex with Men (MSM) and Prisoner respectively. Latest UNAIDS data indicate that the epidemic presently remains under <0.1² percent among the general population, yet has the potential to grow quickly from a small base of PWIDs to their sexual partners and thus to heterosexual men and women unless effective, vigorous, and sustained action is taken early.

At the early stage, NACP collection data from Blood Bank and a project of ICRC. For instance, from 1989-2003 only 28 case were reported to NACP. Then the data from Health Management Information System (HMIS) is also collection by which at the end of 2007, the officially reported number to NACP was 146 HIV cases from HMIS, BB and ICRC. Since 2008 after implementation of several harm reduction project with the financial support of World Bank, Global Fund, UNODC and other partners, case detection improved and so far in 2011, 1367 cases.³ The details information regarding HIV cases are provided in the graph below.

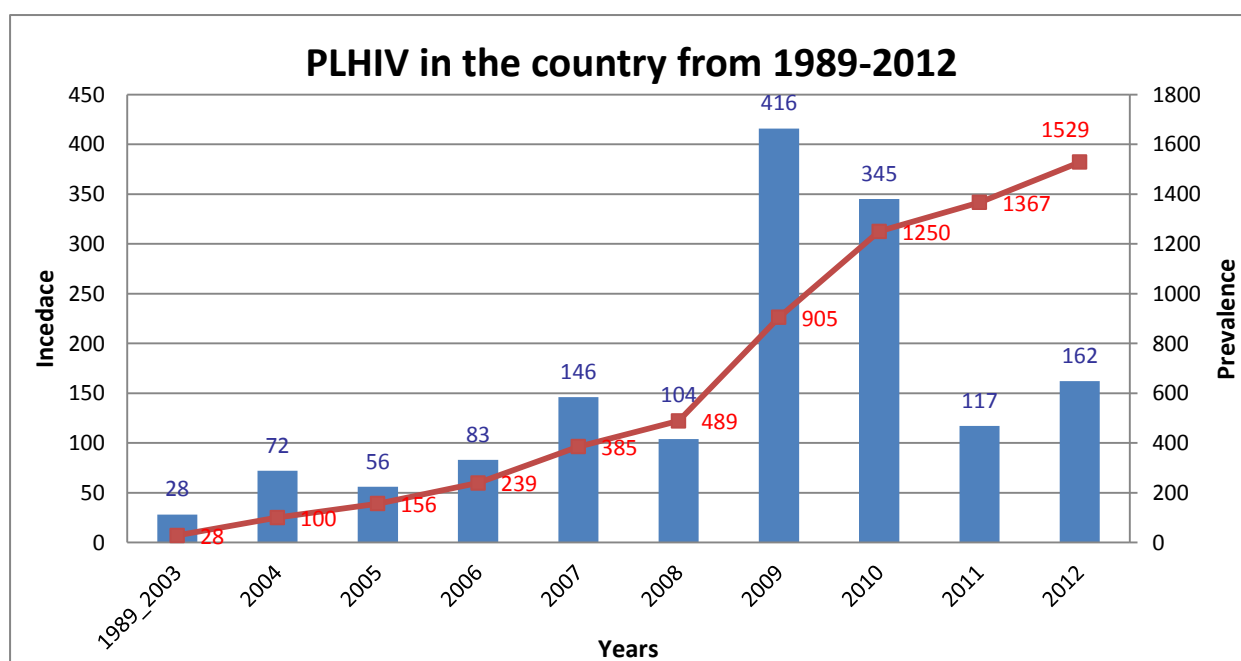


Figure 1: HIV cases reported to NACP (Yearly incidence and Prevalence)

¹ MoPH, NACP, IBBS, 2012

² UNAIDS Global AIDS Report 2013

³ NACP Data, 2012

Till the end of 2012, a cumulative number of 1529 HIV infections were reported to the National AIDS Control Program (NACP) where male to female ratio among PLHIV is almost 6:1 respectively. However, Joint United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) estimates around 4,300 (1,600-14,000) PLHIV in the country. Of the total reported number of HIV cases, 17 cases are AIDS-related deaths.⁴

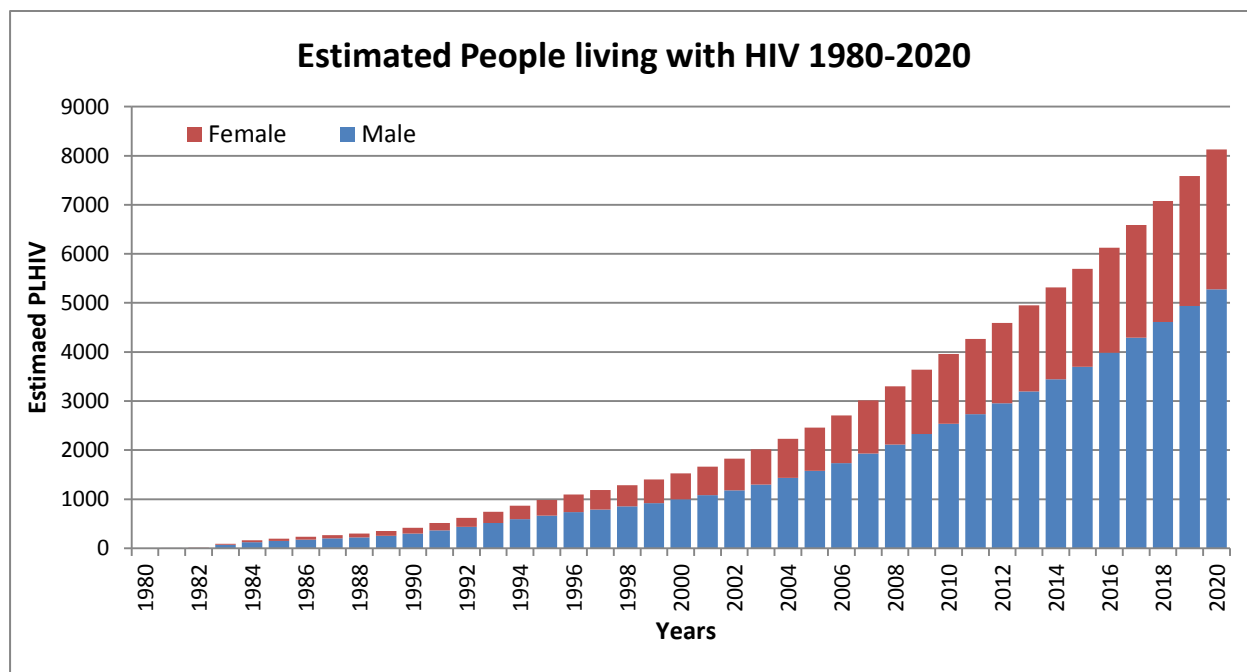


Figure 2: Spectrum produced graph (estimation 2012)

Among general population, accurate data to measure HIV prevalence in Afghanistan is yet needed. However, there is not enough evidence to suggest an established HIV epidemic among adult population. UNAIDS refers to the HIV estimate among general population in the country at the end of 2011 as being less than 0.1%⁵.

B. Key Population

1. People who Injection Drugs (PWID)

Based on UNODC estimation in 2009, there are up to 23,000⁶ PWIDs in Afghanistan. University of Manitoba in a mapping assessment during 2008 estimated 1,251, 159 and 55 PWIDs in the three cities: Kabul, Mazar-i-Sharif and Jalalabad respectively. The study revealed that injecting drug is largely street based and clustered within urban districts, with Kabul having the largest number of PWIDs per cluster (half of all 177 PWID clusters with at least 5 PWIDs). The recent size estimation of PWID through IBBS 2012 and rapid assessment in the western provinces of Afghanistan revealed 12541 PWIDs in Kabul, 1211 PWID in Hirat, 1496 in Mazar, 1471 in Jalal Abad and 484 and 257 PWIDs in Nimroz and Farah respectively.^{9,7} that While size estimation of rural PWIDs is yet not having been done, some sources point at the existence of injecting drug use outside of urban areas. Unsafe

⁴ UNAIDS HIV and AIDS Estimates 2012: <http://www.unaids.org/en/regionscountries/countries/afghanistan/>

⁵ <http://www.unaids.org/en/regionscountries/countries/afghanistan>

⁶ UNODC, Drug Survey, 2009

⁷ NACP, Rapid Assessment of people who inject drugs in Western Afghanistan, 2012

Injecting drug use including sharing of needle and other injecting equipment is considered the key mode of HIV transmission in Afghanistan.

A person who use drug would have the following social and demographic characteristics: 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.⁸

The main driver of the HIV epidemic in Afghanistan is PWIDs through sharing the needle and injecting equipment's, based on IBBS, 2009 the average sample estimation of HIV prevalence among PWIDs was 7.1% with the ranging between 1 percent in Mazar-i-Sharif, 3.2 percent in Kabul to 18.2 percent in Herat, zero prevalence among FSW and no information on other KAP. The IBBS 2012 with a bigger scope found an overall population estimation of 4.4% HIV prevalence among PWIDs with the same ranging 0.3% in Mazar, 0.9% in Charikar, 1.0% in Jalal Abad, 2.4% in Kabul to 13.3% in Hirat. These two figures cannot be compared as the first is only from the sample while the second is estimated for PWID population.

Both IBBS, 2009 and 2012 also reported that PWIDs exhibit a range of high HIV risk behaviors. The majority of sexually active PWIDs surveyed in both round were 58.4% in round 1st and 52.9% in round 2nd bought sex a women in their life time and 20.3% of correspondent in round 1st and 16.8% in round 2nd reported ever had sex with a boy. Based on the studies' the variation is calculated for sexual activeness geographical and periodical. Buying sex from a woman varied from 47.1% in Mazar, 55.6% in Hirat and 64% in Kabul in 2009 but it increased to 50.8% in Mazar and to 74.7% in Hirat but decline in Kabul 34.3% in 2012^{9, 9}. The decline in Kabul will be either severity of the drug addiction with caused impotence, lack of money and other underline causes.

Almost one third (27.4%) of all interviewed PWIDs shared needles or syringes in 2009 which was decreased to 11% in 2012. The same improved is report in the using of non-sterilized syringes and injection equipment from 31% in 2009 to 6.2% in 2012. Both round of IBBS reported a very low condom use among PWIDs at last sex 26.8% in 2009 and 23.8% in 2012.^{8, 9}

Despite the low HIV prevalence among key populations in Afghanistan, behavioral data suggests an alarming signs for an emerging HIV epidemic. For example, ever bought sex from a female was reported among truck drivers (29.1%), prisoners (28.5% in Herat and 21.6% in Kabul), MSM (49.5% in Kabul), PWID (29.3% in Kabul, 37.4% in Herat, 44.5% in Mazar-e-Sharif, 55.8% in Jalalabad, 35.4% in Charikar). Furthermore, data shows risk behavior interactions among key affected populations where more than 87% of FSWs in Kabul, Herat, and Mazar-e-Sharif reported one or more PWID clients in the last year¹⁰.

Additionally, other structural determinants for a wider epidemic exist in the country including large population of young people (more than 60% is below 25 year-old), poverty, increasing insecurity, lack

⁸ C S. Todd et al, Results of the intervention and community phases of integration of needle exchange & VCT in Kabul, Afghanistan, 2010

⁹ MoPH, NACP, IBBS, 2009, Ibid

¹⁰ NACP, IBBS 2012

of access to quality education, and violence. Other determinants include high prevalence of TB and STIs, low literacy rate (27%), and high level of stigma and discrimination against People Living with HIV (PLHIV)¹¹.

2. Men who have Sex with Men (MSM)

Although little is known about the extent of MSM behavior or the size of the MSM population in the country due to a tradition of 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.¹² The 2007 mapping assessment revealed a close interaction of MSM with female partners (spouses) and young males, and reliance on drugs¹³. 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.¹⁴

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.¹⁵ 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.

IBBS 2012 conducted among MSM in Kabul revealed that 51.6% of MSM participated in the survey had heard about HIV and 73.4% had heard about condom but 65% of the interview replied they had unprotected receptive anal sex with men in last 12 months. Almost half of them (49.5) had bought sex from women.¹⁶

3. Female Sex Worker (FSW)

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. 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 Jalalabad) 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).¹⁷ The best available information indicates HIV prevalence among FSWs

¹¹ NACP, National Strategic Framework-II 2012

¹² Understanding HIV in Afghanistan, 2008: The Emerging Epidemic And Opportunity For Prevention, A Desk Review of HIV in Afghanistan by NACP, JHU, IIMMR, 2008

¹³ University of Manitoba, 2008, *Ibid*

¹⁴ University of Manitoba, 2008, *Ibid*

¹⁵ Naz Foundation International, 2009: Rapid Assessment of Male Vulnerabilities to HIV and Sexual Exploitation,

¹⁶ NACP, IBBS 2012

¹⁷ University of Manitoba, 2008: Mapping and Situation Assessment of High Risk Populations in Three Cities of Afghanistan,

currently to be at 0.3 percent.⁹ Although PWIDs 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.¹⁸ A Knowledge, Attitude, Behavior, and Practice (KABP) study conducted by Action Aid in 2006 revealed that 84 percent of FSWs had 1-2 clients per day and the rest had 3 clients and more per day. The study also 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. The majority of clients of FSWs surveyed 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).¹⁹

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.¹⁵ Similarly to the Orphan Refugee and AID (ORA) International 2003 survey of FSWs in Kabul showing 78 percent of them being married²⁰. 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.

36% of FSW participated in IBBS 2012 were aged between 18-24 years, with 57.8% who cannot read and write. 38.6% of the correspondent of the survey had heard about HIV. More than half (59.8%) of interviewed FSW reported that they had 2-5 client in the last one month. 41.7% of participant reported to have heard about STI while 74.4% of them had sex while they had STI symptoms. The study also revealed that 69.5% of the correspondent had heard about condom while 52.3% of them had used condom last time they had sex.²¹

4. 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.²² At the current rate of incarceration, UNODC projects that by 2015 the prison population will raise 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

¹⁸ Andrea Wilson, 2010: HIV in Afghanistan: a review of literature and evidence of disease burden among vulnerable populations, Johns Hopkins University.

¹⁹ Action Aid, Afghanistan, 2006: Knowledge, Attitude, Behavior and Practice in High Risk and Vulnerable Groups in Afghanistan

²⁰ Bazgar, F and Young, A Survey of Groups of High Risk of Contracting Sexually Transmitted Infections and HIV/AIDS in Kabul, ORA International, 2005

²¹ NACP, IBBS 2012

²² UNODC 2010 data

PWIDs, that included prison PWIDs, indicated that over 30 percent of prisoners were injecting heroin.²³

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 among surveyed prisoners in Kabul and 1.6 percent in Herat in 2009.²⁴ However, data obtained in 2008 indicated a prevalence of 11 percent among a small sample of Herat male prison PWIDs.²⁵ The 2009 IBBS conducted in Kabul and Herat prisons, a home to the country's largest number of the incarcerated (4,500 prisoners in Kabul and 1,200 prisoners in Herat) - revealed that majority of the interviewed 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 PWID prisoners.

III. National Response to the AIDS Epidemic

The government of Afghanistan has responded to HIV epidemic with a wide range of interventions ranging from establishing an institutional framework towards a comprehensive national and international support to the development/updating policy, strategic, and program operational guidelines. Through financial support from World Bank, Global Fund, and other UN agencies, there is a number of prevention, treatment and care interventions are currently targeting different key affected populations such as PWID, MSM, FSWs, and prisoners in 9 provinces.

A. Reduce sexual transmission of HIV by 50% by 2015

NSF-II is addressing this High Level Meeting (HLM) target under “priority area 1” among FSWs and MSM²⁶. However, social stigma in a deeply conservative community, like Afghanistan, has resulted in limited HIV infection prevention and programs targeting FSWs and MSM. Therefore, the country is currently facing challenges towards achieving this target by 2015 as underscored by many

²³ Todd, C. S, et al. Prevalence of HIV, Viral Hepatitis, Syphilis, and Risk Behaviors among Injecting Drug Users in Kabul, Afghanistan, 2006

²⁴ IBBS, 2009, *Ibid*

²⁵ The World Bank Afghanistan HIV/AIDS Prevention Project Implementation Support Mission Aide-Memoire, June 2008

²⁶ NACP, NSF-II

stakeholders. Efforts, however, were made in response to that. For instance, the second round of IBBS survey in 2012 included MSM among the studied target populations and two more sites (Mazar and Herat) were added for FSWs IBBS first round in 2009.

Current targeted interventions to these KAPs (FSWs and MSM) are limited in scope and geographical distribution where only one project for FSWs is operating in Kabul, and two for MSM; one in Kabul and one in Mazar-i-Sharif. Only 14.4% of FSWs and 6.8% of MSM were reached with prevention programs.

All stakeholders underscored the fact that data on sexual transmission of HIV in the country is very minimal. According to official National AIDS Control Program (NACP) reports, a cumulative number of 1529 PLHIV was reported at the end of 2012. Of whom, 85% are male and only about 6% were infected through sexual transmission. There is a strong believe, however, at the NACP that these data lack accuracy and a stronger routine surveillance system is needed for more reliable figures. On the other hand, a draft report estimates a total number of 4,694 Afghans living with HIV by 2013²⁷, of whom, 1% (52) are FSWs, and 2% (89) are MSM²⁸.

Though HIV prevalence is low among FSWs (0% in 2009 and 0.3% in 2012)²⁹ and MSM (0.4% in 2012)³⁰, other behavioral and structural factors show potential risk of HIV transmission among these two KAPs. Multiplicity of sex partners, low use of condom, prevalence of STIs, and drug injection are among behavioral risk factors³¹. Low level of literacy in general and HIV awareness in particular, in addition to the high level of stigma and discrimination, political, security, and economic determinants are among structural risk factors for HIV transmission among FSWs and MSM. Program implementers have noted that donors, who were previously interested to support interventions that target FSWs and MSM, are no more in favor to keep on their support because of very low prevalence of HIV among these two populations. This lack of interest among donors to support sex work interventions was addressed by all stakeholders. They also stressed on the need to advocate for these interventions and prioritize on the donors' agenda.

B. Preventing HIV among drug users by 50% by 2015

As described before, the emerging HIV epidemic in Afghanistan is largely due to sharing needles among PWID. Evidence shows that more than 13% of PWID in Herat is living with HIV in 2012³². Preventing HIV among drug users in general, and PWID in specific, is highly prioritized in NSF-II and the country has been taken a number of key actions to achieve this target. Harm reduction activities are implemented in nine provinces in community level as well as the prisons. The list of harm reduction components reflects the international recommendation package; however, not all components are yet available. It is estimated that 1.5% are co-infected with HIV and HCV³³. Absence of HCV treatment facilities may have a great adverse effect on HIV management.

²⁷ NACP: (2013) Mission report, Estimation and Projection Exercise

²⁸ NACP: (2013) Afghanistan HIV and AIDS estimate and projection: Mission report

²⁹ NACP, IBBS (2009) and IBBS (2012)

³⁰ NACP, IBBS (2012)

³¹ NACP, IBBS (2012)

³² NACP, IBBS 2012

³³ Khan, S. and Attaullah, S. (2011), Share of Afghanistan populace in hepatitis B and Hepatitis C infection's pool: is it worthwhile?, *Virology Journal*. 8:2016

Harm reduction interventions in Afghanistan were able to cover 25% of all 18000-23000 estimated PWIDs with main components including HIV testing and counseling, Needle Exchange Programs (NSP) provision of ART and treatment for Opportunistic Infections (OIs), and diagnosis and treatment of TB. Opioid Substitution Therapy (OST) was also part of this harm reduction package; however, target for OST was limited for 71 clients for the last three years.

Though Afghanistan seems to be on track to achieve this target, a number of challenges were identified by policy makers and program implementers that need to be addressed in order to keep the so-far good achievements. These challenges are focused on **a)** the limited resources to include more components to the package of harm reduction interventions (e.g. accurate diagnosis of Hepatitis B and C infections and the availability of treatment); **b)** the technical and human resource capacity of implementers to provide more comprehensive and effective response; **c)** the need to scale up OST to include more beneficiaries, and **d)** the overall security issue of the country.

C. Eliminating new HIV infections among children

Only 70 pregnant women are estimated to be living with HIV in Afghanistan³⁴. Yet, eliminating new HIV infections among new-borne children is addressed as a priority in NSF-II. Services to provide Prevention of Mother-to-Child Transmission (PMTCT) are available through 5 centers in 5 cities with support from UNICEF. No national data are available on how much is the burden of HIV among pregnant women. Despite that, national stakeholders recognize that without targeted prevention programs, unsuspecting wives participating in relatively low-risk behavior (sex with their husbands) will begin to share the burden of HIV as well. The country has taken actions in terms of building the capacity of the already established 5 PMTCT centers through training, provision of referrals to VCT and ART services, and development of PMTCT guidelines for health care providers.

Additionally, there are gaps in women's knowledge regarding HIV and AIDS. Slightly over quarter (26%) of Afghan women aged 15-49% had heard of AIDS and only 2% had comprehensive and correct knowledge of HIV prevention and transmission. Only 8% of all women could identify all three ways of MTCT, while 4% did not know of any specific way³⁵.

Limited access of target population to PMTCT services was identified as a barrier towards achieving this target by 2015. Overall awareness of HIV among general population as well as health care providers and further promoting PMTCT interventions into reproductive health services are actions needed if this target is to be achieved.

D. Universal access to ART

Medical care and provision of HIV treatment are delivered through two ART centers in the country; one in Kabul and one in Herat. Only 4.2% of all PLHIV (4948)³⁶ estimated in Afghanistan who are eligible for treatment are currently receiving ART as the end of 2012. NSF-II prioritizes HIV treatment and the country provides first and second ART treatment lines. Absence of facilities to monitor viral load of those under ART is yet a challenge to effective HIV treatment outcome.

Furthermore, services that involve PLHIV and their affected families and integrate them into a wider continuum of care to include nutritional and psychosocial support and home-based care should be provided in order to mitigate the high level of stigma associated with HIV and AIDS and to improve the overall access to ART.

³⁴ NACP, (2013), Estimation and Projection Exercise: Mission report

³⁵ UNICEF-CSO (2012) Afghanistan Multiple Indicator Cluster Survey

³⁶ NACP, (2013), Estimation and Projection Exercise: Mission report

E. Avoiding TB deaths

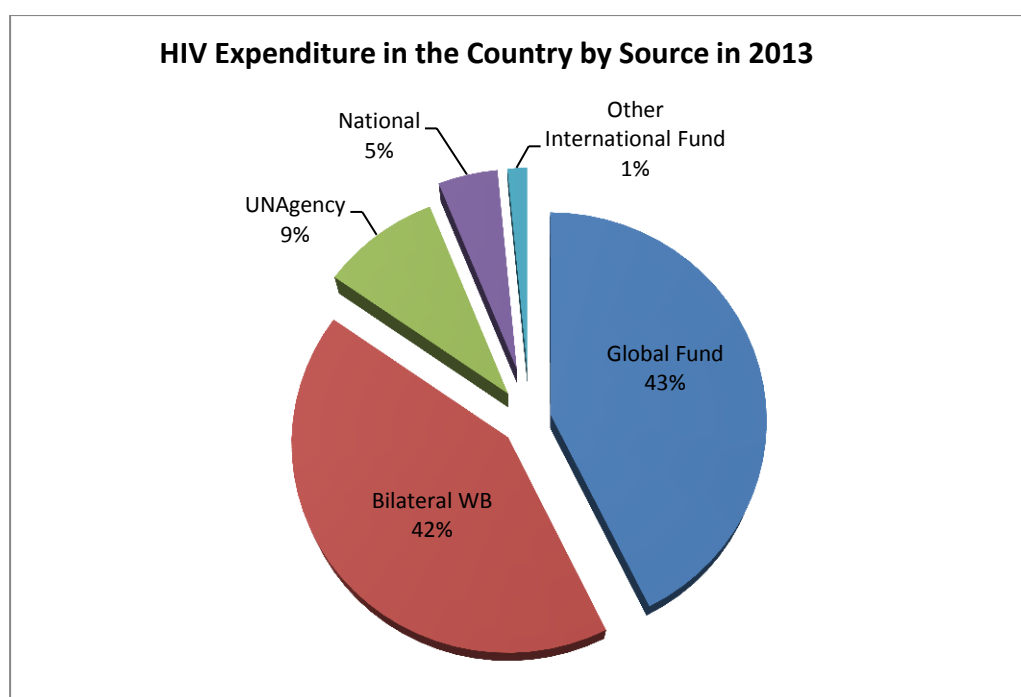
Guidelines and protocols that address HIV/TB collaboration are available and reflect the high level of national commitment towards achieving this HLM and to avoid TB deaths among PLHIV. Almost 100% of HIV positive cases are regularly screened for TB and referred offered necessary prevention and treatment services. Given the low level of HIV epidemic in Afghanistan, only vulnerable TB patients are screened for HIV infection.

Despite the presence of HIV/TB collaborative policy and guidelines, there is a number of operational challenges identified by national stakeholders and program implementers. Among them is the limited access to effective management capacity of HIV/TB co-infection where only 68.4% of all adults and children enrolled in in HIV care had their TB status assessed.

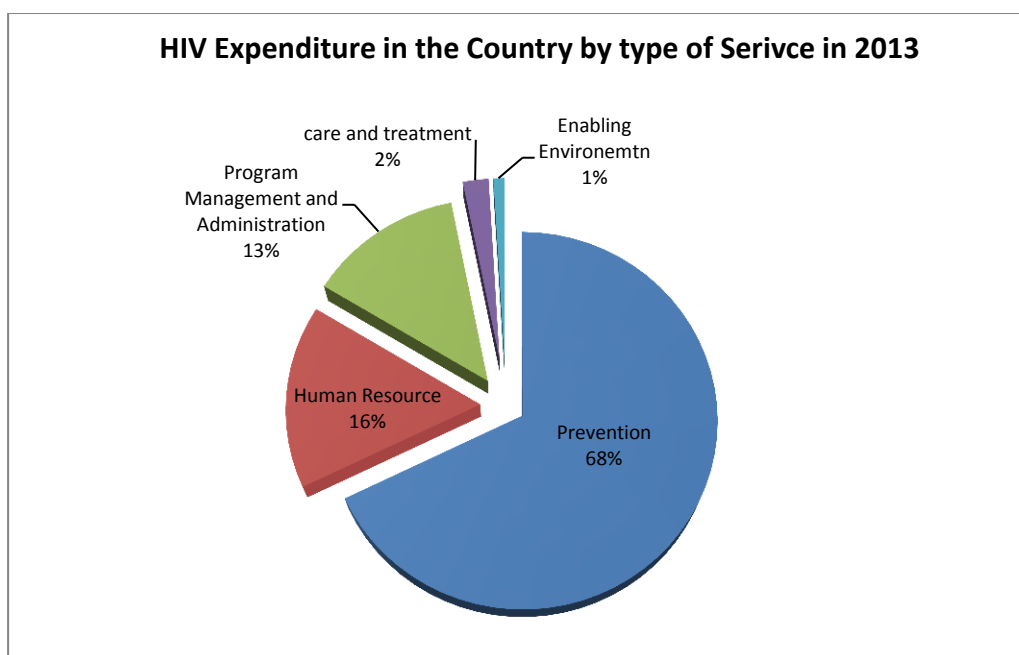
F. Closing the resource gap

Afghanistan is a high donor-dependent country where international sources account for almost all (95.3%) all HIV and AIDS financial support. Resources are mainly available through World Bank, which is committed to secure its support up to 2018 under the overall System Enhancement for Health Action in Transition (SEHAT) project, and GFATM through Transitional Funding Model (TFM) up to 2015, as well as some other UN agencies e.g. UNODC and UNICEF.

In the reporting period (2013) totally 5.3 million dollar was spent on the HIV and AIDS in Afghanistan which was supported mainly from Global Fund (43%) through SPHP and TFM projects and World Bank (42%) through SHARP and SEHAT projects. Around 9% of the supports come from UN agencies (UNODC, UNAIDS, UNICEF and WHO). 5% of the fund is domestics which supported mainly on human resources. The remind 1% is funded from MENAHARA and AUSAID through SHAPE project.



From the 5.3 million fund spent on HIV and AIDS in Afghanistan, majority (68%) is spend on prevention interventions including harm reduction services for PWIDs in the community and prison setting benefits both male and female PWIDs, OST, risk reduction for vulnerable population such as FSW, MSM, VCT service for general population in the community. The rest 16% and 13% of the fund spent on human resource and program management and administration respectively. Only 2% of the fund is spent on treatment and care and one percent on enabling environment.



Health services, including HIV interventions, in Afghanistan are delivered predominantly by NGOs and funded exclusively from the development and external budgets.

G. Eliminating gender inequality

The country is committed to protect the rights of women and end gender-based violence in general, with special focus to HIV context. An alarming statistic shows that 92% of Afghan women feel that their husband has a right to hit or beat them for at least one of a variety of reasons³⁷. In order to eliminate gender inequalities, the country has developed National Gender Strategy (2011-2015) that addresses the equal access among men and women to health services that are free of discrimination and address Gender-Based Violence. Among other strategies, MoPH is committed to create gender-sensitive indicators and does gender M&E for all health programs, including HIV and AIDS³⁸. Recently a guideline is being developing on how to manage gender based violence in the health facility by supported of UN-Women and UNFPA. NACP also identifies the need to increase the overall awareness of gender and HIV among general population as well as health care providers and promote equitable access to HIV services

H. Eliminating stigma and discrimination

HIV policy and strategy are both addressing the elimination of stigma and discrimination associated with HIV, PLHIV, and KAPs. NACP is applying a number of interventions that aim at increase awareness of HIV and enable the environment to challenge the high level of social stigma and discrimination. The HIV/AIDS Coordinating Committee of Afghanistan (HACCA) has been a key link in engaging policy makers, community (women, religious) leaders, civil society, and official from line ministries in addressing this target. IEC materials, media spots, and regular awareness raising workshops are channels used to reach different sectors of the Afghan community with sound information in regards to HIV and AIDS. However, more actions are yet needed to actively involve media personnel, health care professional, journalists to combat the adverse effects of stigma surrounding HIV. In addition, the development of a HIV workplace policy and meaningful involvement of PLHIV and KAPs in planning anti-stigma campaigns would be necessary to continue the national efforts towards eliminating stigma and discrimination.

³⁷ Afghanistan Multiple Indicator Cluster Survey (2012)

³⁸ USAID/HSSP (2011), Developing a national gender strategy for Afghanistan's MoPH

I. Eliminating travel restriction

There are no HIV/AIDS related travel/residency restrictions in Afghanistan

J. Strengthen HIV integration

Most of HIV service delivery in Afghanistan is operated in parallel approaches e.g. VCT, harm reduction services. Some other activities have been integrated (e.g. ART provision and PITC services) into BPHS (Basic Package of Health Service) and EPHS (Essential Package of Health Service). HIV information materials have been also integrated into school curricula. However, some implementation barriers are still challenging complete integration of HIV and AIDS into other health and non-health sectors. The low epidemic level of HIV epidemic in the country makes it problematic to operate HIV services by non-HIV professional. NACP needs to build the capacity of other non-health organizations to carry out basic HIV prevention activities and to strengthen referral linkages to other specialized prevention and treatment services. Conduct human resource needs assessment and review/update human resource strategy and policies of line ministries are among recommendations needed to strengthen HIV response into broader and more collaborative approach.

PMTCT service, for instance, is to be integrated into other family planning and reproductive health facilities. These facilities should be first equipped with well-trained staff, who are able to deal with issues related to HIV testing and counseling provision, ART management, and should be effectively linked to other more specialized harm reduction services.

IV. Best Practice

The National AIDS Control Program (NACP) 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 multisectoral approach to the HIV response in order to arrest HIV transmission from further spread in the community. The HIV epidemic has evolved in the past decade to a concentrated stage among Key Affected Populations in Afghanistan. Throughout this period, the following best practices are to be noted:

Harm reduction package to PWID 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 the community as well as in the prisons including male and female in the nine provinces (Kabul, Hirat, Balkh, Nangarhar, Badakhshan, Kunduz, Kandahar, Ghazni and Parwan).

Advocacy project on integration of HIV and reproductive health services through BPHS setting and approach funded by European Commission implemented during the reported period Jan, 2011 to end of 2013. The project is also addresses the unmet need and rights of women and men living with HIV/AIDS to reproductive health services which improved access to RH and HIV services especially for women, young people, people living with HIV and marginalized groups.

Integrated Biological Behavioral Survey (IBBS) second round has been conducted in the five cities among the following key populations:

- PWID in Kabul, Hirat, Mazar, Jalalabad and Charikar.
- FSW in Kabul, Hirat and Mazar.
- MSM in Kabul
- Prisoners in Kabul and Hirat prison
- RTW in Torkham border site

Second round of knowledge attitude and believe (KAB) regarding HIV and AIDS among policy makers in Kabul, Rapid assessment of PWID in Western provinces (Hirat, Farah and Nimroz) and OST evaluation are the other studies conducted during the reporting period.

V. Major Challenges and Remedial Actions

- ✚ Lack of protection for PWIDs and PLHIV due to lack of Ant discriminatory Law in the country.
- ✚ Security challenges have plagued Afghanistan for a long while and despite this the HIV program has made progress.
- ✚ The Government finance and procurement procedures are lengthy. Therefore, access to much needed supplies takes longer than expected.
- ✚ HCV emerged as a major health challenge for PWIDs while there is no policy and strategy for HCV to address the problem.
- ✚ Mainstreaming of HIV response in the country development plan: The government of Afghanistan has adopted MDG including the MDG6 and ANDS, which focus on halting and reversing and HIV in Afghanistan. However, until now HIV is only at the agenda of Ministry of Public Health and Ministry of Counter narcotics with focus mainly on behavioral interventions, which reduces the risk of HIV transmission. While, HIV vulnerability is beyond the risk and requires a structural response through multi-sectoral approach.
- ✚ Discriminative Policy of Drug Demand Reduction of MoCN-allows only 40% of Drug users to OST.
- ✚ HIV and Human rights are another key and central element of commitment, which remove all policy and law obstacles from access to HIV prevention, treatment, care and support for PLHIV and Key population. This creates an enabling environment for PLHIV and key population to access services and enjoy free of stigma and discrimination life. Nevertheless, in Afghanistan, there is no legal protection for PLHIV and key populations due to lack of anti-discriminatory law. Stigma and discrimination toward PLHIV and key populations are widely spread at the different levels.
- ✚ Low awareness of HIV and risk behaviors
- ✚ Easy availability, production and distribution of drugs, including Heroin.
- ✚ Social and cultural barriers in reaching Key Affected Populations.
- ✚ As Illicit drug use is punishable by law, prison interventions that include harm reduction are difficult to implement. National and sectoral HIV policies and guidelines need to be developed. Although OST policy has been approved, effective implementation and scale-up to those most in need is still a challenge.
- ✚ Effective Integration of HIV and AIDS services within the national health care system, and ensuring Government contribution to the program for sustainability purposes is a major challenge.

- ✚ Quality of service provision and care is not yet optimal; however, steps are being taken towards filling this gap.
- ✚ Gender issues, including needs of female drug users are not fully understood and addressed by the Program at this stage.
- ✚ The coverage of HIV response in the country is still relatively poor limited to only eight provinces.

VI. Support from the Country's development Partners

Through the Joint UN Team on AIDS (UNAIDS) and selected UN Agencies provide technical support to NACP. UNAIDS and co-sponsors including World Bank, UNODC, WHO, UNICEF, UNESCO, and UNFPA have supported the development of NSF II 2011-2015, which focused on ambitious targets within the context of the Millennium Development Goals (MDGs) and supported the implementation of the existing World Bank and Global Fund action plans on AIDS. The Joint Team also provided support and advocacy for implementation of existing action plans, particularly when this required additional advocacy and bridging gaps in funding for maintaining OST, initiating prevention with Key Affected Populations, and developing institutional capacities for prevention of mother-to-child transmission, operational research on risk and vulnerability, and reducing Afghanistan's past isolation through a growing partnership with neighboring countries and in the region on AIDS.

In addition, UNODC is currently running two HIV prevention treatment and care projects for female drug users, prisoners and refugees. UNICEF is providing assistance in establishing programs for PPTCT; UNAIDS, WHO and UNODC provided humanitarian assistance programs for street-based PWID in Kabul; and WHO support was pivotal for the roll-out of the ART program.

Afghanistan received a grant from the Global Fund in Round 7 in 2008. The CCM has selected GIZ IS and the Ministry of Public Health of Afghanistan as co-principal recipients of the grant. Later on, in 2012, the CCM decided to apply for the Transitional Funding Mechanism as continuation of life saving services of Strengthening Provincial HIV Program (SPHP). The GF Round 7 grant had the objectives of strengthening health system as it related to HIV, create a supporting environment for an effective national response to HIV, prevent transmission of HIV among most at risk and other vulnerable populations, effectively address TB and HIV diagnosis and co-morbidity and provide treatment, care, and support to PHLIV, and the objectives of TFM are to Prevent the Transmission of HIV among IDUs and prisoners, to Provide Treatment, Care and Support to People Living with HIV and AIDS, to Effectively Address TB/HIV Diagnosis and Co-morbidity, and to enhance Quality system and enabling environment to facilitate delivery of essential prevention and care services to Target Groups (IDUs, Prisoners and PLHIVs).

The key implementing partners include the NACP/MOPH, Ministry of Interior, 8 provincial health offices, and a number of NGOs involved in HIV prevention, treatment, care, and support. The NACP main role is to provide national coordination, the Ministry of Interior is responsible for prisons, and the provincial health office is responsible for health care, including HIV prevention, treatment, care and support in provinces, while the NGOs will implement the activities. As well as, another grant of Global Fund is running under the regional multi-country proposal in the country for MSM that has two male health clinics in Kabul and Herat provinces.

World Bank's response to AIDS: In 2007, the World Bank signed a three-year USD 10 million grant with the GoA to enhance the national AIDS response through the Afghanistan HIV/AIDS Prevention Project (AHAPP). The project provides harm reduction services to at-risk groups (PWID, sex workers, prisoners, and truckers) in different cities (Kabul, Mazar, Jalalabad, and Herat). Services are provided by NGOs selected through a competitive process. The project is strengthening surveillance through IBBS and knowledge, attitudes, beliefs, and practice studies conducted among at-risk groups by Johns Hopkins University. The project aims to increase awareness of HIV prevention and reduce stigma and discrimination through communications and advocacy activities implemented by the Futures Group International (FGI). The project is funding capacity-building activities to strengthen the NACP in areas such as program management, M and E, communication, etc. As mentioned above, project activities will be carried out by agencies (national NGOs and international institutions) that are contracted by the NACP.

USAID supports the secretariat functions and activities of HACCA, including workshops for line Ministries and a newsletter released monthly. HACCA is an inter-ministerial committee comprised of key line ministries and NGOs. In addition, USAID provided support to the Youth Health and Development Organization, (YHDO) a local Afghan NGO to operate men's health clinics in Kabul and Mazar-e-Sharif. The Kabul Men's Health Clinic opened in January 2010, and the Mazar clinic opened in July 2010. The clinics provide outreach and basic medical services exclusively for men, including HIV counseling and testing and treatment of STIs as well as drop-in services for MSM in these two cities. Starting in December 2011, the Global Fund will provide financial support for these two clinics.

VII. Monitoring and Evaluation Environment

HIV prevalence and epidemiological status: The data on cumulative reported HIV and AIDS cases is updating yearly. Data on HIV estimates, such as adult HIV prevalence, estimated number of people living with HIV, and estimated AIDS deaths, is updating every two year. The last updated is available for 2013 which will be submitted together with GARPR, 2014. HIV prevalence among PWID, sex workers, prisoners and long distance truck drivers are available from IBBS 2012.

Risks, vulnerability and HIV knowledge: The data on risky behavior among PWID, FSW and MSM are collected through IBBS. Two rounds of IBBS had been conducted and the other two rounds are planned in 2015 and 2018. A rapid assessment has also been conducted in the western provinces of Afghanistan.

National response: the data on routine active from harm reduction projects, VCT, PPTCT and ART are collecting regularly on monthly and quarterly bases.

VIII. Annexes

Annex I: Consultation process

Initial Meeting

The first initial meeting conducted in the NACP meeting room with UNAIDS delegation from Pakistan. The agenda points were the UNAIDS assistance on Global Fund proposal assistant, GARPR assistance and GARPR process.

Participants list:




Name	Organization
Dr. Marc Saba	UNAIDS
Dr. Fahmidah Khan	UNAIDS
Dr. Lailuma	WHO
Dr. Bargami	NACP
Dr. Hashim Rahimi	NACP
Dr. Samaruddin Samar	NACP
Dr. Hussain Ali Yousufi	NACP

Discussion:

Two TA for GARPR was proposed by NACP and was accepted by UNAIDS. One TA for NCPI including interview, analysis and preparing the report for NACP and the next TA should work on the narrative part of the GARPR report. As part of the decision Dr. Ajmal Sabawoon is selected for NCPI but the international TA for narrative is not hired due to lack of the time.

Task force Meeting

The first task force meeting conducted on 25th of February 2014 in NACP meeting hall with all the stakeholders. The agenda points are:

-  review of the GARPR indicators
-  Nomination of the informants for NACP
-  Presentation on spectrum (Estimation data)

Participants list:

SN	Name	Resignation	Organization
1	Dr. Bargami	Acting NACP manager	NACP
2	Dr. Ziaurrahman	Project coordinator	UNODC
3	Dr. Sardar Wali	Technical Coordinator	GIZ
4	Dr. Freba Hosham	Technical	AFGA
5	Dr. Nasim Bawar	Executive Director	OTCD
6	Dr. Ajmal Sabawoon	GF	GF
7	Dr. M. Asif Alokozai	Researcher	HPRO
8	Dr. Samaruddin Samar	HR consultant	NACP
9	Dr. Hussain Ali Yousufi	M&E and Surveillance Consultant	NACP
10	Dr. Hashim Rahimi	GF Project Manager	NACP
11	Dr. Ahadia	Advocacy and Communication Cons.	NACP
12	Dr. Lailuma	HIV/TB focal point (NPO)	WHO
13	Dr. Sherzai	Technical Coordinator	SPRO
14	Dr. Naweed	Surveillance Manager	NACP
15	Dr. Rangina Aziz	Capacity and curriculum develop	NACP

Discussion points:

- All the indicators are reviewed and the agreement is made on the relevancy of the indicators and the availability of the data.
- The key informants for NCPI interview were nominated
- The data collection for estimation 2014 in the spectrum is introduced.

List of Key informants for NCPI interview:

Part A: Government

Organization	Name	Respondents to Part A							
		A.I	A.II	A.III	A.IV	A.IV	A.V	A.VI	
DG of Policy and Plan	Dr. Qader	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
DG of Preventive Medicine	Dr. Mashal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
NACP Manager	Dr. Paikan	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
MoCN/DDR section	Dr. Basher Ahmad Fazely	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
MoE/Health Section	Dr. Rahman Rahmani	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
MoWA/Health	Dr. Khara	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
MoJ/Regulation and Law	Fahima Wahidi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
MoJ/Jail Director	Gen. Samit	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
MoRR/HACCA	Qasim Sharafmal	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Parliament/Health Committee	Dr. Faiq/Dr. Saljoqi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

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Part B: Civil Society Organization, Bilateral and UN agency

Organization	Name	Respondents to Part A							
		A.I	A.II	A.III	A.IV	A.IIV	A.V	A.VI	
WHO	Dr. Lailuma	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
UNICEF	Dr. Khaksar Yousufi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
UNFPA	Dr. Malik Faizy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
IOM	Zmaryalai Farahi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
ILO	Anahita Amin	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
USAID	Ikram	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
UNHCR	Dr. Taher Wardak	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
GIZ	Emal Safir	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Future Group	Sher Zaman	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Human Right High Commission	Dr. Soraya Sobrang	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
AFGA	Dr. Akbari	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
ADAA	Dr. Najib Baleegh	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Nejat Center	Dr. Tariq Sulaiman	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

Validation Workshop

Three separate validation workshop have been conducted, two for NCPI (Part A and B) and the third validation was for overall process, data and narrative report. Both part of NCPI were reviewed in each validation workshop and validated. In the last validation workshop all the data as well as the narrative report were reviewed. The comments and inputs have been incorporated and the data has been updated

Participants list:

SN	Name	Resignation	Organization
1	Dr. M. Qasim Sharfmal	Health Director	MRRD
2	Dr. M. Khan Hedayat	ART Manager	NACP/ MoPH
3	Dr. Ab. Mobin Omhar Shahim	Team leader	GIA
4	Dr. Feda M. Paikan	NACP Manager	NACP
5	Dr. Hamid Folad	Program Advisor	DDR/MoPH
6	Dr. Rahmani	Deputy Health Dept	MoE
7	Dr. Najeb Baleegh	M&E /Prog	ADAA
8	Qasim Sharafmal	Health Director	MRRD
9	Dr. Bargami	Coordinator	NACP
10	Dr. Ziaurrahman	Project coordinator	UNODC
11	Dr. Sardar Wali	Technical Coordinator	GIZ
12	Dr. Freba Hosham	Technical	AFGA
13	Dr. Nasim Bawar	Executive Director	OTCD
14	Dr. Ajmal Sabawoon	GF	GF
15	Dr. M. Asif Alokozai	Researcher	HPRO
16	Dr. Samaruddin Samar	HR consultant	NACP
17	Dr. Hussain Ali Yousufi	M&E and Surveillance Consultant	NACP
18	Dr. Hashim Rahimi	GF Project Manager	NACP
19	Dr. Ahadia	Advocacy and Communication Cons.	NACP
20	Dr. Lailuma	HIV/TB focal point (NPO)	WHO
21	Dr. Sherzai	Technical Coordinator	SPRO
22	Dr. Naweed Anwar	Surveillance Manager	NACP
23	Dr. Rangina Aziz	Capacity and curriculum develop	NACP

Annex II: NCPI Narrative Report

IX. Introduction

National AIDS Control Program (NACP) was decided to submit the Global AIDS Progress Response Report to the terms of 2011-2013. The NACP invited key stakeholder in meeting and discussed the plan on submitting GARPR report on Feb 25, 2014. One important agenda point was the NCPI and almost all participants agreed to complete the task due to date of submission of GARPR report. Through this meeting, the participants also agreed to contact 5 key informants for Part A, and 5 key informants for Part B and the number of contact will be increased if we do not reach to information saturation. Data was collected between March 08 and 25, 2014. Validation workshop separately conducted for part A and B to reach consensus on finding from interview. Each component of instrument e.g. strategic plan, political leadership ... reviewed question by question and diverse opinions were unified. The validated version then entered to online GARPR data base.

There were some disagreements in some questions and rating. The workshop facilitator raised the question and facilitates argument. Equal chance was given to participants to share her/his point of view. Final decision took place on evident argument and in mutual agreement.

X. Summary of Finding

I. Part A:

1. Strategic Plan

National AIDS Control Program (NACP) developed a multi sectorial strategic plan for the term of 2011-2015 called National Strategic Framework (NSF II). The development process was extremely inclusive and developed in close consultation with key stakeholders including governmental, non-governmental, donor, UN families, and people living with HIV and people who inject drug. Different sub working groups e.g. prevention group, key affected population group, strategic information group, treatment care and support group were established and draft the strategy. The NSF II includes education, health, labour, military/police, social welfare, transportation, women and young people sectors to prevent HIV transmission. There were no embarked budgets for labor, transportation and women sectors and related activities covered by NACP itself

The NSF II identified key population and vulnerable population utilizing different sources of information such as survey, routine reporting system, integrated biological and behavioral surveillance. The NSF II addressed discordant couples, men who have sex with male (MSM); migrant/mobile population; street orphan and other vulnerable children; people who inject drugs, sex workers, women and girl; young women and young girl and prisoners as key population and vulnerable population. Prison and school were identified as setting for intervention. The strategy also addressed stigma and discrimination, and involvement of PLHIV as cross-cutting issues. The strategy does translated into operational plan and has program goal, clear target and detailed budget by funding source. It is worth mentioning that M&E framework is included as an important component.

The level of involvement of civil society found as moderate. Most of civil societies including PLHIV and PWID to series of meeting and workshop for NSF II development but some of civil societies and key population did not actively contributed. The strategy endorsed by development partners and currently they are providing funds to implement NSF II. However different donors provide funds on their own mandate and it was happened that some of activities do not harmonized across the development partners for example the World Bank do support provision of ART and USAID does not support prison activities. There is no planned evaluation of HIV impact on its socioeconomic development for planning purposes. The health system strengthening program does have planned to establish regional reference laboratories, train health workers and provide CD4 count machine.

Many facilities are offering HIV counseling and testing and tuberculosis as an integrated part. Few facilities such as reproductive health facilities, general outpatient care, ART and TB; and PMTCT offers HIV counseling and testing.

Since 2011, NACP along with its strategic partner succeed to integrate HIV prevention services such as HIV testing and counseling into the Basic Package of health services (BPHS). In addition, in policy level, series of meeting were conducted with different line ministries and consequently some of them put HIV as their mainstream particularly Ministry of counter Narcotic MoCN.

Stigma and discrimination, lack of funds, political commitment and insufficient number of supportive law are the challenges to this program.

2. Political Support and Leadership

However government ministries did not officially speak twice a year in favor of HIV effort at domestic forums but other officials and sub national level officials did so. Main coordination body to HIV is called HIV and AIDS Coordination Committee of Afghanistan (HACCA) chairs by Dr. Ahmad Jan Naeem, the Deputy Minister of Public Health. HACCA has 57 defined members and among them 19 represents civil societies and two member representing PLHIV and PLWID.

There is mechanism in place to promote interaction between government and civil societies to implement HIV strategies. As an example, there was a mandatory rule that all foreigner workers who work within Afghanistan should be tested for HIV. The issue was discussed in HIV and AIDS Coordination Committee of Afghanistan (HACCA) and consequently decided to remove this mandatory rule. Through such interaction the level of stigma and discrimination has been reduced e.g. police acknowledge that drug users are patients not criminals. Law interpretation is a serious challenge and every one infers them to their own perspective. However the level of stigma and discrimination has been reduced but still challenging us to implement and offer HIV related services. OST implementation is still lacking political support and this is a challenge for HIV program.

Almost 80% of budget was spent by civil societies in 2013 and NACP support them in capacity building, coordinating with other partners, information for priority needs, procurement and distribution of medication and technical guidance.

The country did not review national policies and laws that are inconsistent with HIV policy and strategies.

There are two main achievements since 2011 that are:

1. Most of Ministers from line ministries participated in observing World AIDS Day each year and provide statement for audience participated in gathering.
2. Memorandum of understanding (MoUs) has been signed with key ministries such as Women Affairs, MMRD, Justice and Irshad, Haj and Auqaf.

As challenges to this particular area, politicians still do not consider HIV as a priority and do not pay attention to this issue. From other hand NACP is operating under the MoPH framework and this issue sometimes shading the multi-sectorial approach.

3. Human Right

There are some non-discriminatory laws and regulation that specify protection for orphans and other vulnerable children; prisoners; women and girls; and young women and young men. None of other groups such as people living with HIV, MSM, migrant/mobile population, PWID, sex workers and transgendered does not have such rule and laws. Below are some examples of laws

1. There are some laws that are supporting no discrimination. For example in Act 52 of Afghanistan Consortium that says ***“The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions the law...”***.
2. According to article number four of prohibition law against women says that ***“violence is crime, no one has the right to violate in their residence, governmental and non-governmental organization, public and other areas, if someone break the law they will receive punishment accordingly”***.

To ensure the implementation of law, the Afghanistan consortium in its article number 58 clearly stated that ***“to monitor respect for human rights in Afghanistan as well as to foster and protect it, the state shall establish the Independent Human Rights Commission of Afghanistan. Every individual shall complain to this Commission about the violation of personal human rights. The Commission shall refer human rights violations of individuals to legal authorities and assist them in defense of their rights. Organization and method of operation of the Commission shall be regulated by law”***. In addition to this committee, another committee in the State and parliament are bodies that monitoring law implementation.

Measuring the level of implementation is challenging and difficult issue to respond, but based on participants’ ground experiences and understanding from local context, almost 70% of these laws have been implemented.

There are some laws that present obstacle to effective HIV prevention for MSM and sex workers. The Afghanistan Consortium is derived from Sharia Law and based on Sharia Law MSM, Sex Work and Changing gender are prohibited. However, it is difficult to pose barriers particularly to activities as sex work or MSM that are strongly prohibited and not accepted socially, but some law and regulation do exist for example equal access to health services according to Afghanistan consortium and Afghanistan public health law.

4. Prevention

There is a strategy and policy to promote information, education and communication (IEC) on HIV for general population. The key messages are address engage in safe sex, fight against violence against women, acceptance and involvement of PLHIV, PMTCT, promote equality, reduce number of sexual partners, use clean needle and syringe and use condom consistently. There were some activities in 2013 implemented by media to convey accurate information on HIV.

Afghanistan has strategy promoting life skills based HIV education for young people. HIV as a subject included in school curriculum at secondary level. In addition, there is another strategy to out of school your people on HIV education.

NSF II is the main strategy promoting IEC and other preventive interventions for key and other vulnerable population e.g. PWID, MSM, sex workers, clients of sex workers, and prisoners. The elements of these IEC materials are condom promotion; opioid substitution therapy (OST); HIV testing and counseling; needle and syringe program; reproductive health; and targeted information on risk reduction.

Since 2011, the following are achievement in prevention area:

1. The coverage of PWID has been increased in four provinces of Afghanistan.
2. Infection prevention and universal precaution have been applying in almost all health facilities.
3. Blood safety has been promoted and all health facilities that provide transfusion are screening blood for Hep B and C, HIV and Syphilis.
4. Knowledge of people and key affect population on HIV has been increased.

As it concern for challenges, coverage is still low and limited to some selected major cities. It is challenging us to ensure equity to key affected population. In addition, size estimation of key affected population is still a challenge in order to plan HIV prevention program effectively.

Afghanistan has identified the specific needs for HIV prevention programs based on available information such as surveys, routine information, ground experience and IBBS. The identified needs are harm reduction interventions, risk reduction interventions, infection prevention, raising awareness, combat stigma and discrimination and information sharing.

It was found that blood safety, condom promotion, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention for PLHIV, reproductive health services, school based education, treatment as prevention and universal precaution have been implemented to majority of people as HIV prevention program. It is worth mentioning that economic support, harm reduction for PWID, prevention of out of school young people, HIV prevention in workplace, PMTCT, MSM and sex worker risk reduction, and reduction of gender based violence were not implemented among majority of target groups.

5. Treatment, care and support

The country has identified the essential element of a package of HIV treatment, care and support. The essential elements identified as treatment including ART and OI, counseling, social support, family support and provision of transport cost. However the level of scaling up of treatment, care and support is not great but based on information from different sources of information, the services were expended to key affected population.

The majority of people do access to ART, ART for TB patients, Cotrimoxazole, pediatric AIDS treatment, palliative care, post-delivery ART provision to women, post exposure prophylaxis, psychological support of PLHIV and their families, STI management, TB preventive therapy, and treatment of common HIV related diseases while the majority do not have access to economic support, family based care and support, HIV care and support in workplace, HIV treatment services in workplace, nutritional care, and early infant diagnosis.

There is policy in place to support provision of social and economic support for PLHIV such as provision of transportation, social re-integration, vocational training. By social integration the level of stigma and discrimination to some extent could be reduced.

The country has the policy for developing/using generic medications or parallel importing of medications for HIV. Afghanistan has access to regional procurement and supply management mechanisms for critical commodities such as OST, Condom, HIV test kits, ARV, Syringes.

Since 2011, the following are achievement in this area:

1. Number AIDS has been increased based on WHO new recommendation on ARV eligibility.
2. Patient monitoring has been improved.
3. Provision of PMTCT
4. Improvement of patient adherence

Geographical limitation is challenge and there are only two centers that offer ARV services. Geographical expansion is a challenge.

The country has policy that addressed orphan and other vulnerable challenge needs. Under the Global Fund program, HIV education was provided to 75000 street children. Lack of fund is still the challenge to expand HIV related services to orphans and other vulnerable children.

6. M and E

There is an M and E plan for the term of 2011-2015 and some partners aligned and harmonized M&E requirement with the National M&E plan. The M&E plan includes data collection strategy and addressed the behavioral surveys, HIV surveillance, routine program monitoring, data analysis strategy, data dissemination and use, well defined standardized set of indicators, and guidelines for data collection. The plan neither includes the evaluation/research studies nor HIV drug resistance surveillance.

There is around 10 percent budget to implement the M&E plan. The M&E unit is function that operates under the NACP. This function has six full time employees as a M&E and surveillance manager, a research, M&E and surveillance consultant, two M&E and surveillance officers; a M&E expert for GF; and a data officer.

There is a mechanism in place to ensure that all key partners submit their M&E data/reports to the M&E unit for inclusion in the national M&E system. All HIV service delivery points has registration book. There is daily register at service delivery points. There is a dedicated staff to count registers in monthly basis and then generate the report. The report then is sharing with HIV provincial coordinator at provincial level. The provincial coordinator then shares the information to central level in quarter basis. The central level providing feedbacks and finding is presenting in quarterly and annual workshop. Data crosscheck, timely submission of report and completeness of data are challenges in the field of M&E.

There is a national M&E and surveillance working group that meet regularly to discuss all M&E related activities. For routine reporting system, there is no national data base but NACP manage to establish national online data base for HIV case reporting. In addition, there is functional health management and information system (HMIS) in the MoPH that collect information on HIV testing and it result from health facilities at national and sub-national levels.

The needs of number of adults and children requiring ART were estimated based on their current needs and further need was not estimated. The HIV coverage is monitoring disaggregated by sex and sub population such as PWID, FSW, MSM, and Prisoners. Collected information is analyzed, feedbacks are given to stakeholders, and information is sharing through different coordination bodies such as HACCA and annual workshop. The information collected from all sites is then used for decision making process. The coverage is also monitoring by geographical areas but is only limited to capital cities.

The NACP publishes an M&E report on HIV including HIV surveillance in its annual report. M&E data usually is using for program improvement, developing national health response and for resource allocation. As a specific example the M&E data is measuring the performance and quality of services.

During 2013, there was no M&E training conducted on only a small scale M&E capacity building related activity was conducted that subjected to the database development.

Since 2011, the following achievements were achieved:

1. Online database for HIV case reporting has been developed.
2. Routine reporting system is strengthened.
3. Feedback system has been established.
4. Second round of IBBS, rapid assessment of western part of Afghanistan have been conducted.

Size estimation of key affected population and capacity development in central and provincial level of M&E staff are challenges in the field of M&E.

A. II. Part B

1. Civil Societies Involvement

Civil societies were contributed to strengthening the political commitment of top leaders and national strategy/policy formulations here in Afghanistan. For example, the ANDS and other key sectorial policies and strategies are developed in active participation of civil society institutions. In particular the civil society organizations have been involved in the process of NSF II and HIV policy development.

The civil society representatives have been involved in the planning and budgeting process for the NSF II. For example the development and revision of NSF II different working groups including civil societies and PLHIV were involved and their inputs were crucial to the program.

Civil societies were involved in national HIV strategy, national HIV budget and national HIV report. The civil societies are included in M&E framework of HIV national response and they are member of M&E working group and participating in decision making process using M&E data. For example, the civil societies and NACP work together and finalize the tool for routine reporting system.

There is national coordination called HIV and AIDS Coordination committee of Afghanistan which is very broad in structure and include different stakeholders such as civil societies, NGOs, PLHIV, PWID and representative from line ministries. However, there is a diverse participation but they only attended the meeting and do not provide significant inputs particularly from PLHIV and PWID. Other target groups such as female sex workers and MSM did not participate in any meeting or workshop due to connected stigma and discrimination.

The civil societies have access to fund for program implementation from NACP. The NACP along with different key development partners such as WHO and UNAIDS provide technical assistance to civil societies. Still the level of access to fund and technical support is limited. Some of activities for some key affected population such as MSM and FSW are not sufficient.

In general, the civil societies provided services to PWID, MSM and sex worker and mainly offering palliative care and HIV testing and counseling. The civil societies also involved in stigma reduction.

Since 2011, the following are achievement in area of civil society's involvement.

1. Civil society has been involved in the entire task force and working group at NACP. For example, the surveillance working group, PMTCT task force, OST workshop, HTC training, workshop were forums that discussed the new WHO recommendation on ART guideline.
2. The civil societies are active member of HACCA and CCM Afghanistan.

Coordination, security and lack of fund to civil societies are challenges of their further involvement.

2. Political support and leadership

The NACP involved PLHIV and PWID in designing NSF II. Most of coordination and technical forums and working groups have members from PLHIV and PWID such as CCM, HACCA, and M&E working group. However the key affected populations were involved in the NSF II development and HIV policy formulation but they did not involve in program implementation.

3. Human Right

There are some non-discriminatory laws and regulation in place that specify protection for orphans and other vulnerable children; prisoners; women and girls; and young women and young men. None of other groups such as people living with HIV, MSM, migrant/mobile population, PWID, sex workers and transgendered does not have such rule and laws. Below are some examples of laws:

1. There are some laws that are supporting no discrimination. For example in Act 52 of Afghanistan Consortium that says ***"The state shall provide free preventative healthcare and treatment of diseases as well as medical facilities to all citizens in accordance with the provisions the law..."***.
2. According to article number four of prohibition law against women says that ***"violence is crime, no one has the right to violate in their residence, governmental and non-governmental organization, public and other areas, if someone break the law they will receive punishment accordingly"***.
3. According to article number 53 of Afghanistan consortium that says ***"The state shall adopt necessary measures to regulate medical services as well as financial aid to survivors of martyrs and missing persons, and for reintegration of the disabled and handicapped and their active participation in society, s in accordance with provisions of the law. The state***

shall guarantee the rights of retirees, and shall render necessary aid to the elderly, women without caretaker, disabled and handicapped as well as poor orphans, in accordance with provisions of the law”

4. According to article number 17 of Prison Law, there are several items identified to some non-discriminatory policies. One of them is provision of health services and clearly says that ***“Ministry of Justice and MoPH should establish function health center within all prisons; Health providers, in addition to the patient checkup and treatment, are responsible to examine routine health check form all prisoners at least once a month; Prison health facility should provide treatment within prison and detention centers; If treatment is not available within prison health center, the patient should refer out to external facilities; ...”***.

To ensure the implementation of law, the Afghanistan consortium in its article number 58 clearly stated that ***“to monitor respect for human rights in Afghanistan as well as to foster and protect it, the state shall establish the Independent Human Rights Commission of Afghanistan. Every individual shall complain to this Commission about the violation of personal human rights. The Commission shall refer human rights violations of individuals to legal authorities and assist them in defense of their rights. Organization and method of operation of the Commission shall be regulated by law”***. In addition to this committee, another committee in the State and parliament are bodies that monitoring law implementation.

Measuring the level of implementation is challenging and difficult issue to respond, but based on participants’ ground experiences and understanding from local context, almost 80% of these laws have been implemented.

There are some laws that present obstacle to effective HIV prevention for MSM and sex workers. The Afghanistan Consortium is derived from Sharia Law and based on Sharia Law MSM, Sex Work and Changing gender are prohibited. However, it is difficult to pose barriers particularly to activities as sex work or MSM that are strongly prohibited and not accepted socially, but some law and regulation do exist for example equal access to health services according to Afghanistan consortium and Afghanistan public health law.

There are policies and laws to reduce violence against women. According to article number four of prohibition law against women says that ***“violence is crime, no one has the right to violate in their residence, governmental and non-governmental organization, public and other areas, if someone break the law they will receive punishment accordingly”***. In addition Afghanistan committed to the United Nations Security Council Resolution 1325, called upon all countries to allow increased representation for women at all levels.

According to Afghanistan HIV code of ethics the human right issue is describe and says that ***“All persons seeking HIV prevention treatment, care, and support services should be treated with respect and have their well-being and security safeguarded; ... and People living with HIV and AIDS will have the same rights as all other citizens, and will not be discriminated against or stigmatized on the basis of their HIV status, gender, socioeconomic status, or HIV-risk behaviors...”***.

Afghanistan has policies to provide free of charge ART, HIV prevention services and HIV related care and support intervention to all people. Two categories are identified as priority groups PLHIV and PWID. Those PLHIV who are eligible for ART, the treatment including OI, care and support are provided free of charge through two ART centers that are located in Kabul and Herat. The second group is PWID who are provided the harm reduction services without any charge and fee. In addition vocational training was also provided to some of clients under the OST program.

The country has policies to ensure equal access for women and men to HIV prevention, treatment, care and support services. People living with HIV and AIDS will have the same rights as all other citizens, and will not be discriminated against or stigmatized on the basis of their HIV status, gender, socioeconomic status, or HIV-risk behaviors. The NSF II clearly specified the equal access to men and women. It also specifies services for children affected by AIDS. The multi-sectorial strategy address different approach to HIV prevention services such as harm reduction through fixed center and out-reach for PWID, provision of ART and OI to PLHIV who are eligible for ART and OI. For general population the program established VCT centers to offer HIV testing and counseling. For advocacy and inclusive purpose MopH has signed MOU with different line ministries. However, there is no policy or law that prohibiting for general employment purposes but most respondents state that there if employer know people HIV status they will not recruit those individuals who have HIV.

The country has a mechanism to monitor the human right protection but there are no performance indicators or benchmarks for compliance with human right standards.

To raise awareness and educate human right, training has been conducted to key affected population in last two years. In addition some training were conducted to judiciary and law enforcement staffs.

There are some program to health care workers, media and work place to reduce the level of stigma and discrimination associated with HIV and AIDS.

Since 2011 gender strategy and human right strategies were developed and gender departments were established in almost all ministries.

Law and regulation due to some reasons are not fully implemented. In addition, unavailability of specific laws and regulation for key affected are challenges in this particular domain.

4. Prevention

Afghanistan has identified the specific needs for HIV prevention program. The specific needs for HIV prevention were identified through a gap analysis conducted for NSF II. In addition through series of meeting with key stakeholder and key affected population; and conducting rapid assessments in western part of Afghanistan these needs were identified. These needs are:

1. PWID are the main driver of HIV here in Afghanistan so the harm reduction package is provided to PWID as preventive strategy.
2. Targeted interventions for other key affected population such as MSM and FSWs also the needs that have been identified
3. Raising awareness for general public using variety means of communication such as media, leaflet, poster, integration of HIV messages to the school curriculum are the needs for the general population.

It was found that blood safety, condom promotion, harm reduction to PWID, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, PMTCT, prevention for PLHIV, reproductive health services, risk reduction for intimate partners of key populations, risk reduction for MSM and sex workers, school based HIV education for young people have been implemented and accessible to majority of people as HIV prevention program. It is worth mentioning that prevention of out of school young people, HIV prevention in workplace, and universal precaution in health care setting are not accessible to majority of target groups.

Since 2011, following are main achievements:

1. Establishment of VCTs and DICs centers around the country and implementation of harm reduction intervention among PWIDs
2. Signing of MoUs with line ministries, revision of NSF II, developing of NACP policy and guidelines, HTC, and ART guidelines are others achievement since 2011.
3. Targeted interventions for PWID, FSW and MSM and piloting OST could be other achievements.

The program low or no expansion to other part of country and lack of sufficient fund for intervention among FSW and MSM are challenges to risk reduction interventions' implementation.

5. Treatment, care and support

The country has identified the essential elements of a comprehensive package of HIV treatment, care and support services. These services are: Provision of ART, OI, harm reduction services, referral to TB screening, provision of transportation cost, and social integration. However, there are only two ART centers and most of PLHIV may not have access to them but currently the program support PLHIV providing them transportation cost has contributed adhering PLHIV in treatment. Patient monitoring also has improved and now patients trust the program.

The majority of people do access to ART, ART for TB patients, Cotrimoxazole, HIV testing and counseling, post exposure prophylaxis, psychological support of PLHIV and their families, STI management, TB preventive therapy, and treatment of common HIV related diseases while the majority do not have access to early infant diagnosis, HIV care and support in workplace, HIV treatment services in workplace, nutritional care, post-delivery ART provision to women, and post exposure prophylaxis to non-occupational exposure.

Since 2011, the following are the main achievement in this area:

1. Two ART centers functioned, more patient registered for treatment. Drugs are available to treat the patient.
2. Implementation of Harm Reduction package, securing funds from GF under TFM till end of 2015, support for NACP until 2018 from WB through SEHAT project. Also technical support of international partners such as UNAIDS, UNODC, WHO etc. are available to program.

Geographic limitation to ART centers, poverty, illiteracy, and limited fund are challenges in this particular area.

However, there is a policy in place to address the needs of orphans and other vulnerable population but there is no clear definition for orphans and vulnerable children within country.