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TECHNICAL ANNEX

FOR A PROPOSED GRANT

IN THE AMOUNT OF SDR 6.60 MILLION

(US$10.0 MILLION EQUIVALENT)

TO THE

THE ISLAMIC REPUBLIC OF AFGHANISTAN

FOR A

HIV/AIDS PREVENTION PROJECT

July 5, 2007

Human Development Unit
South Asia Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective April 30, 2007)

Currency Unit	=	Afghani
Af 50	=	US$1
US$1	=	SDR 1.450

FISCAL YEAR
March 21 – March 20

ABBREVIATIONS AND ACRONYMS

AHAPP	Afghanistan HIV/AIDS Prevention Project
ACBAR	Agency Coordinating Body for Afghan Relief
AFGA	Afghan Family Guidance Association
AIDS	Acquired Immunodeficiency Syndrome
ANASF	Afghanistan National AIDS Strategic Framework
ANCB	Afghan Non-Governmental Organisations Coordination Bureau
AMI	Aid Medical International
APWC	Afghan Peace-seeking Women's Council
ARDS	Afghanistan Reconstruction and Development Services
ART	Anti Retroviral Treatment (Therapy)
BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
CAF	Children's AIDS Fund
CBHC	Community-based Health Care
CBO	Community-based Organization
CRS	Catholic Relief Services
DA	Designated Account
DaB	Da Afghanistan Bank
DAC	Development Assistance Committee
DIC	Drop in Centre
EC	European Commission
FMA	Financial Management Arrangements
EPAP	Emergency Public Administration Project
FSW	Female Sex Worker
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
GNP	Gross National Product
GoA	Government of Islamic Republic of Afghanistan
HACCA	HIV/AIDS Coordinating Committee of Afghanistan
HIV	Human Immunodeficiency Virus
H-SWG	HIV Surveillance Working Group
HMIS	Health Management Information System
HR	Harm Reduction
I-ANDS	Interim Afghanistan National Development Strategy

IBBS	Integrated Biological and Behavioral Surveys
IBRD	International Bank for Reconstruction and Development
IC-WM	Infection Control and Waste Management
IDA	International Development Association
IDU	Injecting Drug Use(r)
IEC	Information, Education and Communication
IMF	International Monetary Fund
KAP	Knowledge, Attitudes and Practices
KOR	Khatiz Organization for Rehabilitation
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOCN	Ministry of Counter-Narcotics
MOD	Ministry of Defense
MOE	Ministry of Education
MOF	Ministry of Finance
MOHE	Ministry of Higher Education
MOHIA	Ministry of Haj and Islamic Affairs
MOI	Ministry of Interior
MOJ	Ministry of Justice
MOPH	Ministry of Public Health
MORR	Ministry of Returnees and Refugees
MOU	Memorandum of Understanding
MOWA	Ministry of Women's Affairs
MDM	Medecins du Monde
MSM	Men who Have Sex with Men
MSW	Male Sex Worker
NACP	National AIDS Control Program
NCA	Norwegian Church Aid
NGOs	Non Government Organizations
OECD	Organization for Economic Co-operation and Development
OI	Opportunistic Infection
PACBP	Public Administration Capacity Building project
PEFA	Public Expenditure and Financial Accountability
PFM	Afghanistan's Public Finance Management system
PIP	Program Implementation Plan
PLWHA	People Living with HIV and AIDS
POP	Program Operational Plan
PPU	Procurement Policy Unit
SCA	Swedish Committee for Afghanistan
SDU	Special Disbursement Unit
SGS	Second Generation Surveillance
SOEs	Statement of Expenses
STI	Sexually Transmitted Infection
SW	Sex Worker
TIs	Targeted Interventions
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Program
UNGASS	United Nations Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund

UNODC	United Nations Office on Drugs and Crime
VCCT	Voluntary Confidential Counseling and Testing
VCT	Voluntary Counselling and Testing
WADAN	Welfare Association for Development of Afghanistan
WHO	World Health Organization

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AFGHANISTAN

Afghanistan HIV/AIDS Prevention Project

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I. PROJECT RESULTS FRAMEWORK

Project Indicators	Baseline Yr 0	Target End Yr 3*	Frequency and Reports	Data Collection Instruments
Program Development Objectives:				
1. HIV prevalence in general population	<0.5%	<0.5%	Every 2 years	Modeling
2. HIV prevalence among high risk groups (IDU , SW)	IDU: 3%*	<=5%*	Every 2 years	IBBS
Project Key Performance Indicators:				
3. Percentage of IDUs reporting use of sterile injection equipment at last time injected	--%*	30 % age point increase	Every 2 yrs	IBBS
4. Percentage of IDUs reporting use of condom at last time sex	--%*	20 % age point increase	Every 2 yrs	IBBS
5. Percentage of SW reporting use of a condom with their most recent client	--%*	50%	Every 2 yrs	IBBS
6. Percentage of truckers reporting use of a condom last time with sex worker	--%*	20 % age point increase	Every 2 yrs	IBBS
7. Percentage of prisoners who report access to sterile injecting equipment.	--%*	20 % age point increase	Every 2 yrs	IBBS
Project Intermediate Outcomes & Outputs by component:				
Component 1. Advocacy and Communications				
8. Score on subset of National Composite Policy Index (UNGASS)**	--		Every 2 years	Policy assessment
9. Percentage of those aged 15-24 who correctly identify ways of preventing HIV transmission – measured in geographic areas specific to program.	--%*	20 % age point increase	Every 2-3 years	NRVA
Component 2. Strengthening Surveillance				
10. Percentage of urban centers which have done high risk group mapping	3 cities	33% of provinces	Annual	NGO reports
11. Number of annual NACP reports and action plans informed by surveillance and routine monitoring data.	--	Every year	Annual	Annual report and action plan
Component 3. Targeted Interventions for at risk groups				
12. Percentage of most at risk populations (e.g., IDUs, FSWs, truckers, prisoners) reached by HIV prevention program	--	IDU: 60% FSW: 50% Trucker: 25% Prisoner: 80%	Every 2 yrs; Annual	IBBS Routine monitoring
13. Percentage of most at risk populations (e.g., IDUs, FSWs, truckers, prisoners) who correctly identify 2 ways of preventing HIV transmission	--%*	IDU: 50% FSW: 50% Trucker: 50% Prisoner: 75%	Every 2 yrs	IBBS
14. Percentage of TI sites meeting service quality standard	--	IDU: 5 of 6 FSW 1 of 1 Trucker: 1 of 1 Prisoner: 1 of 1	Annual	Balanced score card assessment
Component 4. Program management and Capacity building				
15. Percentage of contracted/ sanctioned implementation units w/ uninterrupted fund flow and service delivery.	--	85%	Annual	GCMU reports

*to be adjusted using results of baseline surveillance data, ongoing;

**A subset of Afghanistan policy priorities to be taken from United Nations Special Session on HIV and AIDS (UNGASS) Policy Index and developed into a score.

II. PROJECT OBJECTIVES AND DESCRIPTION

A. Objectives

1. The project will contribute to the national development goals of the Interim Afghanistan National Development Strategy (I-ANDS) of maintaining Human Immunodeficiency Virus (HIV) prevalence below 0.5 percent in the general population and below 5 percent among vulnerable groups at high risk of infection. The project's development objectives are to slow down the spread of HIV and build up the national capacity to respond to the epidemic. This will be accomplished by: (a) behavior change among vulnerable groups at high risk; and (b) improving knowledge of HIV prevention and reducing stigma related to HIV and (Acquired Immunodeficiency Syndrome) AIDS in the general population.

2. The key performance indicators that will be used to track the project development objectives are:

(a) the percent of injecting drug users who have adopted behaviors that reduce transmission of HIV, that is, who use clean injecting equipment at last time injecting;

(b) the percent of sex workers who report using a condom with their most recent client; and

(c) the percent of young people aged 15-24, in areas covered by the project, who correctly identify ways of preventing HIV transmission.

B. Description of Project Components

Component 1: Communications and Advocacy

3. This component will strengthen the advocacy and communication capacity of the National AIDS Control Program (NACP) to create a policy environment that enables scaling up of targeted interventions for vulnerable populations at high risk, and reduces stigma and discrimination related to high risk behaviors. Specifically, informed advocacy among policymakers and opinion leaders will aim to reduce stigma and harassment of vulnerable populations and have leaders: (a) appreciate the threat of HIV to Afghanistan; (b) better understand the actions that can prevent a full-blown HIV epidemic; (c) become effective sources of information for the rest of the community; (d) take actions themselves to assist their communities to avoid HIV; and (e) provide continuous support for the AIDS control program. It has been agreed that a national policy statement with commitment to the principles of confidentiality and the voluntary nature of HIV testing will be in place at the start of the project, and that during the course of the project, appropriate substitution treatment policy for injecting drug users (IDUs) will be developed. The communications activities, including behavior change communication and media activities described below, will increase access to information and appropriate knowledge of HIV prevention and other related health issues for vulnerable groups at high risk, including sex workers and their clients, truckers, and youth in areas covered by the project. The behavior change interventions will include a focus on the use of clean needles and syringes, and on condom use among IDUs and their partners; on consistent condom use among sex workers and their clients; and, on appropriate knowledge about HIV transmission and ways of preventing it among all vulnerable populations at risk.

4. Activities will include (a) target audience research; (b) development of an advocacy strategy and activities such as high level meetings, training, and dissemination of evidence-based advocacy information packages; (c) development of core training and information packages for target audiences for use by service providers; (d) specific communication training for Non Government Organizations (NGO) service providers, journalists, private practitioners and others; (e) gender- and culturally

appropriate communication media targeting vulnerable persons at risk; (f) audience surveys; and (g) reporting. To ensure a coherent approach and complementarity of activities, one organization will be contracted to develop the plan and implement all elements of the communication and advocacy component under the coordination and guidance of the National AIDS Control Program (NACP).

Component 2: Strengthening of HIV Surveillance

5. This component will build the evidence base for HIV and AIDS planning and help monitor and evaluate the effectiveness of the program. It will build NACP capacity to track the magnitude and trajectory of the HIV epidemic in Afghanistan through the development of second generation surveillance (SGS) system. The SGS system includes separate mapping and size estimation of at risk populations, collection of biological data from representative samples of the populations, and tracking the behaviors that contribute the most to HIV transmission dynamics. Based on the current understanding of the epidemic, these behaviors are injecting drug use and unsafe sex. In addition to providing data for monitoring of the epidemic, the wide array of knowledge, behavioral, and service utilization data collected through SGS will provide the basis for future resource allocation and program management decisions to be made by NACP. All the SGS data will therefore be owned by, and readily available to, the NACP, and generated on an intermittent or routine basis, and not subject to the same internal review processes put in place for research and special studies. All surveillance activities involving HIV testing will follow the standard confidentiality and voluntary testing procedures of the voluntary confidential counseling and testing (VCCT) sites.

6. Epidemiologically relevant data in Afghanistan remain scarce; however some recent studies of at risk populations will be used to refine the selection of survey groups and locations for the baseline round of the surveillance activities. As the baseline round of surveillance data become available, adjustments and potential expansions of the surveillance sites and target populations will be made as needed to more appropriately monitor the epidemic. Likewise, the preliminary targets established by the program (see results framework) will be adjusted based on available data.

7. The SGS activities will be implemented by an organization selected through international competitive bidding. This organization will work with the National AIDS Control Program (NACP), guided by an HIV Surveillance Working Group (H-SWG), to train its staff to conduct surveillance, obtain all necessary test kits and other materials, provide timely reports, and disseminate findings. The surveillance firm is given explicit responsibility for conducting national level capacity building on SGS methods and providing thorough documentation on the design and execution of the various studies. The terms of reference for surveillance include: (a) an initial desk review of currently available information about location and size of at risk populations, including characterization with respect to patterns of mobility and intersection with other risk groups; (b) annual mapping and size estimation of at risk populations in urban centers (up to 8 sites every second year or twice during the duration of the project); (c) integrated biological and behavioral surveys (IBBS) of IDU, female sex worker (FSW), prisoners, and truckers using probability based methods conducted twice during the Program Implementation Plan (PIP) period; (d) two rounds of Knowledge, Attitudes and Practices (KAP) surveys of mainstream opinion leaders to assess the effectiveness of the advocacy and communication component; (e) annual data synthesis and epidemic modeling of available surveillance and other data to project the impact of the epidemic on the overall country scenario.

8. Due to the importance of obtaining baseline measures for the core program indicators in order to measure project results, the data collection activity for the IBBS of IDU, SWs, and prisoners should be completed within the first 6-9 months of the project. The early development of service quality standards and guidelines for different program components will also ensure that the survey instruments are specific and relevant to the program being implemented.

Component 3: Targeted Interventions for High Risk Behaviors

9. This component will support targeted interventions (TIs) to prevent further spread of HIV among vulnerable groups at highest risk (see Appendix 5 for definition of TI packages). The TIs will support safe practices and reduce risky ones. The targeted intervention for HIV prevention among IDUs provides a comprehensive harm reduction package, including needle and syringe exchange, peer counseling and education, and condom promotion, delivered at drop in centers and through other outreach services. The services will be delivered where HIV transmission is most likely to occur, based on mapping of high risk populations and sero prevalence survey data, with flexibility to expand to new sites as they are identified. Proposals will be invited from NGOs for work with identified groups, such as IDUs and their partners, sex workers and their clients, and others as appropriate in selected sites starting with the major urban areas. In Kabul, due to the estimated size and spread of mainly street based IDUs, there will be three contracts covering different parts of the city and surrounding areas, while in the other three cities with surrounding areas (Herat, Jalalabad and Mazar) there will be one contract for each area. NGOs will provide the services under contract with the Ministry of Public Health (MOPH). The Grants and Contracts Management Unit (GCMU) will have the managerial and financial responsibilities and the NACP will provide the technical supervision.

10. The terms of reference (TOR) for targeted interventions for IDUs, sex workers and their clients, truckers and prisoners will include (a) gathering of baseline data to estimate the size of the population to be covered, on a case by case basis, taking into account local data needs and the data that is already available through social mapping; (b) establishment and operation of appropriate services such as, in the case of HIV prevention among IDUs, drop in centers (DIC), social support, needle and syringe exchange, condom distribution, sexually transmitted infections (STI) care, other medical support, and VCCT; and (c) reporting. The contracts for IDUs will target groups in four cities and their surrounding areas with flexibility to expand to new sites each following year based on data showing additional sites (hot spots) with concentration of persons with high risk behaviors. There will be only one contract each for HIV prevention among truckers, sex workers and their clients, and prisons. Procurement of this will be based on competitive bidding. The prison program and one of the IDU TIs will include operations research to assess the feasibility of alternative options for effective substitution therapy, to inform national policy to be developed on substitution therapy. Ethnographic study will be conducted to learn more about MSM networks and how to design appropriate strategies for reaching Men who have Sex with Men (MSM) with HIV prevention interventions.

Component 4: Program Management, Capacity Building, Monitoring and Innovation Activities

11. This component will strengthen the core functions of the national HIV/AIDS prevention program, including program management, capacity development, and monitoring by NACP and the multi sector HIV oversight of the HIV/AIDS Coordinating Committee of Afghanistan (HACCA). This component will also provide funding of innovative approaches – an "Innovation Initiative" for mainstreaming of the national multi sector HIV response. Membership of HACCA is extensive and includes NGOs and civil society representatives as well as ministries listed below. Capacity building activities in this component will facilitate learning and include exposure visits, short term TA, training, including training of health services providers, and conferences leading up to policy development and review. The NACP will be supported though six national advisors, the program manager, and an international advisor – two of the national advisors will support the GCMU on financing and procurement. The Project will support NACP office operations and transport for monitoring and supervision activities, including regular (monthly) visits to activity sites throughout the country.

12. This component will support the development of routine monitoring and service quality assessment, closely aligned with the existing Monitoring and Evaluation (M&E) and Health

Management Information System (HMIS) of the MOPH, and including an action plan, timeline, and assigned responsibilities to the M&E advisor and other NACP staff. Standardized, routine monitoring indicators and formats will be developed for each program area. The principles and operations of routine monitoring for NACP will be consistent with established practices of the larger MOPH M&E and HMIS system for Basic Package of Health Services/Emergency Project Health Services facilities. This includes emphasis on local units reviewing and analyzing their own data for program management purposes. In a few program areas, where other ministries or other MOPH departments (e.g., Ministry of Counter-Narcotics (MOCN) or the MOPH demand reduction unit) play a role in managing NACP supported or externally funded activities, it will be critical to obtain consensus on routine monitoring standards and requirements so that NGOs receiving funds from multiple donors follow a single standard, and data can be analyzed across various types of implementation units.

13. The Innovation Initiative for multi sector mainstreaming will invite proposals from sectors other than health. The Innovation Initiative will enable other line ministries, NGOs and the private sector to develop action plans in support of the project development objectives, through a memorandum of understanding with the MOPH/NACP (line ministries) and through NGO contracts managed by the MOPH/GCMU. This will enable innovative HIV prevention activities, for example among women, youth, refugees and returnees, and other initiatives to reduce stigma in different population groups. The grants under the Innovation Initiative will include: (a) baseline (if available); (b) appropriate innovation activity for an agreed target group in an agreed location; (c) monitoring and evaluation plan; and (d) reporting. The first round may cover several contracts for different audiences and/or target groups. The second and third round may extend these contracts and/or add contracts for additional audiences and/or target groups.

14. **Project Costs.** The estimated cost of the project with contingencies is about US$10.0 million over three years. The project costs summary and cost breakdowns by components are described in more detail in Appendix 1.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional Arrangements

15. The project will be implemented over a three year period by the MOPH. The institutional framework is in place, assigning the program coordination, management and technical roles to MOPH/NACP and the financial management and procurement responsibilities to the MOPH/GCMU, under the overall multi sector oversight of HACCA. Technical working groups are being established (i.e., HIV Surveillance WG) by the NACP to guide its work program, drawing on available technical experts from professional, academic, research or other organizations within the country. These technical working groups will support and report to NACP, which in turn will present the recommendations of the technical working groups to the HACCA for endorsement. The MOPH will contract the surveillance and communications components of the project to agencies that can carry out those functions while developing and transferring capacity in these areas. The targeted interventions for the prevention of HIV among IDUs, sex workers and their clients, truckers and prisoners will be contracted to NGOs and Community-based Organizations (CBOs) with experience in working with the communities at risk. Non-health ministries, private sector and NGOs will be able support or implement HIV prevention programs, funded through the Innovation Initiative, by preparing proposals to be reviewed by a multi sector review panel led by the NACP, and reporting to the HACCA. Specifically, the roles of the NACP, GCMU and HACCA are as follows:

16. **National AIDS Control Program** will lead the implementation of the proposed project, in close coordination with relevant departments within MOPH, i.e., Reproductive Health, Mental Health/Drug Demand Reduction, Information, Education and Communication (IEC), Environmental

Health, and M&E Departments and with key non-health sectors. The targeted intervention activities will be contracted out to NGOs and CBOs. Working with NGOs and CBOs in the prevention, treatment and care of HIV and AIDS is international best practice, and will: (a) facilitate access and use of preventive services among vulnerable groups at highest risk through peer educators and other outreach strategies; (b) ensure the protection of communities at highest risk; and (c) help sustain the program among communities at risk. The strengthening of surveillance and the communications components will also be contracted to organizations with experience in carrying out and building capacity in these areas. MOPH has a good track record of implementing the Health Sector Emergency Reconstruction and Development Project, which includes the NGO-contracting approach to service delivery. In fact, civil society involvement is even more relevant to HIV prevention efforts, because the vulnerable population groups are particularly difficult to reach through governmental channels and need to be involved for effective coverage and quality. The proposed multi sector Innovation Initiative under AHAPP will be managed by the MOPH, reporting to HACCA. A multi sector review board, chaired by the NACP, will approve proposals from non-health sectors, through the Innovation Initiative.

17. The NACP capacity will be strengthened. NACP is currently staffed by a Program Manager, an international advisor (supported by the project), and four officers, most of whom need to further their skills and expertise in HIV/AIDS program management. The NACP is in the process of recruiting a total of six national advisors to help build NACP and GCMU capacity in the following areas: (a) monitoring and evaluation; (b) advocacy and communication; (c) IDU interventions; (d) interventions for other vulnerable populations; (e) procurement; and (f) accountant/financial management. The NACP team will focus on the monitoring, coordination, quality control and management of various activities proposed by the AHAPP, while the GCMU, which has a strong track record of handling project financing and procurement, will manage those aspects of the project.

18. **HIV/AIDS Coordination Committee of Afghanistan** (HACCA) has been established by MOPH to ensure a broad-based and inclusive oversight mechanism. This multi sector committee is chaired by the Deputy Minister for Technical Affairs of MOPH, and includes the participation of key ministries, agencies from public and private sectors, civil society and external development partners. HACCA will have eight provincial representatives (representing all 34 provinces) and two representatives of people living with HIV and AIDS (PLWHAs) to guide the national Program Operational Plan (POP) and the Project Implementation Plan (PIP), a subset of the POP, and begin a deeper involvement of various sectors and partners. HACCA will play a critical role in the process of developing a national policy on HIV/AIDS to be endorsed by key ministries and parliament, including support to the principles of confidentiality and voluntary testing and the protection of vulnerable groups at high risk from stigma and discrimination.

19. **Grants and Contracts Management Unit.** The Head of the accounting department for GCMU in MOPH will manage the financial transactions of the program, such as the preparation of M-16 forms (payment orders), coordination with other line ministries involved in the program, and overall contract and project management. This department is staffed with financial management (FM) personnel who are efficiently managing all current external grants including the (International Development Association (IDA) Health Sector Project. A qualified and experienced procurement specialist and an accountant are being recruited by MOPH to strengthen the financial management and procurement capacity of GCMU to handle the additional work related to the AHAPP.

B. Financial Management, Disbursement and Audit Arrangements

20. An Afghanistan's Public Finance Management (PFM) performance rating system has recently been developed for Afghanistan by the Public Expenditure and Financial Accountability (PEFA) multi-agency partnership program, which includes the World Bank, International Monetary

Fund (IMF), EC, and other agencies. Afghanistan's ratings against the PFM performance indicators portray a public` sector where financial resources are, by and large, being used for their intended purposes as authorized by a budget that is processed with transparency and has contributed to aggregate fiscal discipline.

21. Financial management and audit functions for the proposed project will be undertaken through the agents contracted under the Public Administration Capacity Building project. This is the primary instrument for continuing to strengthen the fiduciary measures put in place for ensuring transparency and accountability of funds provided by the Bank and other donors. Under these contracts, two advisers—Financial Management and Audit—are responsible for working with the government and line ministries to carry out these core functions. The Financial Management Agent (FMA) is responsible for helping the Ministry of Finance (MOF) maintain the accounts for all public expenditures, including IDA-financed projects and for building capacity within the government offices for these functions.

22. At the project level, financial management will be coordinated by the NACP through the GCMU of MOPH. The financial management capacity in GCMU, which has experience in the management of Bank projects, will be strengthened by the recruitment of an additional qualified and experienced accountant.

23. Quarterly Financial Monitoring Reports will be prepared by the NACP/GCMU/MOPH accounting unit. Consolidated project reports will be prepared, reviewed, and approved by the MOF, supported by the FMA.

24. A Designated Account (DA) with a ceiling of US$500,000 will be opened at Da Afghanistan Bank (DaB, Central Bank) in the name of the project on terms and conditions satisfactory to IDA. The DA will be maintained by the MOF. Withdrawal applications for reimbursement will be submitted monthly. Financial management arrangements for the project are detailed in Appendix 4.

Fund Flows

25. Fund management for the Project will follow existing procedures. As with all public expenditure, all payments under the project will be routed through MOF. The FM Agent will assist the MOF in executing and recording project payments. In keeping with current practices for other projects in Afghanistan, the DA will be operated by the Special Disbursement Unit (SDU) in the Treasury Department MOF. Requests for payments from DA funds will be made to the SDU by MOPH. In addition to payments from DA funds, MOPH can also request the SDU to make direct payments to contractors, consultants or consulting firms, and to request issuance of special commitments for contracts covered by letters of credit. Such requests will follow World Bank procedures. All withdrawal applications to IDA, including reimbursement, advances, special commitment and direct payment applications, will be prepared and submitted by MOF. GCMU/MOPH will prepare statements of expenditures based on suggested formats given by the Bank.

Accounting and Reporting

26. A Financial Management Manual will be prepared by MOPH documenting the financial management arrangements for the project, including detailed arrangements and procedures for payments and reporting for those that will benefit from the Innovation Initiative. The manual will outline guidelines for project activities including specific requirements for line ministries involved in the program, and establish a project financial management system in accordance with standard Afghan government policies and procedures. This will include use of the Chart of Accounts

developed by the FMA to record project expenditure. Project accounts will be consolidated centrally in MOF, through the SDU and supported by the FMA. Consolidated Project Financial Statements will be prepared for all sources and uses of project expenditures.

Innovation Initiative

27. An amount of US$1,000,000 is to be set aside from the project funds for innovative activities that will strengthen multi-sector responses from government departments, community NGOs, and private firms according to the project's results framework and essential packages of services. Budgets for the Innovation Initiative will form part of the total project budget for MOPH which will be the responsible line ministry for the expenditures incurred, irrespective of the benefiting line ministry.

28. Disbursements for proposals approved by the multi sector review Board under the Innovation Initiative will require signed performance agreements (i.e., MOUs for line ministries and contracts for community NGOs and private firms) between the MOPH and the recipient institutions. The performance agreements will delineate each party's responsibilities, record procedures for procurement and financial management, and contain a copy of the approved funding proposal. It will also define performance milestones in project implementation that, when verified, serve as triggers for the release of additional payments, after the initial tranche payment made based on the proposal. For NGOs and CBOs, IDA is financing the sub-grant on either a lump sum or tranched basis, with MOPH doing detailed monitoring of actual expenditures of sub-grant funds. For other Line Ministries, IDA is financing the procurement contracts (for works, goods, services) awarded and thus, doing actual expenditure monitoring and requiring expenditures (use of sub-grant proceeds) to be provided via either records (supporting documentation) or reports of statement of expenses (SOEs).

29. For financial reporting from recipient institutions, reports will be submitted quarterly or at the time of request for funds tranche release, whichever is earlier. The reports shall consist of financial and physical progress. MOPH will design common reporting formats or templates, in order to enable it to assemble financial information from a number of participating institutions into an aggregate report for onward submission to the Bank (as part of the quarterly interim un-audited project financial reports). Details and formats would be included in the project's financial management manual.

Disbursement Method

30. Disbursements from the IDA grant will be in accordance with the Bank's Disbursement Handbook for World Bank Clients and include advances reimbursement, direct payment, and payments under Special Commitments including records (full documentation) or against summary reports (statements of expenditures), as appropriate.

Audit of Project Funds

31. The Auditor General, supported by the Audit Agent, is responsible for auditing the accounts of all IDA-financed projects. Annual audited project financial statements will be submitted within six months of the close of GoA's fiscal year.

C. Procurement Arrangements

32. Procurement activities will be carried out by the MOPH through the GCMU.

33. Procurement will be in accordance with the World Bank's "Guidelines: Procurement under International Bank for Reconstruction and Development (IBRD) Loans and IDA Credits" (dated May

2004; revised October 2006); "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" (dated May 2004; revised October 2006); and the provisions stipulated in the Development Grant Agreement. The Bank's Standard Bidding Documents, Requests for Proposals, and Forms of Consultant Contract will be used. In case of conflict/contradiction between the Bank's procurement procedures and any national rules and regulations, the Bank's procurement procedures will take precedence. The summary of the procurement capacity assessment of the implementing agencies and precise arrangements are presented in Appendix 3.

D. Monitoring and Evaluation Arrangements

Monitoring Arrangements

34. M&E of the national program will be NACP's responsibility, in cooperation with the M&E department of MOPH, and aligned with the HMIS. The project will strengthen the capacity of the NACP to monitor program implementation and evaluate progress towards the national HIV development goal, which is to keep national HIV prevalence below 0.5 percent among the general population and below 5 percent among the population groups with high risk behaviors. Strengthening of surveillance is a major component of the project, since sero-prevalence and behavioral data are critically needed to inform policy, priorities and decision making. As part of evaluation, the project is also considering support for a feasibility study of piloted harm reduction interventions, to strengthen the evidence base for the most effective, feasible and appropriate substitution therapy options in the Afghanistan context. Other special studies include an ethnographic survey of MSM and analysis of the relationship between injecting drug use, poppy cultivation and counter narcotics policies. These evaluation data and special studies will supplement the routine monitoring system, which will collect and analyze data, contributing to, and using a compatible database platform as the existing MOPH HMIS system.

35. The project results framework (Section 1) was developed to ensure consistency between the PIP and the broader POP, and linking project components and major actions with expected outcomes. A checklist for the policy assessment index is being prepared to identify core policy issues necessary to create an enabling environment for HIV/AIDS control programs to be effective in Afghanistan. The checklist is intended to award credit for partial achievements in advocacy considering the substantial effort required to pass policy and legislation. Scoring is determined objectively according to whether policies are in place and supportive follow-up actions to enforce or apply such policies have occurred.

36. The ongoing social mapping of high risk groups and the surveys of sero-prevalence and behavioral determinants among those and other groups (University of Manitoba and University of California San Diego/NAMRU-3 respectively) will provide some results by mid 2007 and help build a baseline for the project. The ongoing exercise is also building skills in the country to map high risk groups, skills essential for implementation and monitoring.

37. Project Monitoring will be carried out at different levels. At the level of NACP, the Manager would conduct quarterly reviews with NACP staff and implementation partners (NGOs, CBOs, non-health line ministries that draw from the multi-sector fund and academic or research institutions that would carry out research studies). At the level of MOPH, the Deputy Minister for Technical Affairs would conduct regular biannual reviews. HACCA will also review the progress of project implementation at Annual Review meetings, including all development partners. A routinely collected set of monitoring data and service quality assessments will comprise the basis of these reviews. The specific indicators in both these sets will reflect the terms of reference of the program component, and the guidelines/operations manual developed for use by the implementation agencies.

38. Evaluation would be of two types: (a) project evaluation, which would be carried out at the end of the project; and (b) assessment of the feasibility of pilot activities planned under the project. The former would depend on baseline data, largely collected through the first round of the planned SGS activities, at the beginning of the project period; routine monitoring data and periodic progress reports through the life of the project, a process monitoring based mid-term review 18 months into the project's life and an end-line measurement of achievements. Feasibility studies of pilots would be carried out by robust scientific methods, and would be built into the respective pilots themselves, in order to determine the programmatic effectiveness and feasibility of each intervention being tested, and to learn lessons for incorporation in case the pilot intervention is deemed fit for scaling up.

IV. ENVIRONMENTAL AND SAFEGUARD POLICIES

A. Environmental Assessment

39. Provision of preventive and diagnostic services under the HIV/AIDS project is expected to benefit the health situation in Afghanistan, however, it could generate infectious bio-medical wastes such as sharps (infected needles and syringes, etc.), infected blood, HIV test kits used in Voluntary Counselling and Testing (VCT) centers and laboratories and pharmaceutical wastes. These wastes, if not managed and disposed properly, can have direct environmental and health implications.

40. This project has been classified as category "B" as per the World Bank's Operational Policy on Environmental Assessment (OP 4.01) for environmental screening purposes given the risks associated with the handling and disposal of medical waste and general health waste. Category B projects imply that the potential adverse environmental impacts of the program are site-specific and, in most cases mitigatory measures can be designed readily and appropriately. An Environmental Management Plan, including an Infection Control and Waste Management (IC-WM) Plan has been developed by NACP which focuses on the establishment of a sound management system for the treatment and disposal of the waste related to the testing, treatment and prevention of HIV/AIDS/STIs and includes generic guidance and protocols and alternative technologies for treatment, transportation and disposal in accordance with the size of healthcare facilities. The details of the Environmental Management Plan are described in a separate Addendum to the TA.

B. Safeguard Policies

41. This project has triggered OP 4.01 Environmental Assessment due to the potential adverse environmental impacts of healthcare waste as discussed in the previous section. A limited environmental assessment was undertaken by different stakeholders and included consultations and field visits to some government run and some NGO run facilities. NACP does not have the necessary institutional capacity to implement the IC-WM Plan and will need to obtain appropriate support for components such as training, IEC and monitoring. An external independent evaluation is recommended before the mid term review of the program, to ensure all activities are on track. It is the responsibility of the NACP of the MoPH to make the final version of the Infection Control and Waste Management Plan (to be disclosed in the World Bank InfoShop) available to all relevant national stakeholders in the local languages as well as on the relevant websites.

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Physical Cultural Resources (OP/BP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OP/BP 4.10)	[ ]	[X]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP 7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

Appendix 1: Project Costs

PROJECT COSTS SUMMARY

Project Cost by Component	Local (US$ Million)	Foreign (US$ Million)	Total (US$ Million)
1. Communication and Advocacy	0.30	0.76	1.06
2. Strengthening HIV Surveillance System	0.50	1.11	1.61
3. Targeted Interventions for Vulnerable Groups at High Risk	0.60	3.46	4.06
4. Program Management, Capacity-Building, Monitoring and Innovation Initiative	1.10	0.70	1.80
Total Baseline Costs	**2.50**	**6.03**	**8.53**
Physical Contingencies	**0.40**	**0.60**	**1.00**
Price Contingencies	**0.00**	**0.47**	**0.47**
Total Project Costs	**2.90**	**7.10**	**10.0**
Total Financing Required	**2.90**	**7.10**	**10.0**

COMPONENT DETAILS [1]

Component 1: Communication and Advocacy Component

Item	Year 1	Year 2	Year 3	Total
Communication and Advocacy	100,320	658,480	504,400	1,263,200
Total	**100,320**	**658,480**	**504,400**	**1,263,200**

Component 2: Strengthening HIV Surveillance System

Item	Year 1	Year 2	Year 3	Total
Strengthening of HIV/AIDS Surveillance	260,430	776,070	763,200	1,799,700
Total	**260,430**	**776,070**	**763,200**	**1,799,700**

Component 3: Targeted Interventions for Vulnerable Groups at High Risk

Item	Year 1	Year 2	Year 3	Total
Injecting Drug Users and Their Partners	285,000	1,776,270	1,225,200	3,287,100
Sex-workers and Their Clients	27,270	265,030	216,000	508,300
Prisoners	29,205	268,795	202,300	500,300
Truckers, mobile populations	32,160	323,040	288,800	444,000
Total	**374,265**	**2,633,135**	**1,932,300**	**4,939,700**

Component 4: Program Management, Capacity-Building, Monitoring and Innovation Initiative

Item	Year 1	Year 2	Year 3	Total
Building Capacity for Management and Monitoring	153,100	563,500	280,800	997,400
Multi-sector Innovation Initiative	200,000	400,000	400,000	1,000,000
Total	**353,100**	**963,500**	**680,800**	**1,977,400**

[1] Costs including contingencies

Appendix 2: Economic and Financial Analysis

Project Relation to Afghanistan Development Context

The project is well situated within the overall development context of Afghanistan as expressed in the Interim Afghanistan National Development Strategy (I-ANDS) and in the "Afghanized" MDG targets and indicators.

The I-ANDS. One main pillar of the I-ANDS is to improve the well-being of the poor through social protection as well as to mainstream cross-cutting issues in gender. The project approach to HIV/AIDS prevention and control will necessarily be cross-cutting due to the multi-sectoral nature of the response to this disease. Furthermore, HIV/AIDS presents a major economic shock for infected individuals and their families and preventing infections is an important form of social protection. Costs of treatment for illness, and especially the death of a household member, may push otherwise economically robust households into poverty (Wagstaff, 2005). One recent study from Vietnam estimated that, with the exception of households in the richest quintile, all households with a PLWHA will fall below the poverty line as a result of the income and expenditure effects of HIV/AIDS (United Nations Development Program [UNDP], 2004).

The project focus on targeted interventions (e.g., harm reduction programs) and advocacy efforts reflects another major theme of the I-ANDS. This theme looks to strengthen protection of human rights for all and assure redress for violations. Attempts to reduce the social stigma of, and provide health services to, at risk and vulnerable groups will have the additional advantage of improving the human rights situation for these socially marginalized groups.

The "Afghanized" MDGs. The "Afghanized" MDGs, as they relate to HIV/AIDS, aim to halt and reverse the spread of HIV/AIDS by 2020 and the MDG monitoring includes monitoring of the condom use rate, the percent of the adult population with knowledge of HIV/AIDS, and the HIV prevalence rate among groups at high risk. The MDG targets also include the proportion of injecting drug users in treatment by 2015. Project activities will contribute to all of these outcome measures.

Justification for Government Financing

Public financing of the project is justified because of the positive externalities associated with preventing HIV transmission and because of the public goods nature of advocacy and other communication efforts, the establishment of a second-generation HIV surveillance system, and the piloting of treatment programs among vulnerable groups at high risk. Equity considerations are also relevant as part of the overall economic justification for the project; as suggested above the microeconomic impact of HIV infection on households is severe. An additional important externality of the project arises as a consequence of a reduction in the incidence of HIV/AIDS – an expected corresponding reduction in opportunistic infectious and costly diseases such as pulmonary tuberculosis will further reduce the burden on households and the Afghan health system. Given the public health nature of the interventions supported through the project and their large externalities, the GoA has a central role in supporting activities in this area.

Economic Analysis

The project will fund activities in three broad HIV related components: (a) harm reduction programs and other behavioral interventions (including behavior change communication (BCC) focused on reducing stigma and discrimination) that aim principally to reduce the transmission of HIV; (b) the establishment of a second generation surveillance system; and (c) policy and program development on a pilot basis, including substitution treatment for IDUs. Each of these three components will be discussed separately in this economic analysis.

Harm Reduction Activities

The cost effectiveness of reducing HIV transmission has been demonstrated in numerous global settings. These findings are partly due to the simple fact that the disease largely affects prime age adults and the associated costs of an adult death constitute the key microeconomic impact of the HIV/AIDS epidemic. Over the course of the disease, household labor quality and quantity are reduced, initially as the infected person is less productive, and subsequently with their death. This cost of foregone earnings is one major microeconomic cost of the disease. These costs are exacerbated when there is more than one infected person in the household, which is not unusual given the nature of transmission. Other major costs include health care needs and the foregone earnings of family caretakers.

The general success of HIV prevention interventions, including harm reduction interventions for IDUs, is another reason for its general cost-effectiveness. International and regional evidence, including in resource constrained settings, demonstrate HIV prevention programs do indeed reduce HIV transmissions (Bertozzi et al., 2006). HIV prevention interventions are most timely – many more infections are preventable – in countries where the epidemic is growing rapidly rather than in countries where it is stable or declining. This is the case in Afghanistan where the epidemic is believed to be growing but concentrated in several key sub-groups, mainly IDUs.

IDUs have been the starting point of the HIV epidemic in many East and South Asian countries and the focus of this project on the reduction in HIV transmission among IDUs as well as across to other groups is well justified. Using the Asian Epidemic Model, Saidel et al., (2003) demonstrated that in countries where the epidemic among IDUs starts in advance of a generalized (non-IDU) heterosexual epidemic there is a 171 percent increase over a 15 year period in infections if IDU prevalence is not kept under control.

The total costs of the program are well-anticipated, yet the proposed program will occur in an environment with other donor supported HIV/AIDS activities coordinated under the National Framework and the POP. Bank-funded activities, however, will focus on reducing transmission (including the piloting of substitution therapy) among the groups most urgently requiring interventions for the future health of the country.

Through the targeted interventions, the project will directly benefit socially excluded groups such as IDUs and SWs. This is true for harm reduction as stated above. It should also be true for behavioral change communication and stigma reduction since changing popular attitudes towards PLWHAs as well as attitudes towards vulnerable groups should at the very least increase the effectiveness of harm reduction interventions. As these socially excluded groups find increased social acceptance, at least among important contact populations such as health workers, they will be more likely to respond to public or NGO sponsored interventions.

The economic analysis here attempts to assess the net impact of the program's package of behavioral interventions. Towards this goal it adopts a cost-benefit approach couched in the general epidemiological patterns observed in Afghanistan's neighbors. This approach is adopted because, largely as a result of the longstanding conflict, the absence of a surveillance system on HIV/AIDS in the country and current reliance on sporadic and unsystematic data make it very difficult to (a) determine the magnitude of the actual epidemic today; (b) understand the dynamics of transmission; and (c) assess the potential for its further diffusion.

However, what information exists suggests a potential for rapid increase in disease prevalence:

(a) Countries experiencing war or in complex emergency states, like Afghanistan, are particularly vulnerable to rapid HIV transmission (Wollants et al., 1995; Smallman-Raynor and Cliff, 1991). Factors related to increased transmission during war include poverty, displacement of a population with high HIV prevalence to areas of lower prevalence, and sexual abuse or use of sex as a survival commodity. Additionally, populations within post-conflict states experience psychological effects that lead to increased risk behavior.

(b) Limited health care and education also contribute to the continuation of risk behaviors, particularly among IDUs. Displaced Afghan heroin users exhibit less knowledge regarding HIV transmission and engage in high-risk behavior when compared to Pakistani heroin users (Zafar at al., 2003). A recent study of 464 IDUs in Kabul found that 35 percent claimed to have ever shared syringes, 76 percent had ever paid for sex with a woman, 27 percent had ever had sex with other men/boys, 19 percent had ever been in prison, and 4 percent had ever been paid for donating blood. In this sample 3 percent were already HIV sero-positive and 37 percent carried the Hepatitis C virus (Todd et al., 2006).

(c) Afghanistan is re-emerging as the leading supplier of opium in the global market. Heroin use is widespread in Afghanistan and though injection is not a common route of administration traditionally, this is increasing as displaced persons return to Afghanistan with injection techniques learned in bordering countries (IRINews.org, 2004). UNODC estimates there are 50,000 narcotics addicts in Afghanistan, of which 7,000 inject. They also estimate that a large number of people are injecting over the counter pharmaceuticals (e.g., pentazocin) which suggests there may be as many as 19,000 IDUs in Afghanistan at risk for acquiring HIV (UNODC, 2006).

(d) Central and South Asia are experiencing a rapid increase in HIV cases introduced by injection drug use and the commercial sex trade (Joint United Nations Programme on HIV and AIDS [UNAIDS], 2006). Iran has the highest rate of heroin addiction per capita in the world: 20 percent of Iranians aged 15 to 60 are engaged in drug abuse - 9 to 16 percent of whom inject drugs. Twenty-three percent of IDUs in Tehran are HIV positive (Zamani et al., 2006), this is an increase from 15 percent just one year earlier (Zamani et al., 2005).

The HIV/AIDS epidemic in the Islamic Republic of Iran appears to be accelerating at an alarming rate. The Iranian HIV adult prevalence rate in 2001 stood at less then 0.1 percent, roughly where Afghanistan stands today. By 2006 there were 66,000 HIV positive adults in Iran, or 0.2 percent of the adult population (UNAIDS/World Health Organization [WHO], 2006). The Iranian experience may be particularly relevant for the future of the epidemic in Afghanistan. A 2005 United Nations Office on Drugs and Crime (UNODC) report found that at least 50 percent of injecting drug users in Afghanistan reported to have started in Iran. In addition, the genotype of the virus identified in a recent sero-prevalence study is identical to that found among IDUs in Iran (Todd et al., 2006).

If Afghanistan were to follow the Iranian example then an increase from less than 0.1 percent of the general adult population (15-49) to 0.2 percent over five years represents a minimum of 16,000 new infections (assuming a mortality rate of 15 percent over the next five years for individuals already or soon to be HIV-positive). This hypothetical course of the epidemic in Afghanistan serves as the baseline progression of the disease for this economic analysis.

The impact of the project can be modeled as a series of harm reduction interventions that affect the transmission rates within and across vulnerable groups as well as across to the general population. The likely impact of the proposed interventions on transmission is treated as a random variable with hypothesized distributions. The analysis then adopts Monte Carlo methods to generate a distribution of anticipated total benefits, at the national level, to compare with costs.

The assumed impact on transmission of the project in its entirety is set at the deliberately conservative expected value of a 30 percent reduction in expected infections over the period 2007-2010 (approximately equal to 4800 infections averted). In other words, disease prevalence in the overall adult population in five years time would be 0.03 percent less as a result of the program if the trajectory of the epidemic would have followed the Iranian pattern. To account for heterogeneity in project outcomes, we assume a standard deviation of 25 percent, or 1200 infections averted. In each simulation, a new draw of infections averted is taken from this distribution in order to explore benefits of the project under various levels of effectiveness.

The monetized benefits from a reduced number of HIV infections are here determined as the sum of three factors: the costs of medical treatment foregone, the value of lost earnings for PLWHAs given increased mortality, and the value of lost earnings for the typically familial and unpaid caretakers. Table 1 gives the summary cost parameters used in the analysis. The analysis makes no attempt either to directly value the years of life lost due to premature mortality or to cost the pecuniary savings from a reduction in tuberculosis and other opportunistic infections transmitted to HIV-negative individuals. Clearly, taking these values into account will substantially increase the estimated benefits depicted here.

The number of productive work years lost to premature HIV-related death is assumed to average 20 years across individuals. Wage and earnings information for Afghan workers are incomplete and often of questionable validity. One careful small-scale longitudinal study conducted in three urban centers (Kabul, Herat, Jalalabad) estimates mean annual earnings to be US$425 (Beall & Schutte, 2006). Since this study spans a 12-month period it includes seasonal spells of under- and un-employment. Approximately 80 percent of earners are male, so this wage estimate is heavily weighted towards male earners. However this may not introduce much bias since the majority of IDUs are male and correspondingly many of the infections in the next few years are expected to be male. Real wages are set to grow an average of 3 percent a year (in-line with economic projections), with a standard deviation of 0.5 percent. This additional source of variation ensures that every simulation will have unique real wage growth rates.

When infected individuals fall sick, they need care and the cost of foregone earnings for the care-takers is another substantial cost. For example in Vietnam, three-quarters of PLWHAs interviewed in a recent UNDP sponsored qualitative study claimed they required the assistance of a caregiver on average for five hours a day. A quarter of caregivers reported having to give up a job in order to spend time with the infected person (UNDP, 2004). This analysis sets the expected earnings loss for caregivers at one half of annual earnings, and this loss occurs in the final year of life for PLWHAs when they are most in need of homecare.

The expected lifespan, after infection, of a PLWHA is assumed to be nine years and an enhanced level of health care will be necessary in the final five years, with the final year of life preoccupied with even greater medical care (Zaba et al., 2004). Little information on the costs of care for PLWHAs, both out-of-pocket private expenditures and public sector spending, exists in Afghanistan. One linked facility and household survey estimates that 49 percent of total Afghan health spending was out-of-pocket private expenditure (Johns Hopkins Unit, 2006). The same study estimates that the average monthly expenditure for a sick adult presenting to a health facility is US$20. This analysis

assumes that after an HIV positive individual begins to suffer from opportunistic infections and falls ill, by the fifth year of infection, s/he will present three times annually to a health facility, for an average private cost of US$60 a year. The study further assumes an equal amount of resources in the public sector are devoted to that individual's care (since the amount of spending in the health system from private and public sources is estimated to be roughly equal).

It is to be expected that this level of care, for the maintenance of OIs, will be necessary for several years, while in the final year the costs are expected to rise substantially. The same UNDP sponsored Vietnam study referenced above found that the average per capita health expenditure per PLWHA rose seven fold in the final year of life (UNDP, 2004). This study takes the same multiplier and applies it in the Afghan context. Hence, both public and private spending in the final year of life for a PLWHA averages US$420 each.

The analysis also adopts a discount rate of 5 percent, a typical value for the evaluation of health projects. Table 2 presents the range of benefit-cost figures as determined in the Monte-Carlo analysis. The total gross program cost is US$10 million over three years, yielding a net present value of US$9.40 million given the anticipated disbursement schedule. The median present value of total costs averted is estimated at US$30.8 million, yielding a gross benefit-cost ratio of 3.28. Indeed almost every point in the range of possible outcomes, depicted in the kernel density plot in Figure 1, is associated with a substantially higher present value of total costs averted. In only one simulation (out of 500) is the estimated gross benefit less than cost. Where gross benefits exceed costs, the benefit-cost ratio ranges over the interval (1.16, 6.14).

The median present value of savings to the healthcare system due to reduced system expenditures on PLWHAs is estimated at US$2.04 million, resulting in a net program cost of US$7.36 million and a net benefit-cost ratio of 4.19. Where net benefits exceed costs (which occurs in 499 out of 500 simulations), the benefit-cost ratio ranges over the substantially longer interval (1.25, 9.00). These ranges of gross and net benefit-cost ratios calculated here are consistent with the ratios found in other countries in the region, especially when the conservative estimates of program impact are taken into account. Even with these very conservative assumptions on program impact, made in a data scarce environment, the anticipated net benefits are substantial.

Strengthening HIV Surveillance

The cost to Afghan society of the proposed new surveillance system for HIV/AIDS, which the project would support over the first three years of operation, would be the cost of establishing the new system and subsequently the cost of operating the system as per its design. This component is currently valued at a total cost of US$1.6 million. On the benefits side, the economic benefits that would accrue to society from the new HIV surveillance system are those discussed above, namely the costs of medical treatment foregone and the value of avoided lost earnings for both HIV patients and unpaid caretakers.

In practice, estimating distinct benefits as a direct result of surveillance independent of the overall package of interventions and investments would be very difficult. Instead the influence of the new system on actual health outcomes is reflected in the analysis above in so far as a functioning HIV surveillance system will increase the efficacy and targeting of harm reduction programs. Indeed if the surveillance framework does substantially improve the effectiveness of interventions, then the true benefits estimated above may be even greater than depicted.

Nevertheless, there are several dependent processes nested in the establishment and operation of a surveillance system that need be made explicit. For any economic benefits to arise it would be necessary that:

(a) Competent and qualified personnel are identified and recruited to the organizations charged with establishing and maintaining the surveillance system.

(b) The surveillance system collects reasonably accurate information on HIV/AIDS as per its design.

(c) Relevant personnel process such information into meaningful reports and ensure the dissemination of the reports in a timely fashion to those officials in place that are able to utilize them for policy purposes.

(d) The reports result in effective action taken by the relevant decision makers in the public or private sectors, which in turn improves the delivery of services on the ground in a way that results in the prevention of a number of cases of the disease or a more effective treatment for those already afflicted.

Program design must be such to ensure that these steps are accomplished.

Pilot Treatment Programs for IDUs

The program and policy component of the project includes the establishment of harm reduction and substitution treatment programs among IDUs. Given the current lack of such programs, and the importance of IDUs as a group in the transmission of the disease, the need to develop cost-effective procedures to treat IDUs for substance dependency is an important component in GoA's overall response to the HIV epidemic. The chief economic benefit of any pilot arises from the externalities from learning-by-doing. It is expected that after several years of experience with the treatment of IDUs GoA will be able to implement effective substitution treatment programs for IDUs. Because the value of the pilot lies in the learning opportunities, a formal cost-benefit analysis is not applicable unless the externalities are adequately understood and converted to a monetary value. However the analysis notes that the project should ensure as many key preconditions as possible so that the pilot exercise will indeed be a valuable learning tool for the GoA.

The key preconditions for a successful IDU drug substitution pilot include the following: thorough training and adequate supervision and regulation of clinic staff; a procurement and distribution system that can ensure timely delivery of medication to groups in need; the medication being included in the essential drug list; a M&E system that is able to accurately forecast demand for services and to plan accordingly; and effective cross-sectoral cooperation among all involved ministries, including the Ministries of Interior and Justice.

Fiscal Sustainability

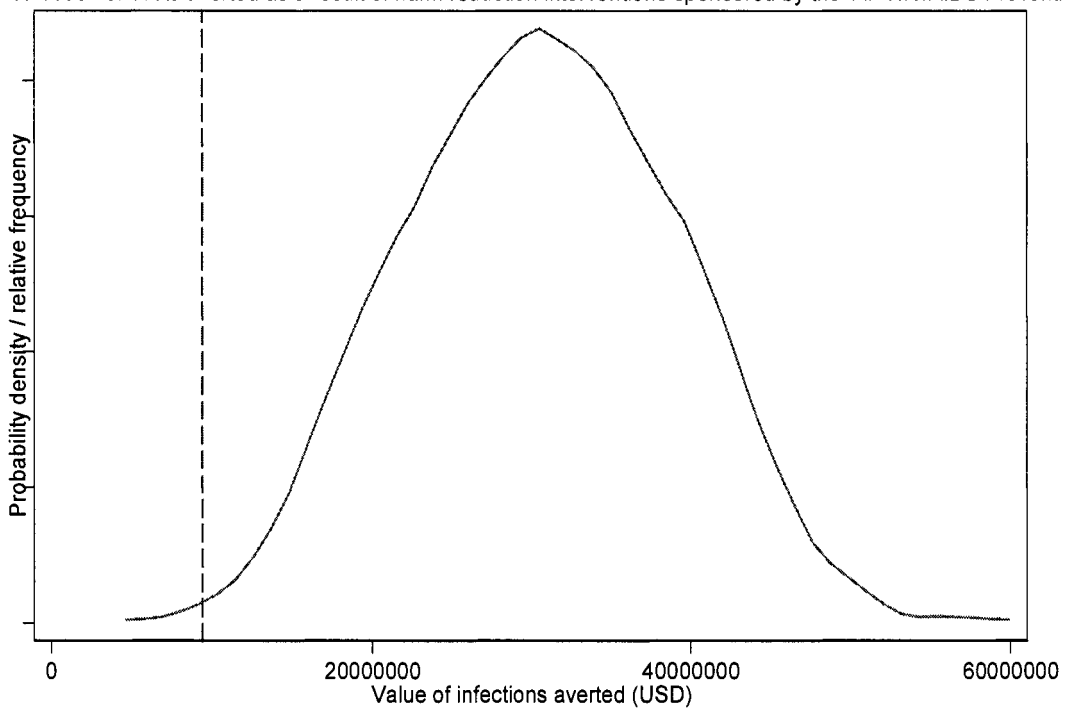
The completion of the project will bequeath modest recurrent costs to GoA. The estimated recurrent costs engendered by the project, listed separately by main areas of activity, are presented in Table 3.

The burden of recurrent government expenditures generated by the proposed project is estimated to equal US$2,976,000 per year after project completion. The uses of recurrent expenditures falling to the central government include the continuing activities of national BCC, the continued operation of the HIV surveillance framework, and the on-going harm reduction activities.

This amount is relatively small (2.1 percent) in comparison with the total health sector Government spending, which is currently US$140 million per year (including donor support) and expected to increase substantially in the coming years. Real gross domestic product (GDP) growth is projected at 12 percent in 2007/08 and 10 percent from 2008/09 onwards. In addition, the share of government health expenditures in total GDP is expect to increase 40 percent by 2009/10 (IMF, 2006). This anticipated growth implies that the inherited recurrent spending will total only 1.2 percent of the public sector health budget by 2009/10.

Furthermore, the budgetary impact of the project recurrent expenditures may very well be over-estimated. The economic analysis for this project determined that the direct costs averted within the health sector as a result of fewer infections may also lessen the budgetary burden.

Figure 1. Distribution of costs averted as a result of harm reduction interventions sponsored by the AF-HIV/AIDS Prevention Project



Dashed line depicts total discounted cost of project

Table 1. Cost parameters

Average annual earnings of all workers	$425.0
Mean annual real wage growth (random variable)	3.0%
Standard deviation of annual real wage growth	0.5%
Average wage loss for caregivers, in final year of illness	$212.0
Average private health care costs, excepting final year of life	$60.0
Average public health care costs, excepting final year of life	$60.0
Average private health care costs in final year of life	$420.0
Average public health care costs in final year of life	$420.0
Assumed discount rate	5.0%

Table 2. Program costs and outcomes

	Costs and outcomes at various levels of intervention effectiveness								
	1st percentile	5th percentile	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile	95th percentile	99th percentile
Total program cost	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000
Present value of total program cost	9,399,600	9,399,600	9,399,600	9,399,600	9,399,600	9,399,600	9,399,600	9,399,600	9,399,600
Number of infections averted	2,087	2,839	3,184	3,891	4,907	5,764	6,452	6,731	7,202
Present value of total costs averted	12,539,100	16,868,500	19,481,900	24,545,100	30,801,800	36,647,600	41,415,300	43,426,700	48,592,700
Present value of public costs averted	869,100	1,182,400	1,326,100	1,620,600	2,044,000	2,400,800	2,687,400	2,803,900	2,999,800
Net program cost	8,530,500	8,217,200	8,073,500	7,779,000	7,355,600	6,998,800	6,712,200	6,595,700	6,399,800
Gross program costs per HIV infection averted	4504	3311	2952	2416	1916	1631	1457	1396	1305
Gross benefit-cost ratio	1.33	1.79	2.07	2.61	3.28	3.90	4.41	4.62	5.17
Net program costs per HIV infection averted	4087	2894	2536	1999	1499	1214	1040	980	889
Net benefit-cost ratio	1.47	2.05	2.41	3.16	4.19	5.24	6.17	6.58	7.59

Table 3. Estimated Recurrent Annual Expenditures after 2010

Activity	**Estimated recurrent cost**
Communication and Advocacy	$404,400
Strengthening HIV Surveillance System	$533,260
Targeted Interventions for Vulnerable Groups at High Risk	$1,457,400
Program Management & Monitoring and Innovation Fund	$580,800
Total	**$2,975,860**

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Appendix 3: Procurement Arrangements and Procurement Plan

Country Context

The Bank has gained substantial experience and understanding of the procurement environment in Afghanistan through its involvement in the interim procurement arrangements put in place through Emergency Public Administration Project (EPAP) as well as with the institutions such as Afghanistan Reconstruction and Development Services (ARDS) that is holding the current responsibility for government's procurement administration. As part of the broader review of PFM system, the Bank recently carried out an assessment of the procurement environment in the country based on the baseline and performance indicators developed by a group of institutions led by the World Bank and Organization for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC).

The first key issue identified through the procurement assessment was the need for ownership and a champion in the Government for reform, deepening of capacity, ensuring integrity in the operation of procurement systems, and promoting sound procurement among ministries.

A new procurement law was adopted in November 2005 which radically transformed the legal and regulatory framework for the procurement administration of Afghanistan. While it provides a modern legal system for procurement, effective implementation of the law may encounter difficulties in the current weak institutional structure and capacity of the Government. A Procurement Policy Unit (PPU) has been established under MOF to ensure the implementation through the creation of secondary legislation, preparation of standard bidding documents, provision of advice and creation of the necessary information systems for advertising and data collection. Afghanistan Procurement Procedures have been effective since April 12, 2007. Procedures for Procurement Appeal and Review have been developed by PPU/MOF. Members have been appointed and the system has been functional since April 2007.

In the absence of adequate capacity to manage procurement activities effectively, some interim arrangements have been put in place to improve the procurement management of the country. A central procurement facilitation service, ARDS, has been established under the supervision of the Ministry of Economy. The Bank and the Government have agreed on a program for country wide procurement reform and capacity building, leading to the transition from centralized to decentralized procurement services. The Bank funded Public Administration Capacity Building project (PACBP) is the primary instrument for implementing the program to strengthen capacity of the line ministries to manage public procurement in an effective, transparent and accountable manner. However, the implementation of the procurement capacity building strategy has not made any significant progress yet due to lack of coordination and delays in decision making within the Government. The envisaged radical changes to the procurement management environment expected from the new law also require the urgent implementation of a comprehensive human resources and capacity development program. The implementation of the procurement reform component of the PACBP and the proposed Public Financial Management Reform Project should be considered with due priority to ensure that fiduciary standards are further enhanced and that capacity is developed in the Government to maintain these standards.

General

The procurement administration of the project would be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated May 2004, revised

October 2006, "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, revised October 2006, and the provisions stipulated in the Financing Agreement. The general description of various procurements under different expenditure categories are described below. For each contract to be financed by the Grant the different procurement methods or consultant selection methods, estimated costs, prior review requirements, and time frame agreed between the Grant Recipient and the Bank project team are described in the Procurement Plan. This Procurement Plan will be updated at least annually or at lesser time intervals as required to reflect the actual project implementation needs and improvements in the institutional capacity.

Procurement of Works: The proposed grant will not finance any works contracts.

Procurement of Goods: Goods procured under this project would include **vehicles**. The procurement will be done using the Bank's SBD for all ICB and National SBD agreed with (or satisfactory to) the Bank. Other methods will be shopping and direct contacting. Threshold for NCB goods will be US$ 200,000 per contact and for shopping will be US$100,000 per contract.

Selection of Consultants: Consultant firms under the project will include: (a) Communication and Advocacy (CA); (b) Second Generation Surveillance (SGS); (c) Targeted Interventions (TI) IDU; (d) Targeted Interventions (TI) - Harm Reduction (HR) with Operation Research; (e) Targeted Interventions (TI) Sex workers (SW); (f) Targeted Interventions (TI) Prisoners with Operation Research; and (g) Targeted Interventions (TI) Truckers.

Under Program Management and Capacity Building the following national individual consultants will be recruited to help build NACP capacity: (a) Project Director; (b) Monitoring and Evaluation Advisor; (c) Communication and Advocacy Advisor; (d) Harm Reduction Advisor; (e) Vulnerable Reduction Advisor; (f) Procurement Specialist; and (g) Accountant.

The above individual consultants would be recruited using the PPF funds and maintained using the project funds once it is approved. The Program Manager will be included in the project budget when his present contract under the Health Sector Emergency Reconstruction and Development Project ends in September 2007.

The selection methods for consultants will include QCBS, QBS, CQS, LCS, FBS, SSS and Section V of Guidelines for individual consultants. Short lists of consultants for services estimated to cost less than US$100,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. Threshold for CQS will be below US$200,000 equivalent per contract.

Specific qualification criteria for selection of consultants under Targeted Intervention will be incorporated in the TOR as well as in the EOI for the assignments. All the assignments under Targeted Intervention will be advertised under one EOI and the option will be given to consultants to apply for one or more assignments. Consultants applying for more than one assignment should demonstrate their capacity to implement the contracts.

RPM Office through an email dated May 19, 2007 has issued a waiver to allow more than six qualified NGOs in the shortlist as the case may be and to allow a shortlist comprising more than two local firms for the TI assignments.

Innovation Initiative: An amount of US$1,000,000 has been allocated under the project. The procedure for use of the fund will be elaborated in the PIP of the project.

Operational Costs which would be financed by the project would be procured using the implementing agency's administrative procedures which were reviewed and found acceptable to the Bank.

Assessment of the agency's capacity to implement procurement

Procurement activities will be carried out by the MOPH through GCMU.

An assessment of the capacity of GCMU, the Implementing Agency, to implement procurement actions for the project, was carried out by World Bank procurement specialists in December 2006.

The GCMU is a group of individual consultants established in 2003 to carry out procurement activities for the Bank financed Health Sector Emergency Reconstruction and Development Project, HSERDP (P078324). The agency is staffed by 30 people and the procurement unit is staffed by four procurement officers. One of the four procurement officers is working on procurement of health sector goods and the three others are busy with hiring and managing consultant contracts under the Health Sector Emergency Reconstruction and Development Project.

The procurement specialists responsible for hiring consultants do not have adequate experience. The procurement officer working on the procurement of health sector goods is involved only with procurement of small contracts (less than US$200,000) of health sector goods. Big contracts (more than US$200,000) of health sector goods are procured through ARDS. ARDS is a Government Procurement Facilitating Agency.

As previously indicated, the existing procurement personnel: (a) do not have adequate experience for procuring and managing large value contracts; and (b) are fully busy with their procurement activities under the Health Project. To mitigate the risk, the following arrangement will be adopted for the Project:

(a) A competent procurement specialist will be hired under GCMU of MOPH to procure small value goods, works and consultancy contracts. The procurement specialist will be responsible for managing procurement for the project based on technical specifications/TOR provided by NACP. The procurement specialist, if needed, will also get help from the procurement team already hired under the IDA financed Health Sector Emergency Reconstruction and Development Project (P078324).

(b) To ensure compliance with World Bank policies and procedures, procurement documentation for complex and large value goods and consultancy contracts will be carried out in consultation with the ARDS.

The overall project risk for procurement is high.

Frequency of Procurement Supervision: In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended two supervision missions to visit the field to carry out post review of procurement actions. As the overall project risk for procurement is high, 20 percent of contracts will be post reviewed.

Procurement audit: In addition to the prior review and post review supervisions to be carried out from Bank offices, an independent procurement audit will also take place during the project life.

Details of the Procurement Arrangement Involving International Competition

Goods: All contracts estimated to cost above US$200,000 equivalent for goods per contract and all direct contracting will be subject to prior review by the Bank.

Consulting Services:

(a) **List of consulting assignments with short list of international firms**

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost per Contract**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
HIV/Con-1	Communication and Advocacy	$1,063,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-2	Survey (Second Generation Surveillance-SGS and Knowledge, Attitudes, and Practices-KAP	$1,599,700	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-3	Targeted Interventions (TI) -Harm Reduction (HR) Kabul-District A	$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-4	TI -HR Kabul-District B	$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-5	TI -HR Kabul-District C-with Oper Research	$646,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-6	TI HR City B Mazari Sharif	$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-7	TI HR City C-Herat	$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-8	TI HR City D-Jalalabad	$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-9	TI Sex worker (SW) City TBD	$308,300	QBS	Prior	1 Sep 07	Three years contract
HIV/Con 10	TI Prisoners with Oper Research	$300,300	QBS	Prior	1 Sep 07	Three years contract
HIV/Con 11	TI Truckers	$444,000	QBS	Prior	1 Sep 07	Three years contract

(b) Consultancy services estimated to cost above US$100,000 per contract and all Single Source selection of consultants (firms/individual) will be subject to prior review by the Bank.

Procurement Plan

General

The Borrower, at appraisal, developed a Procurement Plan for project implementation which provides the basis for the procurement methods. This plan was agreed between the Borrower and the Project Team on May 31, 2007 and is available at GCMU in the MOPH, Wazir Akbar Khan Mina, Charahi-i-Masood. It will also be available in the Project's database and on the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Project information:

Country: Islamic Republic of Afghanistan

Project Name: Afghanistan HIV/AIDS Prevention Project P101502

Loan/Credit No.:

Project Implementing Agency (PIA): National AIDS Control Program, Ministry of Public Health.

Bank's approval Date of the procurement Plan: [Original: May 31, 2007]

Date of General Procurement Notice: May 7, 2007 and the number is WB1779-703.

Period covered by this procurement plan: 1 July 2007 to 30 June 2010

Goods and Works and non-consulting services

Prior Review Threshold: Procurement Decisions subject to Prior Review by the Bank as stated in Appendix 1 to the Guidelines for Procurement:

	Procurement Method	Prior Review Threshold	Comments
1.	Goods	US$ 200,000	
2.	Direct Contracting	All	

Prequalification. Bidders for NIL_____ shall be prequalified in accordance with the provisions of paragraphs 2.9 and 2.10 of the Guidelines.

Proposed Procedures for CDD Components (as per paragraph. 3.17 of the Guidelines): NA

Reference to (if any) Project Implementation Plan (PIP)/Procurement Manual:

Any Other Special Procurement Arrangements: NIL

Procurement Packages with Methods and Time Schedule.

1	2	3	4	5	6	7	8	9
Ref. No.	**Contract (Description)**	**Estimated Cost**	**Procure-ment Method**	**Prequalifi-cation (yes/no)**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**	**Comment**
G-1	2 (vehicles for NACP)	US$50,000	Shopping	NO	NO	Post	30 Aug 07	

Selection of Consultants

Prior Review Threshold: Selection decisions subject to Prior Review by the Bank as stated in Appendix 1 to the Guidelines Selection and Employment of Consultants:

	Selection Method	Prior Review Threshold	Comment
1.	Competitive Methods (Firms)	US$100,000	
2.	Individual	US$50,000	
3.	Single Source (Firms/Individual)	All	

Short list comprising entirely of national consultants: Short list of consultants for services, estimated to cost less than US$100,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Any Other Special Selection Arrangements: Retroactive financing of up to US$1.0 million is envisaged for the reimbursing related to start-up activities between March 1, 2007 and when the grant agreement is signed. The retroactive finance can be disbursed only after the grant becomes effective.

Consultancy Assignments with Selection Methods and Time Schedule

1	2	3	4	5	6	7
Ref. No.	**Description of Assignment**	**Estimated Cost per Contract**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**	**Comments**
HIV/Con-1	Communication and Advocacy	US$1,063,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-2	Survey (Second Generation Surveillance-SGS and Knowledge, Attitudes, and Practices-KAP	US$1,599,700	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-3	Targeted Interventions (TI) - Harm Reduction (HR) Kabul-District A	US$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-4	TI -HR Kabul-District B	US$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-5	TI -HR Kabul-District C-with Oper Research	US$646,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-6	TI HR City B Mazari Sharif	US$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-7	TI HR City C-Herat	US$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-8	TI HR City D-Jalalabad	US$473,200	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-9	TI Sex worker (SW) City TBD	US$308,300	QBS	Prior	1 Sep 07	Three years contract
HIV/Con 10	TI Prisoners with Oper Research	US$300,300	QBS	Prior	1 Sep 07	Three years contract
HIV/Con 11	TI Truckers	US$444,000	QBS	Prior	1 Sep 07	Three years contract
HIV/Con-12	Project Director	US$54,000	IC	Prior	Sept 07	Hired under health project
HIV/Con-13	Monitoring and Evaluation Advisor	US$54,000	IC	Prior	April 07	To be hired under PPF
HIV/Con-14	Communication and Advocacy Advisor	US$54,000	IC	Prior	April 07	To be hired under PPF
HIV/Con-15	Harm Reduction Advisor	US$54,000	IC	Prior	April 07	To be hired under PPF
HIVCon 16	Vulnerable Group Advisor	US$54,000	IC	Prior	April 07	To be hired under PPF
HIV/Con 17	Procurement Specialist	US$54,000	IC	Prior	April 07	To be hired under PPF
HIV/Con 18	Accountant	US$54,000	IC	Prior	April 07	To be hired under PPF

Agreed Procedures for National Competitive Bidding

In order to ensure economy, efficiency, transparency and broad consistency with the provisions of Section I of the Procurement Guidelines, the following criteria will be followed in procurement under National Competitive Bidding procedures:

(a) Standard bidding documents approved by the World Bank will be used.

(b) Invitations to bid will be advertised in at least one (1) widely circulated national daily newspaper and bidding documents will be made available to prospective bidders, at least twenty eight (28) days prior to the deadline for the submission of bids.

(c) Bids will not be invited on the basis of percentage premium or discount over the estimated cost.

(d) Bidding documents will be made available, by mail or in person, to all who are willing to pay the required fee.

(e) Foreign bidders will not be precluded from bidding.

(f) Qualification criteria (in case pre-qualifications were not carried out) will be stated on the bidding documents, and if a registration process is required, a foreign firm determined to be the lowest evaluated bidder will be given reasonable opportunity of registering, without any hindrance.

(g) Bidders may deliver bids, at their option, either in person or by courier service or by mail.

(h) All bidders will provide bid security as indicated in the bidding documents. A bidder's bid security will apply only to a specific bid.

(i) Bids will be opened in public in one place preferably immediately, but no later than one hour, after the deadline for submission of bids.

(j) Evaluation of bids will be made in strict adherence to the criteria disclosed in the bidding documents, in a format, and within the specified period, agreed with the Association.

(k) Bids will not be rejected merely on the basis of a comparison with an official estimate without the prior concurrence of the IDA.

(l) Split award or lottery in award of contracts will not be carried out. When two (2) or more bidders quote the same price, an investigation will be made to determine any evidence of collusion, following which: (a) if collusion is determined, the parties involved will be disqualified and the award will then be made to the next lowest evaluated and qualified bidder; and (b) if no evidence of collusion can be confirmed, then fresh bids will be invited after receiving the concurrence of the IDA;

(m) Contracts will be awarded to the lowest evaluated bidders within the initial period of bid validity so that extensions are not necessary. Extension of bid validity may be sought only under exceptional circumstances.

(n) Extension of bid validity will not be allowed without the prior concurrence of the IDA (a) for the first request for extension if it is longer than eight (8) weeks; and (b) for all subsequent requests for extensions irrespective of the period.

(o) Negotiations will not be allowed with the lowest evaluated or any other bidders.

(p) Re-bidding will not be carried out without the IDA's prior concurrence; and

(q) All contractors or suppliers will provide performance security as indicated in the contract documents. A contractor's or a supplier's performance security will apply to a specific contract under which it was furnished.

Appendix 4: Financial Management

Country Issues

The Bank has gained substantial experience and understanding of the financial management environment in Afghanistan through the large number of projects under implementation over the past four years. The PACBP is the primary instrument to continue and enhance the fiduciary measures put in place during the past years to help ensure transparency and accountability for the funding provided by the Bank and other donors.

A PFM performance rating system using 28 high-level indicators that was developed by the Public Expenditure and Financial Accountability (PEFA) multi-agency partnership program was applied in Afghanistan in June 2005. PEFA is comprised of the World Bank, IMF, EC, and several other agencies. The system is structured around six core dimensions of PFM performance: (a) budget credibility; (b) comprehensiveness and transparency; (c) policy-based budgeting; (d) predictability and control in budget execution; (e) accounting, recording, and reporting; and (f) external scrutiny and audit. Afghanistan's ratings against the PFM performance indicators generally portray a public sector where financial resources are, by and large, being used for their intended purposes. This has been accomplished with very high levels of support from international firms; this assistance will continue to be needed over the medium term if these ratings are to be maintained. There is also much room for improvement.

In spite of undeniable gains made in reconstruction since the end of 2001, the challenges facing Afghanistan remain immense; not least because of the tenuous security situation in the region and continued prevalence of a large illegal and illicit economy. The policy framework benchmarks have not yet been fully costed so various priorities are funded through the annual budgeting process. The rising costs of the security sector constitute the major constraint on attainment of fiscal sustainability. With regard to executive oversight, the national assembly will play an increasingly active role. All in all, the new national strategy has created high expectations of the executive which could prove to be quite difficult to meet.

The public sector, in spite of considerable efforts to reform its core functions, remains extremely weak outside of Kabul. The lack of qualified staff in the civil service and the absence of qualified counterparts in the government after 30 years of war and conflicts is a binding constraint. Delays in reforming the pay structure and grading of civil servants have severely crippled the public administration of the country. Domestic revenues lag behind expenditures by a factor of ten to one. Large-scale corruption could emerge to undermine the government's efforts to enhance aid flows through national accounts. Capacities to track expenditures and monitor expenditure outcomes have improved, but they need rapid and substantial strengthening if progress toward the attainment of national development targets is to be monitored. Currently, 75 percent of external revenues bypass government appropriation systems.

The World Bank is financing a Financial Management Advisor to assist the Ministry of Finance, an Audit Advisor to assist the Control and Audit Office, and a Procurement Advisor to assist in Procurement-related activities. Also an Internal Audit function is being developed within the Ministry of Finance with World Bank financing. USAID, and earlier the Indian Aid Assistance Program, is financing a team of consultants and advisors to assist the Da Afghanistan Bank in local as well as foreign currency operations. The activities carried out under the existing Public Administration projects have helped the Government to ensure that appropriate fiduciary

standards are maintained for public expenditures, including those supported by the Bank and the donor community.

Progress has been slower than expected in shifting from operations support provided by the three Advisors to capacity development and knowledge transfer to the civil servants. Given that, it is expected that the Advisors will continue to be required for the medium term. Challenges still remain in attaining the agreed upon fiduciary standards and also to further enhance them. And to make matters more complex, the regulatory environment in Afghanistan has advanced significantly in the past three years. Unfortunately, even mastery of basic skills in the early environment does not fully qualify the civil servants to work effectively in the new emerging environment.

Risk Assessment and Mitigation

The table below identifies the key risks that the project may face and indicates how these risks are to be addressed.

Risk	Risk Rating	Risk Mitigation Measures	Residual Risk	Condition of negotiations, Board or Effectiveness (Y/N)
1. INHERENT RISK				
Country Inherent Risk	M	Source - PFM study	M	N
Project Financial Management Risk	H	Minimize use of Designated Account, maximize direct payments to consultants; all procurement through Procurement Advisor	S	N
Perceived Corruption	H	Government commitment, internal controls and new internal audit will help to reduce the high level of perceived corruption	S	N
Overall Inherent Risk	H		S	
2. CONTROL RISK				
1. Weak Implementing Entity	H	Bulk of the implementation will be through contracts issued to NGOs and CBOs. Recruitment of International Advisor to strengthen the management capacity at NACP. MOPH has adequate staffing in GCMU to implement the program; however, a qualified accountant will be recruited to strengthen the financial management capacity at GCMU. Each line ministry involved in the program will have a	S	Y

		dedicated manager and accounting staff to maintain minimal records and report on their transactions.		
2. Funds Flow	S	Payments will be made to consultants, suppliers, Innovation window recipients, etc. from the Designated Account (DA) by SDU-MoF. In addition to payments out of DA funds, the implementing entities can also request the SDU to make i) direct payments from the Credit Account to consultants or consulting firms, and ii) special commitments for contracts covered by letters of credit. These payments would only be made by SDU after due processes and proper authorization from the respective component implementing entities.	M	N
3. Budgeting	S	A budget committee will be appointed to coordinate the preparation of annual work plan and the derivation of annual budget there from. Representatives will be from HACCA, NACP, GCMU and MOPH, and shall report to the HACCA.	M	N
4. Accounting Policies and Procedures	S	Will follow international standards. Project accounting procedures and details of the FM arrangements will be documented in an FM Manual to be approved by the Bank	M	Y
5. Internal Audit	H	Newly-created internal audit department will review project internal control systems	S	N
6. External Audit	H	Will be audited by CAO with support from Audit Advisor	S	N
7. Reporting and Monitoring	H	Strengthening the SDU is a priority under the new FM Advisor contract, to provide information that will comply with agreed format of financial reports.	S	Y Negotiations

OVERALL CONTROL RISK	H		S	
DETECTION RISK	S	Adequate accounting, recording, and oversight will be provided in project procedures. Accounting/Recording/oversight by SDU – MOF of all advances/M-16 supported by Financial Management Advisor.	M	N
RISK RATING: H=HIGH RISK; S=SUBSTANTIAL RISK; M=MODEST RISK; L-LOW RISK				

Strengths and Weaknesses

Strengths

The Government provides assurance to the Bank and other donors that the measures in place to ensure appropriate utilization of funds will not be circumvented. The Government support for PACBP is strength in itself to enhance financial management in Treasury operations, public procurement, internal audit in the public sector, and external audit by the Auditor General. This is the second IDA-funded grant for MOPH so the agency has experience in implementing Bank projects and following Bank procedures.

Weaknesses and Action Plan

The main weakness in this project, as in many others in Afghanistan, is the ability to attract suitably qualified and experienced counterpart staff especially for Financial Management. The additional staff to be funded by the project, together with intensive training programs included in this project, is expected to strengthen the fiduciary arrangements.

Action Plan

Significant Weaknesses	Action	Responsable Agent	Completion Date
Shortage of qualified And experienced FM staff	Appointment of an FMS in GCMU and an International Advisor in NACP.	MOPH	15th June 2007
Project internal controls and procedures need to be defined	Financial Management Manual developed	MOPH	15th June 2007
Interim reports need to include required information	Un-audited interim financial report formats confirmed	IDA/MOF/MOPH (DBER)	Before negotiations

Implementing Entity

The institutional framework is in place, assigning the program coordination, management and technical roles to MOPH/NACP and the financial management and procurement responsibilities to the MOPH/GCMU, under the overall oversight of the multi sector HACCA. Technical working groups are being established (i.e., HIV Surveillance WG) by the NACP to guide its work program, drawing on available technical experts from professional, academic, research or other organizations within the country. These technical working groups will report to NACP, which in turn, presents the recommendations of the technical working groups to the HACCA for endorsement. The MOPH will contract the surveillance and communications components of the project to agencies that can carry

out those functions while developing and transferring capacity in these areas. The targeted interventions for the prevention of HIV among IDUs, sex workers and their clients, truckers and prisons will be contracted to NGOs and CBOs with experience working with the communities at risk. Non-health ministries, the private sector and NGOs will be able support or implement HIV prevention programs, funded through the Innovation Initiative, by preparing proposals to be reviewed by a multi sector review panel led by the NACP, and reporting to the HACCA.

Specifically, the roles of the NACP, GCMU and HACCA are as follows:

National AIDS Control Program. NACP will lead the implementation of the proposed project, in close coordination with relevant departments within MOPH, i.e., Reproductive Health, Mental Health/Drug Demand Reduction, IEC, Environmental Health, and M&E Departments and with key non-health sectors. The targeted intervention activities will be contracted out to NGOs. The strengthening of surveillance and the communications components will also be contracted to organizations with experience in carrying out and building capacity in these areas. MOPH has a good track record of implementing the Emergency Health Project, which includes the NGO-contracting approach to service delivery. In fact, the civil society involvement is even more relevant to the HIV/AIDS prevention efforts, because the vulnerable population groups are particularly difficult to reach through governmental channels and need to be involved for effective coverage and quality. The proposed multi sector Innovation Initiative under AHAPP will be managed by the MOPH, reporting to HACCA. A multi sector review panel, chaired by the NACP, will approve proposals to the Innovation Initiative from non-health sectors.

HIV/AIDS Coordination Committee of Afghanistan. HACCA has been established by MOPH to ensure a broad-based and inclusive oversight mechanism. This multi sector committee is chaired by the Deputy Minister for Technical Affairs of MOPH, and includes the participation of key ministries, agencies from public and private sectors, civil society and external development partners. While HACCA ensures multi sector coordination and oversees the broad Program Operational Plan (POP), the MOPH has the technical lead role, and provides the programmatic accountability for NACP.

Grants and Contracts Management Unit. The head of the accounting department for GCMU in MOPH will take responsibility for the financial management activities of the program. GCMU will carry out the day-to-day financial management operations of the project, preparation of M-16 forms (payment orders), preparation of summary reports/simplified statements of expenditures, coordination with other line ministries involved in the program and overall contract and project management. This department is adequately staffed with FM personnel who are efficiently managing all current external grants including the IDA Health Sector Project. However, a qualified and experienced procurement specialist and accountant are being recruited by MOPH to strengthen the financial management and procurement capacity of GCMU to manage the additional contracts under this project.

Budgeting

A Planning Committee will be appointed to coordinate the preparation of annual work plans and the derivation of annual budgets. This committee will be made up of representatives from the HACCA, NACP, GCMU, and MOPH and shall report to the HACCA. The Planning Committee shall also coordinate quarterly budget reviews to ensure adequate budget discipline and control. The committee will be responsible for ensuring that project expenditures for each fiscal year are captured in the Governmental Development budget of that fiscal year. The MOPH must get approvals from the presidential office and the parliament and attach them to B27 and PCS forms at the time of requesting yearly allotments for contracts under the project to avoid delays in payment processing.

Funds Flow

The standard funds flow mechanism in Afghanistan will be followed in this project. Project funds will be deposited in the DA to be opened and maintained at the Da Afghanistan Bank (DaB). The DA, in keeping with current practices for other projects in Afghanistan, will be operated by the SDU in the Treasury Department of MOF. Requests for payments from the DA will be made to the SDU by the GCMU/MOPH when needed.

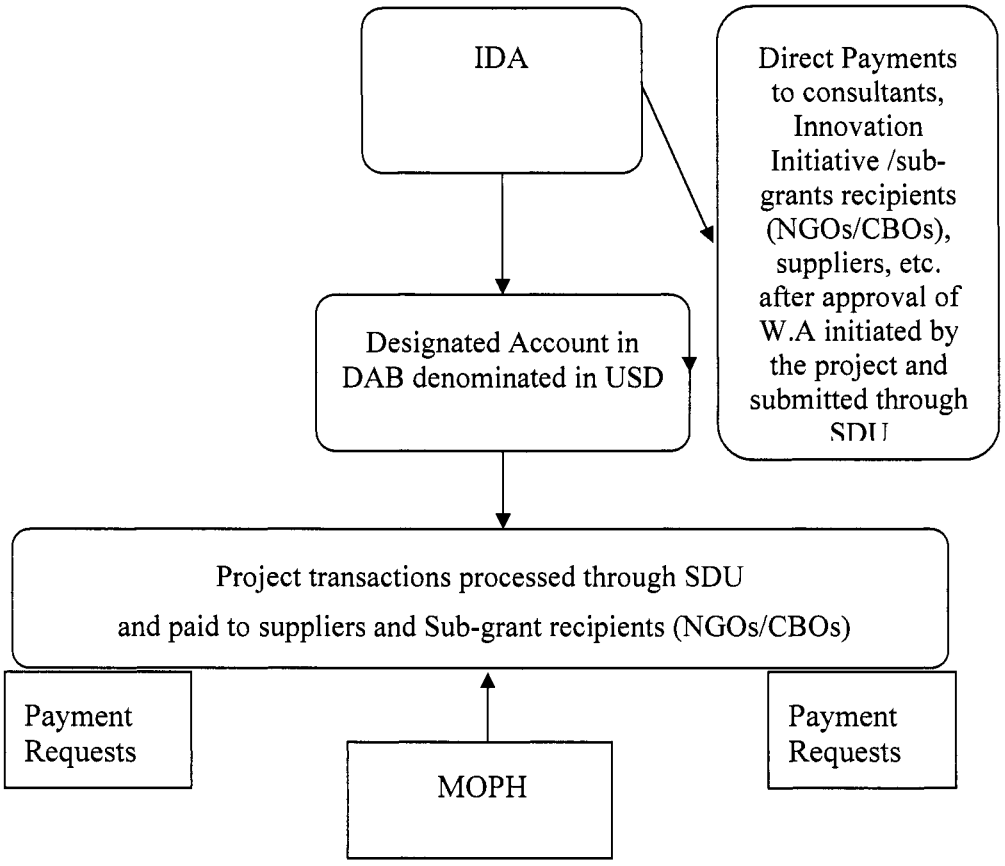
In addition to payments out of DA funds, the GCMU/MOPH can also request the SDU to make (a) direct payments from the Grant Account to contractors, consultants or consulting firms; (b) transfer sub-grant amounts to beneficiaries (awarded out of the Innovation Initiative component); and (c) request issuance of special commitments for contracts covered by letters of credit. These payments will follow World Bank procedures. All project payments will be made to either international firms, local firms or individuals or sub-grant recipients that have bank accounts in DaB, a local commercial bank, or an overseas bank. All payments will be made either through bank transfers into the account of such firms or by check. Expenditures for each component will be paid centrally from MOPH in accordance with the approval mechanisms documented in the HIV/AIDS project FM Manual.

Payments to line ministries, community NGOs and the private sector from the Innovation window will be based on the approved performance agreement, i.e., memorandum of understanding (MOU) for line ministries and contracts for NGOs and private firms. The request for payments should be authorized by the line ministry's designated representative to enable NACP and GCMU to commence processing the payments. Release of first tranche payments, where necessary will be based on the terms of the performance agreement. Subsequent release of funds will be dependent on the achievement of performance milestones stated in the agreement, submission of SOEs to GCMU/MOPH by sub-grant recipients and relevant supporting documents (if required), and submission of financial and physical progress reports to GCMU/MOPH as of that date. Where it is observed by NACP and GCMU that a recipient has utilized the funds to finance activities other than those stated in the approved work plans, these would be considered as ineligible expenditures and the amounts would need to be refunded to the project.

Cash advances may be taken from the Designated Account, and held and managed by MOPH. This agency's controls, holding, accounting, and preparation of SOEs have been satisfactorily assessed. New cash advances will only be made when all other prior cash advances have been justified through submission of SOEs to the SDU.

Retroactive financing of up to SDR 657,000 (US$1.0 million equivalent) is envisaged for expenditures between March 1, 2007 and when the grant is signed. Retroactive financing can be disbursed only after the grant becomes effective.

FUNDS FLOW CHART



Legal requirements for authorized signature

Ministry of Finance has authorization to disburse funds from the Grant. Specimen signatures of authorized signatories in MOF are on file.

Accounting

The SDU will maintain a proper accounting system of all expenditures incurred along with supporting documents to enable IDA to verify these expenditures. The FM staff of GCMU in MOPH will: (a) supervise preparation of supporting documents for expenditures; (b) prepare payment orders (Form M16); (c) obtain approval for M-16s by the Minister or Deputy Minister depending on the payment amount; and (d) submit them to the Treasury Department in MOF for verification and payment. Whilst original copies of required supporting documents are attached to the Form M16, the project is required to make and keep photocopies of these documents for records retention purposes. The FM Advisor in the MOF/SDU will use the government's computerized accounting system, AFMIS, for reporting, generating relevant financial statements, and exercising controls.

GCMU FM staff will maintain essential project transaction records using Excel spreadsheets and generate required monthly, quarterly, and annual reports. At each of the line ministries involved in the program, the assigned accounting officer will maintain essential project records and prepare basic financial reports (Receipts and Payments Account) on their activities. GCMU FM staff will prepare summary reports (statements of expenditures), reconcile the designated account and ensure accuracy of DaB statements and monitor procedural compliance for Sub-grants disbursed under the Innovation Initiative.

The FM Manual, to be prepared by MOPH and approved by the Bank, will include: (a) roles and responsibilities for all FM staff; (b) documentation and approval procedures for payments and release of funds to each of the Innovation Initiative recipients; (c) project reporting requirements; and (d) quality assurance measures to help ensure that adequate internal controls and procedures are in place and are being followed.

Internal Control & Internal Auditing

Project–specific internal control procedures for requests and approval of funds will be described in the FM Manual to be developed before disbursements begin including segregation of duties, documentation reviews, physical asset control, and cash handling and management. Adequate procedures, guidelines, and controls on payments to line ministries involved in the program will also be included in the FM Manual.

The Head of the FM unit of GCMU will be responsible for coordinating FM activities of the project with the SDU.

Annual project financial statements will be prepared by SDU/MOF detailing activities pertaining to the project as separate line items with adequate details to reflect the details of expenditures within each component.

The project financial management systems will be subject to review by the newly-established internal audit directorate of the MOF, according to programs to be determined by the Director of Internal Audit using a risk-based approach.

External Audit

The project accounts will be audited by the Auditor General, with the support of the Audit Advisor, with terms of reference satisfactory to the Association. The audit of the project accounts will include an assessment of the: (a) adequacy of the accounting and internal control systems; (b) ability to maintain adequate documentation for transactions; and (c) eligibility of incurred expenditures for Association financing. The audited annual project financial statements will be submitted within six months of the close of fiscal year. All agencies involved in implementation and maintaining records of expenditures would need to retain these as per the IDA records retention policy.

The following audit reports will be monitored each year in the Audit Reports Compliance System (ARCS):

Responsible Agency	Audit	Auditors	Date
MoF, supported by Special Disbursement Unit	SOE, Project Accounts and Designated Account	Auditor General	Sep 22

Financial Reporting

Financial Statements and Project Reports will be used for project monitoring and supervision. Based upon the FM arrangements of this project, Financial Statements and Project Reports will be prepared quarterly and annually by the GCMU in the MOPH. These reports will be produced based on records kept on Excel spreadsheets after due reconciliation to expenditure statements from SDU (as recorded in AFMIS) and bank statements from DaB.

The quarterly Project Reports will show: (a) sources and uses of funds by project component; and (b) expenditures consolidated and compared to governmental budget heads of accounts, MOPH will forward the relevant details to SDU/DBER with a copy to IDA within 45 days of the end of each quarter. The government and IDA have agreed on a pro forma report format for all Bank projects; a final customized format for HIV/AIDS was agreed prior to project negotiations.

The annual project accounts to be prepared by SDU from AFMIS after due reconciliation to records maintained at the GCMU will form part of the consolidated Afghanistan Government Accounts for all development projects. This is done centrally in the Ministry of Finance Treasury Department, supported by the Financial Management Advisor.

Disbursement Arrangements

Disbursements procedures will follow the World Bank procedures described in the *World Bank Disbursement Guidelines and the Disbursement Handbook for World Bank Clients (May 2006).* Table 1 shows the allocation of IDA proceeds in a single, simplified expenditure category. The single category for "goods, works, consultancy services, training, Sub-Grants (under the Innovation Initiative) and operating costs" is defined in the financing agreement to facilitate preparation of withdrawal applications and record-keeping. Project funds will be disbursed over 36 months. The closing date of the project will be December 31, 2010 with a final disbursement deadline four months after the closing date.

During this additional 4-month grace period, project-related expenditures incurred prior to the closing date are eligible for disbursement.

Table 1: IDA Financing by Category of Expenditure (SDR million)

Expenditure Category	Amount of the Grant Allocation (SDR)	Financing Percentage
(1) Goods, consultants' services, training, sub grants and Incremental Operating Costs[2]	6,502,000	100 %
(2) PPF Refinancing	98,000	
Total	**6,600,000**	-

Summary Reports/Records. Summary reports in the form of Statements of Expenditure will be used for expenditures on contracts below US$25,000; for all training programs, operating costs and all Sub-grants (to NGOs/CBOs) financed from the Innovation Initiative regardless of whether Bank procurement prior review is required or not. Records (supporting source documentation) are required only for contracts for goods, works and services exceeding US$25,000 including procurement carried out by other Line Ministries related to the Innovation Initiative.

Designated Account. A single Designated Account with a ceiling of US$500,000 will be opened at DaB representing three months of estimated expenditures. The SDU in MOF will manage payments from and new advances/reimbursements to this account. Cash advances may be taken from the Designated Account, and held and managed by MOPH in accordance with MOF/MOPH procedures. This agency's controls, holding, accounting, and preparation of SOEs have been satisfactorily assessed. New cash advances will only be made when all other prior cash advances have been justified through submission of SOEs to the SDU/MOF. The Designated Account will be reconciled and a reimbursement application prepared on a monthly basis.

Direct Payments. Third-party payments (direct) and Special Commitments will be permitted for amounts exceeding 20 percent of the advance in the DA (US$100,000). All such payments require supporting documentation in the form of records (copies of invoices, bills, purchase orders, etc.). In the event a direct payment of a Sub-grant to an NGO/CBO is made under the Innovation Initiative, then copies of the relevant Sub-grant agreement are required. For any tranche or installment payments, other appropriate records (progress reports, as required under terms of the Sub-grant agreement) would be required.

Preparation of Withdrawal Applications. MOPH will prepare Summary Reports (simplified Statements of expenditures based on those in "A Guidance Note on Disbursement Procedures – World Bank HIV/AIDS Program") and forward those reports to the SDU for further processing as a reimbursement application. The SDU will review withdrawal applications for quality and conformity to Treasury procedures, and then obtain signature. Selected MOPH and SDU finance staff will be registered as users of the World Bank Web-based Client Connection system, and take an active hand in managing the flow of disbursements.

[2] Incremental Operating Costs refers to project-related incremental expenses incurred on account of project implementation support and management including the rental of office space; the operation, maintenance, rental and insurance of vehicles; fuel; communications supplies and charges; advertisements; books and periodicals; office administration and maintenance costs; bank transaction charges; utility charges; domestic travel and per diem but excluding salaries of officials and staff of the Recipient's civil service.

Financial Management Covenants

(a) MOF shall submit audited financial statements for the project within six months of the end of each fiscal year. The Project's audit report will cover the financial statements, the DA, and SOEs, in accordance with terms of reference agreed with the Association.

(b) Un-audited project interim financial reports will be submitted by MOPH on a quarterly basis to the World Bank and a copy to SDU-MOF within 45 days after the end of each quarter.

(c) MOPH will ensure that the new Financial Management Specialist to be employed is retained throughout the duration of the project in order to ensure smooth project implementation.

Supervision Plan

During project implementation, the Bank will supervise the project's financial management arrangements. The team will:

(a) Review the project's quarterly un-audited interim financial reports as well as the project's annual audited financial statements and auditor's management letter.

(b) Review the project's financial management and disbursement arrangements (including a review of a sample of SOEs and movements on the DA and bank reconciliations) to ensure compliance with the Bank's minimum requirements.

(c) Review agency performance in managing project funds to ensure that it is timely, accurate, and accountable. Particular supervision emphasis will be placed on asset management and supplies.

(d) Review of financial management risk rating and compliance with all covenants.

Conclusion

The FM arrangements, including the systems, processes, procedures, and staffing are adequate to support this project - subject to implementation of the items listed in the action plan.

Appendix 5: Core services of the National HIV/AIDS Prevention Program

Intervention	Core services	Sample Monitoring Indicators	Multi sector partners (actual and potential)
1. Reproductive Tract Infections/ STI case management	•Syndromic management of STI	% STI cases who are correctly assessed & treated	Integrated into Essential Health Services/PHC NGO/Private sector
2. HIV preventive services in general population, including vulnerable groups at high risk	•Promotion of knowledge & consistent condom use •Voluntary Counseling and Testing, PMTCT, RTI, •Community based responses	% of general population with knowledge about HIV transmission and prevention % consistent condom use	Integration into essential health services/ PHC *Ministry of Education*, Strategic communications/ BCC, *Transport sector,* Prison health services
3. Refugees, Returnees and Migrant workers support centre	•Referral for VCCT and STI, •BCC peer education	% Refugees & Returnees with appropriate knowledge regarding HIV	*Ministry of Refugees and Returnees. Transport* sector
4. Blood safety program	•Voluntary non-remunerated blood donation •Rational use of blood •HIV testing of Blood units /QA Blood banks	% HIV prevalence in blood transfusions % of transfused blood units screened for HIV	Red Cross/Red Crescent Integrated into Essential Health Services / PHC
5. Youth Friendly Services & programs	•Life skills (sexuality, substance abuse) •Health education & social services	% HIV prevalence among adolescents % youth knowing about HIV Prevention	Education sector, Social Development *Ministry of Religious Affairs, Ministry of Education*
6. HIV preventive services involving sex workers and their clients & other vulnerable groups at high risk (i.e., truckers & other migrant labor, refugees and returnees, prison populations)	•Voluntary Counseling and Testing •Community based response •Promotion of knowledge & consistent condom use	% sex workers/clients reporting use of condom with their most recent client/sex worker % prison inmates with access to HIV preventive services	FSW and MSW programs NGO/CBO Peer education Prison services
7. Comprehensive IDU program	•Needle syringe program •Oral substitution (in pilot programs) •Referral (OI, DOTS, STI, VCCT, ART, drug de-addiction) Social services/Peer education & Counseling on HIV prevention, condom promotion	% HIV prevalence among Injecting Drug Users % IDUs who used sterile equipment in their last injection	Community based services NGO/CBO Peer education BCC Communications sensitization of police & legal system prison health services *Ministry of Counter Narcotics*
8. Workplace program, including migrant labor, long distance bus and truck drivers	•Workplace policy & protocols implemented (HIV/AIDS code, referral VCCT, IEC, non discrimination	% of employees, including truckers, with access to HIV/AIDS information & services	*Transport sector*/trucking companies, private sector, labor unions, business corporations – with large migrant populations
9. Treatment and care for PLWHA	AIDS case management appropriate care, non discrimination, community support	% PLWHA seeking care who are correctly managed (including ART)	Integrated into public health services

Appendix 6: Project Preparation and Supervision

Processing Schedule:

	Planned	Actual
PCN review	9/29/2006	10/31/2006
Initial PID to PIC	10/05/2006	11/02/2006
Initial ISDS to PIC	10/10/2006	11/11/2006
Appraisal	04/15/2007	04/15/2007
Negotiations	05/31/2007	05/31/2007
Board/RVP approval	07/31/2007	
Planned date of effectiveness	08/31/2007	
Planned date of mid-term review	03/31/2009	
Planned closing date	12/31/2010	

Key institutions responsible for preparation of the project:

National AIDS Control Program, Ministry of Public Health

Other relevant departments in the Ministry of Public Health (M&E Department, IEC Department, Environmental Health Department, Drug Demand Reduction Department, Reproductive Health Department).

Ministry of Finance

Other relevant line ministries (Counter-Narcotics, Education, Higher Education, Women's Affairs, Labor and Social Affairs, Haj and Religious Affairs).

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Mariam Claeson	Regional HIV/AIDS Coordinator & Task-Team Leader	SASHD
Sundararajan S. Gopalan	Senior HNP Specialist	SASHD
Deepal Fernando	Senior Procurement Specialist	SARPS
Kenneth O. Okpara	Senior FM Specialist	SARFM
Asha Narayan	Financial Management Analyst	SARFM
David Freese	Senior Finance Officer	KBLWB
Laura Kiang	Operations Officer	SASHD
Sheila Braka Musiime	Counsel	LEGMS
Martin M. Serrano	Counsel	LEGMS
Jed Friedman	Economist	DECRG
Ghulam Dastagir Sayed	Public Health Specialist	SASHD
Rahimullah Wardak	Procurement Analyst	SARPS
Mohammad Arif Rasuli	Environmental Specialist	SASES
Alex Wodak	Consultant	SASHD
Nagaraju Duthaluri	Consultant	SARPS
Nilufar Egamberdi	Consultant	HDNGA
Silvia M. Albert	Program Assistant	SASHD
Hasib Karimzada	Team Assistant	SASHD

Bank funds expended to date on project preparation:

1. Bank resources: US$120,000
2. Trust funds: Nil
3. Total: US$120,000

Estimated Approval and Supervision costs:

1. Remaining costs to approval: US$80,000
2. Estimated annual supervision cost: US$100,000

Afghanistan HIV/AIDS Prevention Project
Addendum to TA: Environmental Management Plan

Environment

Provision of preventive and diagnostic services under the HIV/AIDS project is expected to benefit the hygiene and sanitation situation in the country however it could generate infectious bio-medical wastes such as sharps (infected needles and syringes, etc), infected blood, HIV test kits used in VCT centers, blood banks and laboratories and pharmaceutical wastes. These wastes, if not managed and disposed properly, can have direct environmental and public health implications.

The proposed project has been classified as category "B" as per the World Bank's Operational Policy on Environmental Assessment (OP 4.01) for environmental screening purposes given the risks associated with the handling and disposal of medical waste and general health waste. Category B projects imply that the potential adverse environmental impacts of the program are site-specific and in most cases mitigatory measures can be designed readily and appropriately.

The MoPH and the NACP team are feeling that under this project we are focusing on the Infection Control and Waste Management issues only in the activities pertaining to this current HIV/AIDS project but it could be a good start and foundation stone for a more comprehensive Waste Management Framework with other programs and institutions in the country in the future.

An Infection Control and Waste Management (IC-WM) Plan has been developed by NACP which focuses on the establishment of a sound management system for the treatment and disposal of the waste related to the testing, treatment and prevention of HIV/AIDS STI and includes generic guidance and protocols and alternative technologies for treatment, transportation and disposal in accordance with the size of healthcare facilities.

Safeguard Policies

This project has triggered OP 4.01 Environmental Assessment due to the potential adverse environmental impacts of healthcare waste as discussed in the previous section. A Limited environmental assessment was undertaken, by different stakeholders, by visiting some government run and some NGOs run facilities, which included field visits and consultations. NACP does not have the necessary institutional capacity to implement the IC-WM Plan and would need to obtain appropriate support for components such as training, IEC and monitoring. An external independent evaluation is recommended before the mid term review of the program to ensure all activities are on track.

The final version, of the Infection Control and Waste Management Plan should be disclosed in the World Bank InfoShop prior to Appraisal and also it is the responsibility of the NACP and the MoPH to make it available to all relevant national stakeholders in the local languages as well as in the relevant websites.

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Physical Cultural Resources (OP/BP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OP/BP 4.10)	[ ]	[X]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP 7.60)	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

Activities and Responsibilities of NACP

NACP is the platform where the following Activities must take place:

(a) Development, revision and implementation of Afghanistan National HIV/AIDS Strategic Framework;

(b) Establishment and running VCCT centers in different parts of the country;

(c) Development and adaptation of different types of guidelines and protocols;

(d) Establishment and co-ordination of HIV/AIDS Co-ordination Committee of Afghanistan(HACCA);

(e) Supervising different surveys and studies regarding HIV/AIDS; and

(f) Fund raising for smooth running of Program.

Provision of preventative and treatment services under the NACP is expected to generate infectious bio-medical wastes such as sharps (infected needles and syringes, equipment, IV sets) infected blood, HIV test kits used in VCT centers, blood banks and laboratories and pharmaceutical wastes. These wastes, if not managed and disposed properly, can have direct environmental and public health implications. Healthcare workers (HCWs) are at great risk as most bloodborne occupational infections occur through injuries from sharps contaminated with blood through accidents or unsafe practices. Systematic management of such clinical waste from source to disposal is therefore integral to prevention of infection and control of the epidemic.

In this context, governments have an obligation to implement the provisions of the 2001 United Nations Declaration of Commitment on HIV/AIDS, which include a commitment to strengthen health-care systems and expand treatment, as well as to respond to HIV/AIDS in the world of work by increasing prevention and care programs in public, private and informal work-places.

HIV/AIDS Control Program in Afghanistan

The first HIV positive case was identified in central blood bank in 1989. As the country was in conflict in that time the Government of Afghanistan responded to it by launching awareness programs. In 2003 the Government of Afghanistan formed National AIDS Control Program (NACP) in MoPH. The first National HIV/AIDS Strategic Plan was developed which was revised in 2006. Now the six functional VCCT centers are functioning throughout the country.

Afghanistan National Development Strategy has a statement regarding HIV/AIDS which indicate a high political commitment on government side.

Environment and Public Health Impacts of the Program

Provision of preventative and treatment services under the HIV AIDS project is expected to generate infectious bio-medical wastes such as sharps (infected needles and syringes, surgical equipment, IV sets) infected blood, HIV test kits used in VCT centers, blood banks and laboratories and pharmaceutical wastes. These wastes, if not managed and disposed properly, can have direct environmental and public health implications. Healthcare workers (HCW) are at great risk as most blood-borne occupational infections occur through injuries from sharps contaminated with blood through accidents or unsafe practices. Systematic management of such clinical waste from source to disposal is therefore integral to prevention of infection and control of the epidemic.

In this context, governments have an obligation to implement the provisions of the 2001 United Nations Declaration of Commitment on HIV/AIDS, which include a commitment to strengthen health-care systems and expand treatment, as well as to respond to HIV/AIDS in the world of work by increasing prevention and care programs in public, private and informal work-places.

The NACP projects specially world bank supported project for the first time, has been classified as Category "B" as per the World Bank's Operational Policy on Environmental Assessment (OP 4.01). Category B projects imply that the potential adverse environmental impacts of the program are site-specific and in most cases mitigatory measures can be designed readily and appropriately. NACP is developing an Infection Control and Waste Management Plan which defines a structured a systematic approach to institute best practices in managing health and environmental risks effectively.

Also the ministry has developed guidelines on Auto-Disable Syringes Use and Disposal. Auto-Disable (AD) syringes have been introduced in the country as part of the Universal Immunization Program. Accordingly, the MoPH has laid down the National Guidelines on use and disposal of AD syringes.

In the following are some rules for Bio-medical Waste Management to be followed during the project Implementation.

Table 1: Bio-medical Waste Management Rules		
Category	**Waste Category**	**Treatment and disposal**
1	Human Anatomical Waste (human tissues, organs, body parts).	Incineration/deep burial
2	Animal Waste (animal tissues, organs, body parts carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals colleges, discharge from hospitals, animal houses).	Incineration/deep burial
3	Microbiology & Biotechnology Waste (wastes from laboratory cultures, stocks or specimens of micro-organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of cultures).	Local autoclaving/microwaving /incineration
4	Waste sharps (needles, syringes, scalpels, blades, glass, etc. that may cause puncture and cuts. This includes both used and unused sharps).	Disinfection (chemical treatment/autoclaving/microwaving and mutilation/shredding)
5	Discarded Medicines and Cytotoxic drugs (wastes comprising of outdated, contaminated and discarded medicines).	Incineration, destruction and drugs disposal in secured landfills
6	Solid Waste (Items contaminated with blood, and body fluids including cotton, dressings, soiled plaster casts, lines, beddings, other material contaminated with blood)	Incineration /autoclaving /microwaving
7	Solid Waste (wastes generated from disposable items other than the waste sharps such as tubing, catheters, intravenous sets etc).	Disinfection by chemical treatment /autoclaving /microwaving and mutilation shredding
8	Liquid Waste (waste generated from laboratory and washing, cleaning, house-keeping and disinfecting activities).	Disinfection by chemical treatment and discharge into drains
9	Incineration Ash (ash from incineration of any bio-medical waste).	Disposal in municipal landfill
10	Chemical Waste (chemicals used in production of biological, chemicals used in disinfection, as insecticides, etc.).	Chemical treatment and discharge into drains for liquids and secured landfill for solids

Notes:

(1) Chemicals treatment using at least 1% hypochlorite solution or any other equivalent chemical reagent. It must be ensured that chemical treatment ensures disinfection.

(2) Mutilation/shredding must be such so as to prevent unauthorized reuse.

(3) There will be no chemical pretreatment before incineration. Chlorinated plastics shall not be incinerated.

(4) Deep burial shall be an option available only in towns with population less than five lakhs and in rural areas.

Institutional and Administrative Framework

National AIDS Control Program was established in 2003 as a unit in MoPH to lead the country response to the epidemic of HIV/AIDS. NACP has the responsibility of steering, supporting, coordinating and overseeing the activities carried out for HIV/AIDS control program. HIV/AIDS Co-ordination Committee of Afghanistan (HACCA) is the entity which oversees NACP.

NGOs form an important element of targeted intervention. NGOs undertake HIV prevention activities through the public health system as well as through targeted interventions. Thus while the bulk of VCTCs, STD clinics are in the public sector, targeted interventions are implemented through NGOs who work with the high risk groups. For the most, these NGOs also make testing services available through the same public networks.

BASELINE DATA AND CURRENT PRACTICES OF IC-WM

Sites and Facilities Visited and Stakeholders Consulted

The information relating to current practices enumerated below is based on site visits to (Place, Facilities number ----------

The facilities visited included primary, secondary and tertiary health-care facilities (government-run), VCCTCs, Blood banks, and STD Clinics (including associated laboratories). The stakeholders consulted during site visits included:

(a) HACCA;

(b) NGOs;

(c) Health-care workers at blood banks, VCCTs, blood banks, and STD clinic;

(d) . Primary/secondary/tertiary health-care facilities;

(e) . Local communities, including patients, peer educators, commercial sex workers; and

(f) Waste management facilitators (private organizations).

Prevailing IC-WM Practices

Survey Findings

The findings from the site visits and primary data collection have been grouped in two categories:

(a) Government-run Facilities ("Government Facilities") that include primary, secondary and tertiary healthcare facilities; and

(b) NGO-run Facilities ("NGO Facilities") that include VCTC and STD clinics.

Government-run Facilities

Overview

Most of the government-run facilities surveyed had poor standards of hygiene and inadequate IC-WM practices. Although awareness of the Bio-medical Rules and Hospital Waste Management Guidelines is high (over 90% of the facilities visited), lack of funds, irregular supply of barrier protection and PEP(Post Exposure Prophylaxis) and human resource shortage were cited as the main reasons for poor implementation of IC-WM practices. Though more than 90% of the facilities visited were aware of the Applicable statute and guidelines, specific compliance requirements were not known to the majority of the HCWs interviewed.

In most of the facilities surveyed, hospital infection control committees had not been constituted. Even in those facilities in which IC-WM committees were present, the authorities admitted that these were not very active.

Few or none IEC material were observed in most of the facilities visited. Additionally, there is no evaluation process to assess the quality of training imparted and its outcome in terms of improved IC-WM practices.

Employment of Infection Control Measures

The general assessment was that a large number of nurses, paramedics were found to be ignorant of good practices. Since these HCW also will work with HIV/AIDS patients, the lack of availability of barrier protection, disposable needles and PPE becomes a critical issue. In several instances the staff admitted to not using gloves during blood handling procedures. They also admitted to using the same disposable syringe for several patients and thus needle recapping was a common practice. AD syringes could not be observed at any of the facilities visited. On the contrary glass syringes were being used at several places for which the general practice is reuse after sterilization.

Needle Cutters were rarely available and were mostly electric ones which are prone to being underutilized during power cuts or being damaged due to voltage fluctuations. It was observed that HCW either did not utilize the needle-cutters or instead broke the needles with their bare hands, or by using a heavy object, or even not at all. In majority of the instances the intact syringes or mutilated needles were not immersed in 1% hypochlorite solution as required.

HCW in several of the secondary and tertiary facilities did report accidents due to needle stick injuries. However, the incidence of reporting was low, with only 30-40 percent of the total injuries being reported.

In PHCs, no waste segregation and disinfection practices could be observed. The general standards of sanitation and hygiene were found to be very low. Infectious waste (blood-soaked cotton, used un-mutilated syringes, worn gloves) was seen scattered under the patients' beds, in the corridors and washrooms. All infectious and non- infectious waste was observed to be collectively disposed in shallow open pits.

In secondary and tertiary facilities partial waste categorization and segregation practices were observed though awareness of statutory (Regulatory) requirements was largely absent. Even if known, non-availability of appropriately colored poly-bags and bins, leads to improper segregation with waste being generally handled without any barrier protection.

NGO–run Facilities

Overview

In general, all NGO run-facilities demonstrated awareness of and adherence to good IC-WM practices, partial or complete. These facilities typically had regular training, sufficient funds, regular supply of barrier protection and PEP and human resources. Awareness of NACP publications was also high as these form the basis of training and functioning of these facilities. Since the funding of NGO facilities is separate from that of Government facilities, hence selective training and equipment availability could be observed.

Employment of Infection Control Measures

Due to systematic training and re-training, the awareness is significantly higher in these HCW. NGO have been providing barrier protection, PEP, disposable needles and needle cutters (electrical type) on a regular basis. Accident Reporting is also observed to a large extent and most workers had been vaccinated against HBV.

Employment of Waste Management Measures

The fact that the waste disposal for NGO facilities is dependent on the host facility's disposal practices further compounds the problem of waste management. In instances where waste management is being carried out by third parties (such as at Common Treatment Facilities) there is a higher degree of conformance to Biomedical Rules.

RECORD OF CONSULTATION/DISCUSSION WITH RELEVANT STAKEHOLDERS

Two types of consultations were held during the course of this study:

(a) Consultation with individual stakeholders during the site visits; and

(b) Consultation convened by the NACP design team and facilitated by environmental department of MoPH.

The IC-WM Plan proposed below is based on existing documentation, observations during site visits, review of existing practices amongst other health initiatives and discussions and consultations with stakeholders.

INFECTION CONTROL AND WASTE MANAGEMENT PLAN

The **IC-WM Plan** ("Plan") provides a consolidated, reference material on IC-WM good practices that may be further tailored to suit the facility's needs. The Plan is build on the following framework:

(a) Section I: Infection Control and Waste Management;

(b) Section II: Capacity Building;

(c) Section III: Institutional Framework;

(d) Section IV: Monitoring and Evaluation; and

(e) Section V: Implementation Schedule.

Section I: Infection Control and Waste Management

Healthcare workers involved in the NACP face the highest occupational risk due to the nature of their work dealing with testing and treatment of HIV/AIDS cases. Infectious waste from AIDS related activities include primarily: needles and sharps, blood and blood bags, used test kits, culture samples and slides and other related infectious waste such as swabs, gloves, bandages, sputum cups etc. Thus it is imperative that good IC-WM practices are implemented. This activity should not be restricted only to certain sections of the healthcare facility like VCTC, PPTCT, but extend to all facilities runned by NACP.

1. Waste Segregation and On-site Storage

Segregation at source is the most critical step towards a well- functioning waste management system. Separation of infectious and non- infectious waste becomes impossible once mixed, resulting in greater risk to all concerned.

The Bio-medical Rules provides color coding for waste segregation and their respective treatment options, as listed below in Table 2.

Table 2. Waste segregation and color coding		
Color coding	**Waste Category**	**Treatment option**
Yellow	Plastic bag Cat. 1, Cat. 2, and Cat. 3, Cat. 6.	Incineration/deep burial
Red	Disinfected container/plastic bag Cat. 3, Cat. 6, Cat.7	Autoclaving/Microwaving / Chemical Treatment
Blue / White Translucent	Plastic bag/puncture proof Cat. 4, Cat. 7. Container	Autoclaving/Microwaving / Chemical Treatment and Destruction/shredding
Black	Plastic bag Cat. 5 and Cat. 9 and Cat. 10. (solid)	Disposal in secured landfill

The facility should ensure that there are designated segregation points, as close to the generation points as possible. Segregation requires appropriate consumables, such as good quality and adequately sized containers, non-chlorinated plastic bags, needle cutters and safety boxes. The specifications and color-coding provided in the Biomedical Rules need to be strictly followed.

2. Collection and Transportation of Bio-medical Wastes

Transportation of bio- medical wastes, within and outside the healthcare facility needs to be secure and well-managed. Spills and leakages can be risky for patients and the community, but can also result in pilferage and reuse of potentially infectious items such as syringes etc.

Specific steps to be taken by each facility include:

(a) Waste should be collected from various sources and transported to a central location;

(b) Within the facility, special waste routes should be designated to avoid patient care areas. Special timing should be identified for transportation of bio-medical waste to the central point;

(c) Dedicated wheeled containers, trolleys or carts should be used to transport the waste to the collection/treatment site. These should be such that the waste can be easily loaded and emptied and remain secured during transportation. They should not have any sharp edges and be easy to clean and disinfect;

(d) If disposal is done within the premises of the healthcare facility, care should be taken that different categories of waste are disposed of accurately (sharps in sharps pit, anatomical waste in deep burial pits etc) as designated in the Biomedical Rules; and

(e) Waste handlers should be properly trained and should use barrier protection during transportation.

3. Treatment and Disposal of Bio-medical Wastes

(a) Used sharps (needles, slides, scalpels etc), blood bags, syringes and other infectious plastic and liquid wastes (Categories 4, 7, 8, and 10 of the Biomedical Rules) need to be disinfected by immersion in 1% hypochlorite solution or any other equivalent chemical reagent. It must be ensured that chemical treatment ensures disinfection;

(b) Waste containers should contain freshly prepared disinfectant solution and be kept closed all the time. At all times, the waste container should not be more than 3/4th full;

(c) The waste containers should be emptied at least once everyday;

(d) Infected linen in the hospital should be carefully packed in plastic bags, and disinfected before being sent for washing. Personnel involved in laundering infected linen should take adequate precautions to prevent the exposure to infections;

(e) A log of quantity of waste generated by type, name of waste handler, time of emptying waste container, time of cleaning container and pouring disinfectant should be maintained; and

(f) Disposal as recommended in the Rules, should be as follows:

(i) **Sharps** in their puncture proof containers should be drained of the disinfectant and disposed in the sharps pit, constructed within the premises;

(ii) **Infected organic waste** should be disposed of in the deep burial pits also constructed within the facility and covered with a layer of lime and soil; and

(iii) **Infected recyclables** such as plastics and metals, can be sent for recycling but only after disinfection and/or autoclaving.

All equipment used for bio-medical waste treatment should be periodically subjected to maintenance checks to ensure its functioning. Both preventive and corrective maintenance schedules and records should be retained in the facility. As a general practice of maintaining good hygiene, the floors of the facility should be first swabbed with a wet cloth, then swept to remove grits to avoid dust carrying pathogens from rising into the air and, finally, swabbed with a disinfectant solution. The swab cloth should be washed with detergent after every use. The housekeeping personnel should employ use of protective barriers to prevent exposure to infection.

4. Sharps Management

Given the high risk of infection from infected sharps, a separate section on the safe use and disposal of sharps is being detailed. Sharps are anything that may cause puncture and cuts. Sharps include needles, scalpels, blades, broken glass, slides, lancets, sutures, and IV catheters. Infected needles, sharps and blood, if improperly handled, can be a source of infection for the HCWs.

Although the risk of infection from contaminated sharps is high for all categories of HCW, those most at risk of exposures are nurses, medical staff and clinical laboratory staff (blood collectors). Physicians are at some risk, but surgical and dental staff, although at high risk of injury, have a lower risk of infection. It must be remembered that all health care personnel (including cleaners, laundry staff and waste contractors) may be exposed to inappropriately discarded sharps. While emergency rooms and operating theatres pose high risk for HCW, it has been found that a) the majority of exposures have occurred in general ward areas and b) a larger number of exposures which would be classified as high risk have occurred in medical wards.

The following measures must be taken to ensure sharps safety in the work-place:

(a) Barrier protection must always be used when handling sharps;

(b) Sharps must be segregated and stored in puncture-proof containers at the point of generation;

(c) Sharps must be mutilated before treatment and disposal. Used disposable or Autodisable (AD) syringes should be mutilated by using needle cutters/ destroyers and hub-pullers and dropped into a puncture-proof container. Clipping, bending or breaking of needles by hand or re-capping should be avoided as this may cause accidental injuries;

(d) Used sharps should not be left untreated or carelessly on counter tops, food trays, or beds, as this can pose a risk to all concerned;

(e) Mutilated sharps should be immersed in 1 percent hypochlorite solution or any other equivalent chemical reagent for disinfection. Treatment by autoclaving / microwaving is also approved; and

(f) Final disposal should be in a secured landfill. Wherever this is not available everywhere, sharps pits or encapsulation should be used.

A sharps pit is a circular or rectangular pit, where sharp wastes are disposed. These pits are lined with brick, masonry or concrete rings. The pit should be covered with a concrete slab. When the pit is full, it should be sealed completely and another pit is prepared.

Encapsulation is another method. When a container (puncture and leak proof containers) is three-quarter full, material such as cement mortar, bituminous sand, plastic foam or clay is

poured until the container is completely filled. After the medium has dried, the containers are sealed and disposed in landfill sites.

Guidelines for Disposal of Used Disposable Syringes	
No.	**Steps / Stages**
1	Severe needles from disposable syringe immediately after administering injection using a needle cutter/hub-cutter that removes the needle from disposable syringes or cuts plastic hub of syringe from AD syringes.
2	The cut needles get collected in the puncture proof container of the needlecutter/ hub-cutter. The container should contain an appropriate disinfectant and the cut needles should be completely immersed in the disinfectant
3	Segregate and store syringes and unbroken (but discarded) vials in a red bag or container.
4	Send the collected materials to the common bio-medical waste treatment facilities. If such facilities do not exist, then go to the next step.
5	Treat the collected material in an autoclave. If this is unavailable, treat the waste in 1% hypochlorite solution or boil in water for at least 10 minutes. It shall be ensured that these treatments ensure disinfection.
6	Dispose the autoclaved waste as follows: (i) Dispose the needles and broken vials in a pit / tank, (ii) Send the syringes and unbroken vials for recycling or landfill.
7	Wash the containers properly for reuse.
8	Make a proper record of generation, treatment and disposal of waste.

5. Blood safety in Laboratory

Blood is the single most important source of HIV, HBV, HCV and other blood borne infections for HCWs. It is mandatory to screen blood units for five transmissible infections: Hepatitis B, Hepatitis C, HIV, syphilis and malaria. The Rules in the country also require for testing procedures, quality control, standard qualifications, and experience for blood bank personnel, maintenance of complete and accurate records, strict guidelines for holding of blood donation camps etc. and to be further improved.

Careful donor screening, discouraging use of paid donors, stringent screening of donated units of blood to prevent HIV transmission through blood and blood products. Another important action taken by MoPH has been to modernize the blood banks in the country.

Risk of infection varies with a number of factors, including type and number of exposures, amount of blood involved in the exposure, amount of virus in the patients' blood etc. Modes of exposure to blood borne pathogens in a laboratory have been defined as below:

Modes of Exposure to Blood-borne Pathogens in the Laboratory		
Procedure	**HCW at risk**	**Source/Modes of Transmission**
Collection of blood/body fluid	Laboratory technician	❑Needle stick injury ❑Broken specimen container ❑Blood contamination of hand with skin lesions/breach
Transfer of specimen	Laboratory technician and transport worker	Contaminated exterior of container ❑Broken specimen container ❑Spills/splashes of specimen
Processing of specimen	Laboratory personnel	Puncture of skin ❑Contamination of skin from spills, splashes, glassware and work surface ❑Faulty techniques ❑Perforated gloves
Cleaning /Washing	Laboratory support staff	❑Puncture of skin ❑Contamination of skin from spills, splashes, glassware and work surface
Disposal of waste	Laboratory support staff	❑Contact with infectious waste, specially sharps, broken containers
Specimen transportation/mailing	Transport/postal staff	Broken/leaking container or packaging

As per the Bio-medical Rules, infected blood and blood samples is characterized as liquid waste and should be disinfected with hypochlorite solution.

Screened positive blood bags, contaminated test kits and items are categorized as infected solid waste and should be disinfected by chemical treatment / autoclave and mutilated before disposal.

Transport of specimens should be done in a diligent manner. The sample should be kept first in primary container with enough absorbent material around it. The primary container should then be placed in secondary container.

Staff should take care that the secondary container is also leak-proof, properly sealed and labeled. Upright position must be maintained at all times.

6. Infection Control

The four key areas of infection control for the NACP are:

(a) Immunization against nosocomial infections;

(b) Availability and use of barrier protection;

(c) Management of PEP; and

(d) Awareness.

(i) Activities of high risk include invasive diagnostic and therapeutic procedures, wound dressing, operation theatre procedures, handling of blood/serum/body fluids and tissues etc. and special attention should be paid to ensuring safety precautions during these activities;

(ii) Barrier protection (gowns, masks, caps, gloves, shoes) should be maintained to prevent contact with contaminated blood/body fluids;

(iii) HCW working in high risk areas should be immunized, at the minimum, against HBV;

(iv) Daily cleaning of facility premises with appropriate disinfection should be done;

(v) Spills are an important source of infection and should be cleaned up immediately. The spill should be covered with absorbent material, disinfectant poured around the spill and over the absorbent material. The surface should be wiped again with disinfectant. HCW must utilize barrier protection, especially gloves, when managing spills; and

(vi) General observance of personal hygiene is important. All staff must be neat and clean always, with clean uniforms, nails, short or tied-up hair, etc.

PEP is required when there has been contact with known HIV/AIDS infected materials resulting from:

(a) Percutaneous inoculation (needle stick, cut with a sharp, etc.);

(b) Contamination of an open wound;

(c) Contamination of breached skin (chapped, abraded, dermatitis); and

(d) Contamination of a mucous membrane including conjunctiva.

(i) I n all such instances immediate post-exposure management is crucial to reducing the risk of acquiring infection. This should be done in the manner prescribed by the above mentioned guideline to be developed by NACP; and

(ii) All accidents whether needle stick injuries or spills should be reported.

Section II: Capacity Building and Awareness

Training and sensitization of various HCWs and functionaries within and outside the health care system is vital for the successful implementation of any IC-WM Plan. The training should focus on Universal Precautions, principles of waste management, identification of roles and responsibilities for implementation, monitoring and reporting.

All awareness, training and communication initiatives should be oriented towards providing knowledge / information, building skills and competencies and bringing about a fundamental, mindset change in the attitudes of staff and personnel. The Training Plan and budget should be included into the MoPH PIP and into NACP PIP and program budget.

The following steps should be followed for implementing training:

(a) Conduct baseline assessment of training needs for HCWs involved in the implementation of AIDS Control Program. For an integrated approach;

(b) A Training Plan needs to be developed based upon existing capacity and training needs. At the outset, this plan should distinguish between trainers and non-trainers and elaborate the criteria for identifying trainers and their requirement for training;

(c) Training should be provided to all HCWs, including doctors, nurses, ward boys, paramedics, laboratory technicians, and Class IV and/or housekeeping staff; and

(d) Training should be imparted through:

(i) Dissemination of Information, Education and Communication (IEC)material that will sensitize HCWs and create general awareness on importance of IC-WM; and

(ii) Technical training for HCWs with specific responsibilities for discrete activities related to IC-WM.

(e) Training in Infection Control and in Waste Management should be a comprehensive package as the two are closely inter-twined;

(f) The Train the Trainer program will have to be undertaken at two levels – state and district levels. Training should be provided on an annual basis, with refresher courses annually or biannually;

(g) In addition to classroom type training, IEC material and awareness-creating activities also need to be employed for training the HCW. Training should preferably be provided on site;

(h) Each facility should keep records of training provided to employees, by category of employee; and

(i) The IEC material must be prepared in the local language on both IC and WM and should be prominently displayed at various places. It should serve as a reminder for all the trained employees as well as sensitize patients visiting the facility.

Section III: Reporting, Monitoring and Evaluation

Monitoring & evaluation will be done through a mix of internal and external approaches. The internal reporting and evaluation mechanism on the IC-WM implementation should be integrated with overall NACP reporting. Management Information Systems (MIS) indicators pertaining to the IC-WM will be developed during implementation. External monitoring in the form of IC-WM implementation audits is also being recommended.

1. Quarterly monitoring

Each facility must establish a robust system of monitoring through regular documentation and assessments. Ideally, each facility should designate one senior employee responsible for documentation and another for internal evaluation. In the case of VCTC, PPTCT and blood banks, the laboratory technician should maintain records of waste sharps, gloves, etc. and infectious waste. The records must be maintained on a daily basis and internal assessments should be conducted on a monthly basis. The monthly report from NGO should directly be send to NACP.

2. Periodic Implementation Review

Periodic implementation review of the IC-WM should be undertaken, and as far as possible, this review should be inbuilt into the regular review process of the NACP.

This review should focus on consolidated information and reporting from individual facility level. To facilitate regular and sustained monitoring, each NGO implementing HIV/AIDS program develops annual Action Plans specifically for IC-WM, which should be included into the MoPH PIPs.

3. Performance Indicators

NACP envisages a robust nationwide Strategic Information Management System (SIMS) with focus on implementation, monitoring, evaluation and strategic surveillance, appropriate standards for measuring performance, analyzing variances, identifying bottlenecks, alerting program managers and facilitating corrective measures. Some generic Performance Indicators of the IC-WM Plan have been recommended below, which should be integrated into the NACP SMIS.

(a) Implementation of all components of the IC-WM Plan;

(b) Timely procurement and distribution of IC-WM consumables and equipment;

(c) Regular and timely training programs undertaken;

(d) Regular evaluation of training effectiveness and assessment of employee behavioral practices;

(e) Timely interventions and coordination with host facility on significant issues which could hinder effective implementation of IC-WM Plan; and

(f) Timely and regular reporting and evaluation undertaken, with corrective measures when necessary.

4. External Implementation Audits

The NACP will be responsible for hiring of an external technical consultant/firm to undertake an independent evaluation of the program and its implementation. The agency to conduct this technical review should be chosen on the basis of their technical expertise and established experience in Bio-medical waste management and environmental auditing. Such an independent audit review will be undertaken once during the life of the program, preferably before a mid-term evaluation is conducted.

MAP SECTION


AFGHANISTAN & CENTRAL ASIA
TOWNS
NATIONAL CAPITALS
RIVERS
PROVINCE BOUNDARIES
INTERNATIONAL BOUNDARIES
0 100 200 300 400 500
KILOMETERS
KAZAKHSTAN
UZBEKISTAN
TURKMENISTAN
KYRGYZ REP.
TAJIKISTAN
CHINA
AFGHANISTAN
IRAN
ISLAMIC REPUBLIC OF IRAN
IRAQ
KUWAIT
BAHRAIN
QATAR
U.A.E.
OMAN
PAKISTAN
INDIA
NEPAL
Arabian Sea
Aral Sea
Syrdar'ya
Amu Darya
Helmand
Indus
Ganges
Yarkant He
Zaysan
Karamay
Urumqi
Yining (Gulja)
Uxxaktal
Yuli (Lop Nur)
Aksu
Saryshagan
Tyuratam
Nukus
Chimkent
Chirchik
Tashkent
Almaty
Bishkek (Frunze)
Fergana
Samarkand
Kashi
Hotan
Dushanbe
Ashgabat
Tehran
Kermanshah
Mashhad
Esfahan
Tabas
Herat
Kabul
Peshawar
Islamabad
Rawalpindi
Srinagar
Gar
Lahore
Faisalabad
Multan
Qandahar
Quetta
Kerman
Shiraz
Bushehr
Al Basrah
Khorramshahr
Kuwait
Dhahran
Manama
Doha
Dubai
Abu Dhabi
Bandar Beheshti
Muscat
Karachi
Hyderabad
Bhuj
Ahmadabad
Jabalpur
Indore
Nagpur
New Delhi
Agra
Jaipur
Lucknow
Kanpur
Allahabad
Varanasi
Patna
Kathmandu
BALKH
KONDOZ
BADAKHSHAN
TAKHAR
SAMANGAN
Mazar-e Sharif
FARYAB
JOWZJAN
BAGHLAN
KAPISA
KONAR
LAGHMAN
BADGHIS
BAMIAN
PARVAN
GHOWR
HERAT
KABOL
VARDAK
NANGARHAR
LOWGAR
ORUZGAN
PAKTIA
GHAZNI
FARAH
PAKTIKA
ZABOL
NIMRUZ
HELMAND
KANDAHAR
JAMMU & KASHMIR
AKSAI CHIN
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