COUNTRY PROGRESS REPORT 2012

Islamic Republic of Afghanistan

Ministry of Public Health
Director General of Preventive Medicine and Primary Health Care
Communicable Disease Directorate (CDC)

Submission date: 30th March 2012

Contents

Table of Abbreviations

ADB	Asian Development Bank
AHAPP	Afghanistan HIV/AIDS Prevention Project
AIDS	Acquired Immune Deficiency Syndrome
ANASF	Afghanistan National AIDS Strategic Framework
ANBSTS	Afghanistan National Blood Services and Transfusion Safety
ANDS	Afghanistan National Development Strategy
ANP	Afghanistan National Police
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral
BBD	Blood Borne Diseases
BCC	Behavioral Change Communication
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CBC	Community Based Care
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDC	Communicable Disease Directorate
CHABHA	Children Affected by HIV/AIDS
CHW	Community Health Worker
CSO	Civil Society Organization
DFID	Department of International Development, UK
DIC	Drop-In Center
EC	European Commission
EPHS	Essential Package of Hospital Services
EU	European Union
FBO	Faith-Based Organization
FC	French Cooperation
FMS	Financial Management System
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
GCMU	Grants and Contracts Management Unit
GDPM	General Directorate of Preventive Medicine
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GoA	Government of Afghanistan
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit GmbH/International Services
HACCA	HIV/AIDS Coordination Committee for Afghanistan
HBC	Home-Based Care
HBV	Hepatitis B
HBC	Hepatitis C
HIV	Human Immunodeficiency Virus
HMIS	Heath Management Information System
HPRO	Health Protection and Research Organization
HSV-2	Herpes Simplex Virus
HR	Harm Reduction
IBBS	Integrated Bio-Behavioral Surveillance
ICRC	International Committee for the Red Cross
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education, and Communication
IDPA	Integrated Drug Prevention in Afghanistan

ILO	International Labor Organization
IOM	International Organization on Migration
IP	Implementing Partners
IPD	Internally Displaced Persons
IPIP	Instances, Police Intervention Project
JHU	John Hopkins University
KAP	Key Affected Population
MARA	Most at-Risk Adolescents
MARP	Most-At-Risk Populations
MDG	Millennium Development Goals
MDM	Medecins Du Monde
MICS	Multi Indicator Cluster Surveys
M and E	Monitoring and Evaluation
MSM	Men who Have Sex with Men
MoCN	Ministry of Counter Narcotics
MoD	Ministry of Defense
MoDM	Ministry of Displaced and Martyred
MoE	Ministry of Education
MoF	Ministry of Finance
MoHE	Ministry of High Education
MoHRA	Ministry of Hadj and Religious Affairs
MoI	Ministry of Interior
MoIYC	Ministry of Information, Culture and Youth Affairs
MoJ	Ministry of Justice
MoLSA	Ministry of Labor and Social Affairs
MoPH	Ministry of Public Health
MoRR	Ministry of Returnees and Refugees
MoWA	Ministry of Women Affairs
MTCT	Mother-To-Child-Transmission
NACP	National AIDS Control Program
NCB	National Competitive Bidding
NCPI	National Commitment and Policy Index
NGO	Non-Governmental Organization
NSF	National Strategic Framework
NSP	Needle Syringe Programs
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PMTCT	Prevention of Mother-to-Child Transmission
POP	Program Operational Plan
PAD	Project Appraisal Document
PLHA	People Living with HIV/AIDS
PLHIV	People Living with HIV
PPTCT	Prevention of Parent-To-Child Transmission
PWID	People Who Inject Drugs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWG	Surveillance Working Group
TA	Technical Assistance
TB	Tuberculosis
TBD	To Be Determined
TFM	Transitional Funding Mechanism
TIU	Truckers Implementation Unit
TOR	Terms of Reference
ToT	Training of Trainers

UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VCCT	Voluntary Confidential Counseling and Testing
WB	World Bank
WHO	World Health Organization
WFP	World Food Program

Foreword

د افغانستان اسلامی جمهوریت

دولت جمهوری اسلامی افغانستان

Islamic Republic of Afghanistan

Ministry of Public Health

March 27, 2012

Foreword

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

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

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

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

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

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

Sincerely,

Dr. Nadera Hayat Burhani

Deputy Minister

Ministry of Public Health, Kabul, Afghanistan

I. Status at a glance

Since the UNGASS Afghanistan Country Report 2010, an AIDS situation and response assessment was conducted as part of the Afghanistan National AIDS Strategic Framework (ANSF) II, 2011-2015. New sources of data on AIDS during this period included: the National Drug Use Survey 2010; the Assessment of Drug Use Levels and Associated High Risk Behaviors amongst the Prison Population of Sarpoza Prison, Kandahar; a Knowledge, Attitudes, Behavior and Practices survey carried out among most at-risk adolescents; a review of the Opioid Substitution Therapy (OST) program in place since 2010; and some information resulting from assessments in selected Provinces outside of the capital, Kabul. There is also updated programmatic data for 2010-2011 from the programs supported by the World Bank and the Global Fund that are being implemented by the Ministry of Public Health (MoPH) and civil society organizations on such aspects as: coverage of HIV harm and risk reduction, including OST, numbers of people on ART, and HIV/TB referrals. However, all mapping and HIV prevalence data among Key Affected Populations (KAPs) is the same as in 2010 and the years prior to this as the Integrated Bio-Behavioral Survey (IBBS) baseline had just been completed in 2009 (published in 2010) and the next IBBS round, including mapping, is planned for 2012.

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

The process of preparation of this report encompassed an initial consultation meeting between the National AIDS Control Program (NACP), UNODC, UNAIDS, WHO, Johns Hopkins University, and the designated consultants. Civil society, community members as well as researchers were also consulted following which data collation and interviews for the NCPI were planned. This effort was divided out amongst various stakeholders. Data collation took about two weeks. The first ever IBBS of Afghanistan was completed in 2009 and this data provided the main source of information on the relevant targets in this report. Using primary data from IBBS, interviews of the NCPI and funding matrix responses, and secondary data, the two consultants[1]commissioned by UNAIDS, working closely with MoPH, prepared the first draft of the report. This was presented to a wide variety of stakeholders, including the Government, civil society and researchers. The observations made during this second consultation on the Global AIDS Response Progress Report (GARPR) 2012 were incorporated. Overall, the NACP took the lead in data collation and has taken care to include all relevant stakeholders and information and had jointly planned and validated the data. More on the process is included in Annex 1.

(b) Status of the epidemic

Thirty years of protracted periods of war and unrest made Afghanistan, a country with a population currently estimated at over 30 million, reach a rank 181 out of 182 countries with regard to the Human Development Index and be classified as among the poorest nations in the

1Dr Angela Chaudhuri and Joseph Julian from Swasti- Health Resource Center (www.swasti.org)

world in recent years.[2] Through studies conducted on persons who inject drugs (PWID) and IBBS 2009, it is now clear HIV is a public health concern among the key affected and vulnerable populations. Other than drug cultivation, trade and use, there are several other underlying factors of vulnerability in the country, including: poor HIV-related knowledge and limited access to sex and reproductive education, low literacy level (85%), high stigma and of people living with HIV (PLHIV), as well as of Key Affected Populations – PWID, female sex workers (FSWs), men who have sex with men (MSM), and prisoners, are the most affected by this. Challenges to HIV prevention are, in addition to the security and humanitarian environment, poor infrastructure and a chronic lack of capacity, including absence of a comprehensive surveillance system on HIV and STIs and current reliance on data which is only available for some of the most at-risk groups. This makes it difficult to further (a) understand the dynamics of transmission, and (b) assess the potential for further diffusion.

Injecting drug use in Afghanistan is associated with the intravenous injection of (a) heroin, (b) pharmaceutical drugs, or (c) tranquilizers and painkillers. Both 2005 and 2009 national drug surveys point to the alarming rates of high-risk behavior among PWID, including sharing of needles and syringes, use of other substances, low condom use, and exchange of sex for money and drugs. It was reported in the 2005 survey that at least half of the heroin users shared needles. In 2009, the majority of interviewed PWID (87 per cent) reported such behavior.[3] Interestingly, the 2010 cohort study, while reporting lower rates of needles and syringe sharing (17%), revealed a much higher rate of sharing of injecting equipment (40%). This study also provided important information on common use of other substances, such as hashish and alcohol (61% and 65%, respectively), and, most disturbingly, transitioning from smoking to injecting of heroin among 98% of PWID.[4]

(c) Policy and programmatic response

In view of the status of the epidemic, the Government of Afghanistan (GoA) with the support of development partners has adopted both a priority focus on policy and programs in this area. Several policies and guidelines have been developed and approved in the country to date. One of the important achievements includes the adoption of the *Harm Reduction Strategy for IDUs and HIV/AIDS Prevention* in 2005 by the Ministry of Counter Narcotics (MoCN) and MoPH; the *National Drug Control Strategy* by the MoCN in 2006, and the *National OST Policy* in 2010. These policy documents were intended to assist in the implementation of a comprehensive package of services for drug-related harm reduction in Afghanistan. HIV-related concerns were also addressed in a number of other strategies, including the *National Health Policy 2005-2009* and the *National Health Communications Policy and Strategy2004-2007* that include objectives on HIV. In 2007, a *Communication Strategy for Building an Enabling Environment for Targeted Interventions* was developed. In 2007 as well, a plan for the

[2] Afghanistan at A Glance, World Bank, 2009; WHO, 2010; Human Development Report, 2009; Human Development Index (HDI) ranks countries based on income, life expectancy and literacy rates. In 2007, the Afghanistan National Human Development Report placed the country at 174 out of 178 countries.
[3] UNODC, MoCN 2005 and 2009 Drug Surveys, *Ibid*
[4] Todd C.S et al, 2010, *Ibid*

Monitoring and Evaluation of the MoPH was elaborated. The same year also saw the development of an *HIV Communication Strategy and a Monitoring and Evaluation Plan for HIV Prevention, Treatment, Care and Support in Afghanistan* [5]. Finally, the *National HIV/AIDS Policy* has been developed in 2010-2011 and has been approval by the MoHP.

Strategic interventions in the area of HIV prevention have been reinforced since 2006-2007 and focused on: key affected populations (PWID, FSWs and MSM), (b) vulnerable populations (migrant workers, police and the military) and (c) the general population, implemented with assistance from 10 international and national NGOs or implementing partners (IPs) and financed through the Global Fund Round 7, the World Bank's Afghanistan HIV Prevention Project (AHAPP), and, partially, through UN agencies (UNODC, UNAIDS, WHO, UNICEF, UNFPA, etc.) across eight provinces of the country – Kabul, Herat, Mazar-e-Sharif, Ghazni, Badakhshan, Kunduz, Kandahar, and Jalalabad.

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

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

[5] Building an Enabling Environment for Targeted HIV/AIDS Interventions: A Communication Strategy, 2007

(d) Indicator data in an overview table

	Indicator	Value 2012	Comments
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015			
	General Population		
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NA	
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	NA	
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in last 12 months	NA	
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercouse	NA	
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	NA	
1.6	Percentage of young people aged 15-24 who are living with HIV	NA	
	Female Sex worker		
1.7	Percentage of sex workers reached with HIV prevention programmes	6.3%	The data extracted from IBBS 2009 as it was submitted in 2010 to UNAIDS. following two questions were used for its calculation; Do you know where you can go if you wish to receive an HIV test? And In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)
1.8	Percentage of sex workers reporting the use of a condom with their most Recent client	58%	Data was extracted from IBBS 2009.
1.9	Percentage of sex workers who have received an HIV test in the past 12 Months and know their results	4%	Data was extracted from IBBS 2009.
1.10	Percentage of sex workers who are living with HIV	0%	Data was extracted from IBBS 2009.
	Male who have sex with male		
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	NA	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partners	NA	
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	NA	Program data indicates that totally 290 MSM have been tested in 2011 for HIV. Among those 121 were under age 25 while 169 had age 25 or above.
1.14	Percentage of men who have sex with men who are living with HIV	NA	Program data also indicates that among those one found as HIV positive.

	Indicator	Value 2012	Comments
	Target 2: Reduce transmission of HIV among people who inject drug by 2015		
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	80	Programme data - 80 per IDU been distributed. Denominator used is 20000. Need to mention in the narrative that total number of (1601765) needles distributed as reported here is among 5560 IDUs
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	35.02%	Data was extracted from IBBS 2009.
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	94%	Data was extracted from IBBS 2009.
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	22%	Data was extracted from IBBS 2009.
2.5	Percentage of people who inject drugs who are living with HIV	7.13%	Data was extracted from IBBS 2009.
	Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substanitially reduced AIDS related maternal deaths		
3.1.	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother to child transmission	NA	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NA	
3.3	Mother-to-child transmission of HIV (modelled)	NA	
	Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015		
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	NA	Program data suggest that there are 116 people with HIV who recived currently ART
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	96%	Program data from ART site
	Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015		
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	NA	Program data indicates that 11 HIV positive cases received treatment for both TB and HIV
	Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries		
6.1	Domestic and international AIDS spending by categories and financing sources	15805536	Total expenditure for the terms of 2010 and 2011

	Indicator	Value 2012	Comments
	Target 7: Critical Enablers and Synergies with Development Sectors		
7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace evaluation)programmes, stigma and discrimination and monitoring and evaluation)		Presented as Annex 2
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		2500 cases registerd 2010-11 with Ministry of Women Affair
7.3	Current school attendance among orphans and non-orphans aged 10–14		
7.4	Proportion of the poorest households who received external economic support in the last 3 months		300 Families got a small loan - implemented through Minitstry of Labour and Social Affairs supported by WB

II. Overview of the AIDS epidemic

Afghanistan has an estimated population of around 28 million as of 2009[1], with a gross domestic product estimated at USD 724 per capita[2]. The country is made up of 34 provinces. Infant mortality rate is at 157 per 1,000 live births, life expectancy at birth is at 43.8 years[1], and literacy is at 28%[2]. The Human Development Index is a low 0.346[2]. Afghanistan shares its border with Iran, Pakistan, China, Tajikistan, Turkmenistan, and Uzbekistan. Economic migration occurs to countries of the Persian Gulf, Pakistan, India and beyond. Afghanistan is a country that continues to experience the consequences of war. Over two decades of armed conflict have resulted in severe breakdown of the country's infrastructure and institutions, affecting its capacity to respond to emerging health concerns, including HIV. Hundreds of thousands of people have been internally displaced by conflict and natural disasters, staying in camps and cities across the country. In addition, external displacement is also significant, particularly as refugees to Iran and Pakistan.

Data on HIV prevalence is scarce. With a health information system not yet fully functional, the HIV and other STI surveillance system is basic. Available data shows Afghanistan is currently considered to have low HIV prevalence in the general population, but a concentrated epidemic among people who inject drugs.

According to the Afghanistan Drug Use Survey in 2009 carried out by UNODC, Ministry of Counter Narcotics (MoCN) and Ministry of Public Health (MoPH), there are an estimated 20,000 (18,000 - 23,000) PWID in the country of which two-thirds were current and regular injectors. Almost 70 per cent of Mazar-e-Sharif IDUs and 80 per cent of those in Kabul lived for a period of time outside Afghanistan, mostly in Iran or Pakistan. However, more recently it has been observed that the number of injecting drug users who have not traveled abroad is

increasing. HIV prevalence among PWID is estimated at a national average of 7% (18% of PWID in Herat, 3% in Kabul and 1% in Mazar were infected with HIV according the IBBS, 2009).

HIV prevalence among FSWs is estimated to be zero[6]. A 2005 University of Manitoba study mapped a total of 1,160 FSWs in three major cities of Afghanistan (Kabul, Jalalabad and Mazar), of which Kabul alone accounted for over 77%. Given the socio-cultural stigma attached to accessing FSWs, it is likely that this figure is underestimated. There are 23,800 prisoners and detainees in Afghanistan's 35 prisons as of March 2012. HIV prevalence among prisoners is rising and appears to be primarily related to the proportion of PWID in prison.

Unlike FSWs and prisoners, there is still almost no information on MSM. Although 100 MSM were reached by a study in 2009[7], there are no robust estimates or behavioral or biological measures of this population. The ANSF-II displays insufficient knowledge and understanding of the HIV needs of MSM,, lacks a description of how to develop services to meet their sexual health needs (including HIV and other STI-related issues), and absence of an advocacy and policy strategy to address service delivery weakness and barriers, such as significant levels of stigma and discrimination. While there is no reliable data on HIV prevalence among MSM in Afghanistan, information suggests there are high HIV-risk networks of MSM that are not being addressed.

Afghanistan has a low and concentrated HIV, and therefore orphans are most likely not AIDS orphans. According to the results of the Multi Indicator Cluster Surveys (MICS) 2010-2011, the latest data for school attendance of children age 10-14 years by orphans is as follows :(1) Percentage of orphans who are attending school: 34.4 %, and (2) Percentage of non-orphans who are attending school: 57.4 %.

III. National response to the AIDS epidemic

Policy Response

In 2003, MoPH established the NACP. In 2005, the NACP and Drug Demand Reduction Directorate of the MoCN approved a national harm reduction strategy for PWID and the prevention of HIV and AIDS, and in 2006 the NACP produced the first Afghanistan National HIV/AIDS Strategic Framework for 2006-10 and a corresponding Program Operational Plan as a guide for a wide range of stakeholder involvement in the response to HIV prevention, care and treatment. In 2008, the MoPH approved the Blood Transfusion Policy, which aims to strengthen transfusion safety, including quality testing of blood for HIV and other blood-borne diseases. In 2010, the Government also approved the national OST Policy, which has paved the way for implementing a full package of services for drug-related harm reduction in the country. In

[6] Integrated Bio-Behavioral Surveillance (IBBS) 2009
[7] Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan – Naz Foundation, 2009

addition to the MoPH and MoCN, there is also commitment and dialogue with other relevant ministries, including the Ministry of Interior, Ministry of Justice, and Ministry of Ershad, Hajj and Awqaff.

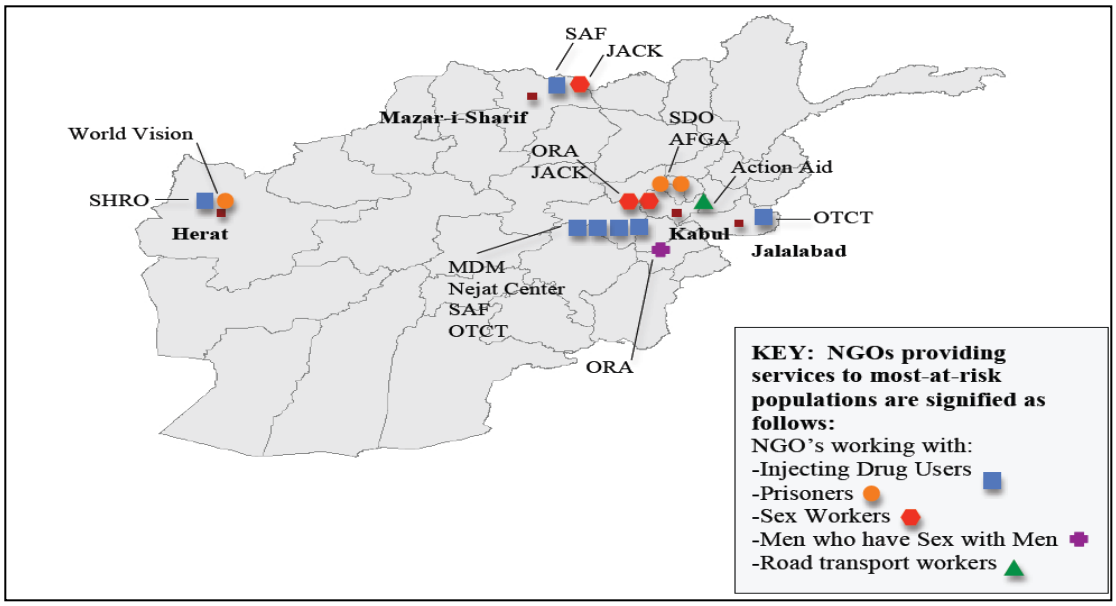
Program Response

In December 2011, Afghanistan released it's Second National Strategic Framework for HIV. The strategic framework (NSF-II) has been formulated as a guiding strategic and policy document for the GoA to launch, monitor and evaluate its HIV interventions as a continuation of ANASF-I. The NSF-II put forward key directions for Afghanistan that will help accelerate the scaling-up of the HIV interventions based on the principles of Universal Access to Treatment, Care and Support, as well as the UNAIDS vision of 'Zero New Infections, Zero Discrimination, and Zero AIDS-related Deaths'. The Strategic objectives of NSF-II include:

- Provision of preventive services for key affected population (PWID and their partners, FSW, MSM, and Prisoners)
- Prevention services for vulnerable populations (Truckers, IDPs, refugees, and uniformed populations)
- HIV awareness and prevention in the general population through strengthening STI management and blood screening
- Strengthen national capacity for Universal Access to Treatment , Care and Support
- Strategic information and expansion of research
- Strengthen M&E aligned with the Health Management Information System (HIMS)
- Reduce stigma and discrimination of PLHIV and KAPs
- Strengthen institutional capacity of NACP to lead national HIV response, enhance coordination and strengthen multi-sectoral response

The GoA views HIV as multi-sectoral issue and has established the HIV/AIDS Coordination Committee for Afghanistan (HACCA) as an independent body to coordinate AIDS-related issues among government entities, international and national partners (i.e. donors, UN agencies, NGOs, private sector, and civil society). Additionally, the Country Coordinating Mechanism (CCM) constituted in the context of GFATM, plays a major role in coordinating HIV, TB and malaria responses in the country. The NSF-II will be implemented by the NACP under the technical guidance and oversight of the General Directorate of Preventive Medicine (GDPM) and Primary Health Care and Communicable Disease Directorate (CDC) to ensure successful execution and monitoring of the national response.

Program coordination is also facilitated through a number of Working Groups, including on Harm Reduction, Vulnerable Populations, Surveillance, and ART. The MoPH also has included HIV and AIDS in the Basic Package of Health Services (BPHS) and Essential Package of Health Services (EPHS). Eight of the 34 provinces of the country have HIV advisors who facilitate coordination and integration at the provincial level. Many provincial governmental directorates, such as Women Affairs, Prisons, Culture and Youth Affairs, and Religious directorates, are involved in the HIV program at national and provincial levels.



The diagram above indicates a sample of civil society and its efforts in HIV prevention, treatment care and support complementing the Government response. Afghanistan has both international and national NGOs involved in the provision of health services. Eighty percent of existing health facilities are either operated or supported by NGOs. The support of NGOs by the health care system is critical, including drug supplies, supervision, training, and incentives. NGOs play a key role in reaching most at-risk and vulnerable groups (injecting drug users and their partners, sex workers and their clients, prisoners, and others). Several NGOs are involved in targeted interventions to prevent HIV among at-risk groups, though still on a small scale.

Guidelines, tools and procedures for HIV prevention, treatment, care and support have been developed periodically through a consultative process to provide guidance to implementation and adherence to quality standards. Key tools and guidelines include on Voluntary Counseling and Testing (VCT), Opioid Substitution Therapy (OST) in 2009, Code of Ethics in 2007, and on communications.

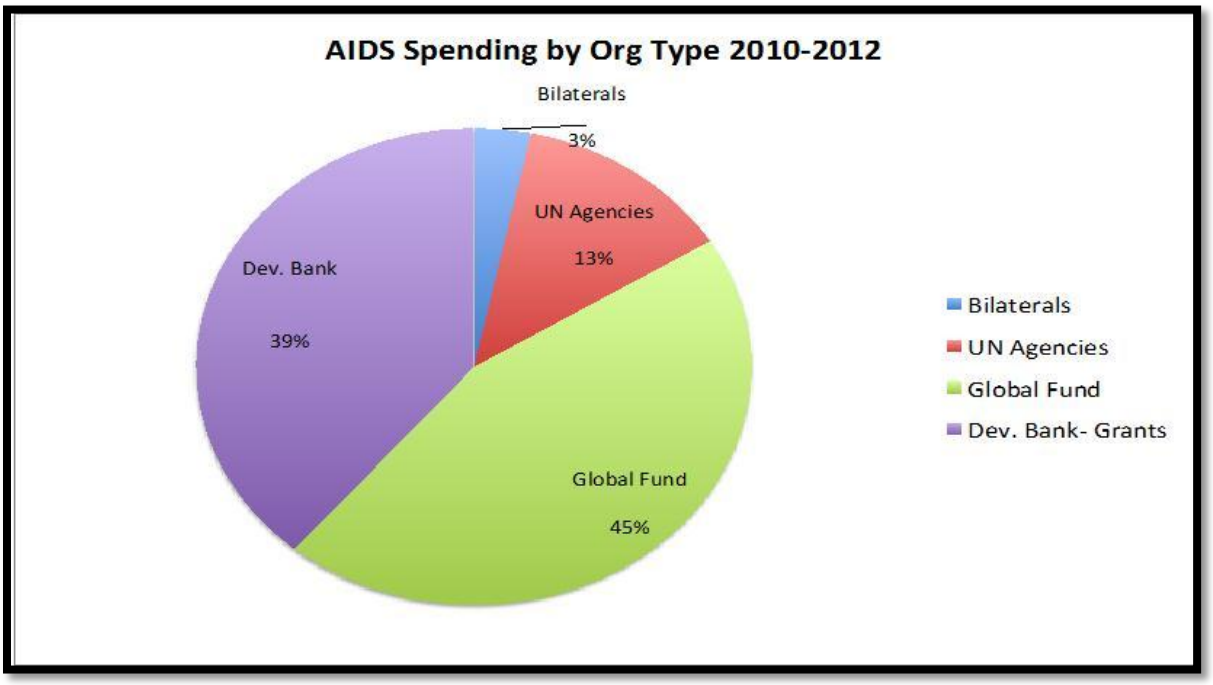
Interventions in the area of HIV prevention have been reinforced since 2006-2007 and are focused on: (a) key affected populations (PWID, FSWs and MSM), (b) vulnerable populations (truckers, migrant workers, police and military) and (c) the general population, implemented with assistance from 10 international and national NGOs or implementing partners (IPs) and financed through the GFATM Round 7, the World Bank-supported AHAPP, and, partially, through UN agencies across eight provinces of the country.

Coverage of risk and harm reduction, in particular of NSP, remains low and insufficient to have an impact on the epidemic. Harm and risk reduction activities encompass primarily prisoners who inject drugs in provinces under the World Bank and GFATM-supported nationally implemented projects. In addition, as mentioned above, UNODC is supporting interventions for female drug users and prisoners in a few cities.

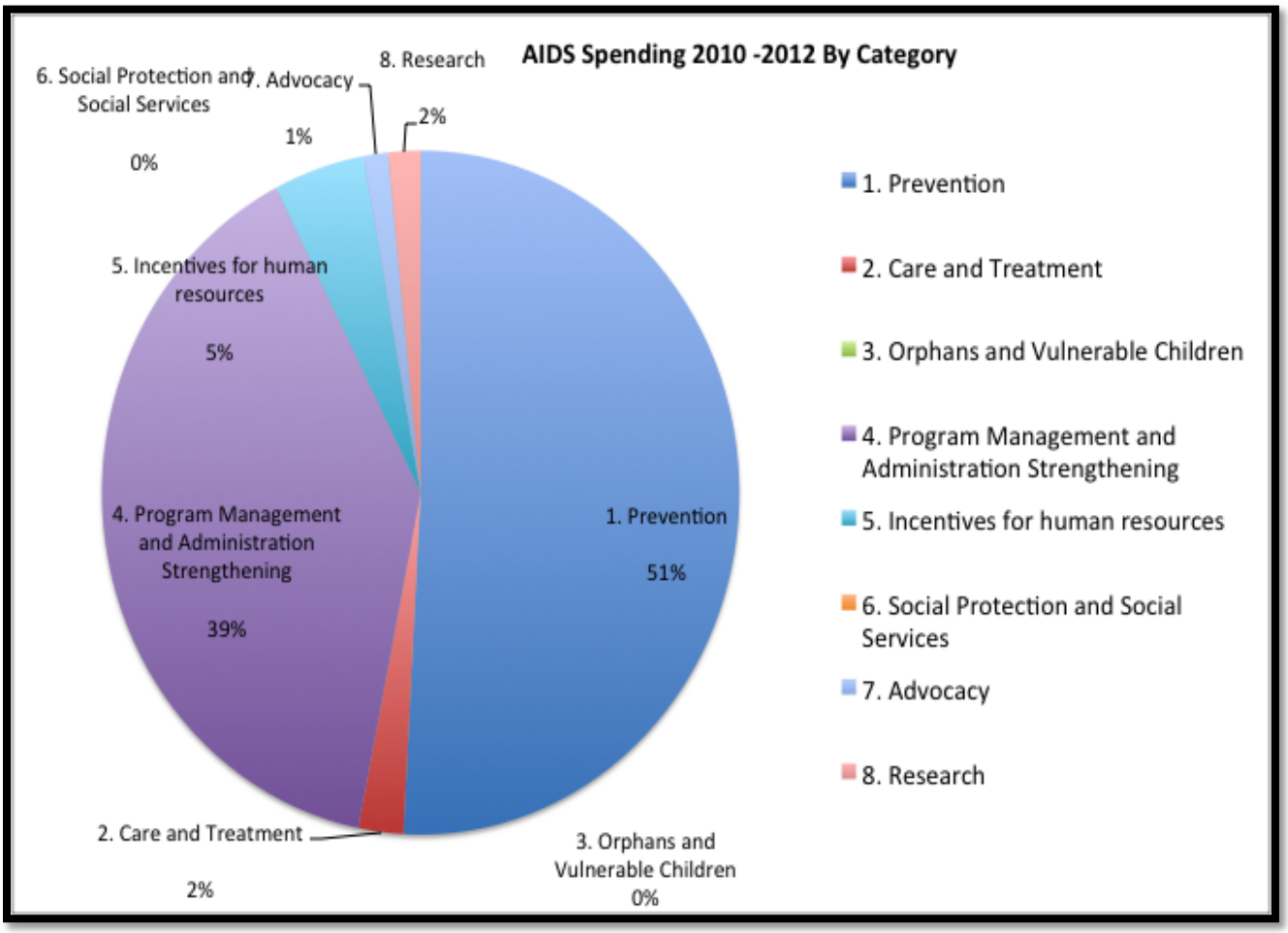
Interventions have been expanded among PWID, prisoners and to a limited extent among FSW and MSM in the last two years. One of the unique achievements of the country's response has been the initiation of the OST and a drug overdose prevention program. MoPH has developed a comprehensive plan for strengthening access to safe blood and blood components in the country. In 2008 and 2009, 31,239 units of blood were collected from the public Blood Banks. Quality-assured screening occurs in 6 of the 12 blood banks. By 2007, the MoPH had established 6 VCT centers – two in Kabul and one each in Jalalabad, Mazar-e-Sharif, Faisalabad and Herat. In 2008 and 2009, 5 more centers were added. During 2008-09, 19,875 persons tested themselves for HIV and knew their status, of which 42% were women. In selected provinces, the MoPH has initiated reproductive health and HIV-related activities specifically for out-of-school youth by providing youth-friendly services. Currently, ART is provided at two clinics located in Kabul and Herat. Prevention of Parent-To-Child Transmission (PPTCT) has been included in the National Reproductive Health Strategy. A national task force has been established for PPTCT.

Financing and spending:

To fight HIV and AIDS, Afghanistan spent 5.5 million USD in the years 2010-12. The funds spent were from a variety of sources including the World Bank, UN Agencies, Global Fund, International NGOs, Bilateral and the National Government. While the contribution of the National Government is small, it is to be seen in the context of the conflict recovery process the current Government is grappling with.



The lion's share of expenditure is through the Global Fund, followed by World Bank in terms of grants. Government contribution is minimal during this period, as is expected in a new and recovering government particularly when HIV is not priority.



The proportion of funds spent by Afghanistan is largely focusing on prevention as is rightly so. However, the portion on Research will need to be higher, as evidence-informed programming is the need of the hour. Surveillance systems, qualitative studies to understand the dynamics etc., are very critical, and therefore there needs to be more investments in this area.

IV. Best practices and achievements

Afghanistan's HIV response remains fairly nascent. Given the security and conflict situation still existent in parts of the country, Afghanistan has responded to HIV quite well despite such challenges. Some of the achievements are highlighted below:

The ANASF-II was developed with a wide involvement of relevant ministries and civil society, including affected community groups, religious groups, UN, and other development partners. Technical Assistance (TA) was funded by the World Bank and UNAIDS. ANASF-II took into account all evidence available in country through several studies and surveys conducted in recent years, such as IBBS 2009, drug reports, estimations and routine programmatic data. This framework will guide the HIV program in the coming four years. ANSF-II was costed and the strategy approved by the MoPH. Targets have been defined and there is a detailed M and E framework with globally relevant and country appropriate indicators. Technical guidance and overall supervision was provided by the General Directorate of Policy & Planning and GDPM of the MoPH and HACCA. In addition, a number of line ministries participated in stakeholder consultations that helped shape the content and direction of the Strategy. Specifically, those included the Ministry of Counter Narcotics (MoCN), Ministry of Interior (MoI), Ministry of Justice (MoJ), Ministry of Returnees, Refugees, and Displaced Populations (MoRRD), Ministry of Hadj & Religious Affairs (MoHRA). Also, the Ministry of Education (MoE), Ministry of Women Affairs (MoWA), Ministry of Labor, Social Affairs, Martyred & Disabled (MoLSAMD), and Ministry of Information, Culture & Youth (MoICY) were also consulted. At the same time, a large number of local and international NGOs were part of the series of discussions culminating in the Strategy design and setting of priorities. Finally, operations research agencies such as John Hopkins University, ActionAid, and HPRO, as well as members of the PLHIV and PWID community participated in the preparation of this document.

A National HIV Policy was approved by MoPH in 2011.Tthe Policy has been developed through consultative processes by all stake-holders, including active participation of PLHIV. It was presented to the MoPH technical committees and the comments of the latter were included prior to endorsement by MoPH.

The Harm Reduction (HR) service package was included in the Drug Demand Reduction Policy of the MoCN. OST is a component of the HR package. In addition, the Parliament's Health Committee was recently oriented on OST. An evaluation of OST was conducted through WHO with UNAIDS funding support which reiterated the critical need for OST in Afghanistan.

Extension has been obtained of the World Bank-supported Afghanistan HIV/AIDS Prevention Project (AHAPP) project and the Global Fund Round 7 Phase 2, until the third quarter of 2013. In both the case of the World Bank and the GFATM proposal further extensions are being requested, including through the submission of a Global Fund Transitional Funding Mechanism (TFM) request in March 2012. This reflects a commitment of the part of the Government and the Donor (in this case World Bank) to support sustaining and progressively expanding the HIV response.

Mainstreaming efforts have been successful in Afghanistan. Memorandums of Understanding have been developed with 4 line ministries: Hajj, Counter Narcotics, Justice, and Women Affair for inclusion of HIV programs.

There has been improved availability of strategic evidence in recent years, although more information is needed on diverse aspects of risk and vulnerability to develop strategies and work-plans. Recent studies include those on MARA, Returnees, the Police, and Army.

Afghanistan is a part of a GFATM regional project Round 9 on men who have sex with men (MSM). Despite the need to adapt HIV prevention outreach approaches to the context, this has allowed a focus on MSM programming.

During the reporting period, the PPTCT program was initiated and five focal points were established across the country. This includes training and funding support to the designated centers and establishing referral linkages with ARV treatment centers.

ART Treatment has expanded from a modest beginning where now ART is being provided to 110 persons as of December 2011.

V. Major challenges and remedial actions

1. Security challenges have plagued Afghanistan for a long while and despite this the HIV program has made progress.
2. Low awareness of HIV and risk behaviors.
3. Easy availability, production and distribution of drugs, including Heroin.
4. There are social and cultural barriers to reach Key Affected Populations.
5. As Illicit drug use is punishable by law, prison interventions that include harm reduction are difficult to implement. National and sectoral HIV policies and guidelines need to be developed. Although OST policy has been approved, effective implementation and scale-up to those most in need is still a challenge.
6. Although there is a referral system between HIV and TB, it needs to be strengthened and thus increase the possibility of detection of cases and appropriate treatment. Similarly, referral systems need to be strengthened between outreach, drop-in centers, drug treatment, VCT and ART centers.
7. Effective Integration of HIV and AIDS services within the national health care system, and ensuring Government contribution to the program for sustainability purposes is a major challenge.
8. The Government finance and procurement procedures are lengthy. Therefore, access to much needed supplies takes longer than expected. There is a shortage of CD4 counting machine, test kits, syphilis test kits, etc.
9. Quality of service provision and care is not yet optimal; however, steps are being taken towards filling this gap.
10. Since Afghanistan's national AIDS program is largely donor driven in terms of financing, there are multiple reporting systems that increase the work load and possibly result in duplicate reporting.

11. Gender issues, including needs of female drug users are not fully understood and addressed by the Program at this stage.
12. The coverage of HIV response in the country is still relatively poor limited to only eight provinces.
13. The coverage of programmes across Key Affected Populations is also low, due to the hidden nature of this population as well as the security situation that makes access difficult.

VI. Support from the country's development partners (if applicable)

Through the *Joint UN Team on AIDS* established in 2009, UNAIDS and selected UN Agencies provide capacity-building and technical support for national governmental and civil society partners. UNAIDS Secretariat and Co-sponsors, including World Bank, UNODC, WHO, UNICEF, UNESCO, and UNFPA, supported the development of ANASF 2011-2015, which focused on ambitious targets within the context of the Millennium Development Goals (MDGs) and support the implementation of the existing World Bank and Global Fund action plans on AIDS. The Joint Team also provided support and advocacy for implementation of existing action plans, particularly when this required additional advocacy and bridging gaps in funding for maintaining OST, initiating prevention with Key Affected Populations, and developing institutional capacities for prevention of mother-to-child transmission, operational research on risk and vulnerability, and reducing Afghanistan's past isolation through a growing partnership with neighboring countries and in the region on AIDS.

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

World Bank's response to AIDS: In 2007, the World Bank signed a three-year USD 10 million grant with the GoA to enhance the national AIDS response through the Afghanistan HIV/AIDS Prevention Project (AHAPP). The project provides harm reduction services to at-risk groups (PWID, sex workers, prisoners, and truckers) in different cities (Kabul, Mazar, Jalalabad, and Herat). Services are provided by NGOs selected through a competitive process. The project is strengthening surveillance through IBBS and knowledge, attitudes, beliefs, and practice studies conducted among at-risk groups by Johns Hopkins University. The project aims to increase awareness of HIV prevention and reduce stigma and discrimination through communications and advocacy activities implemented by the Futures Group International (FGI). The project is funding capacity-building activities to strengthen the NACP in areas such as program management, M and E, communication, etc. As mentioned above, project activities will be carried out by agencies (national NGOs and international institutions) that are contracted by the NACP. Based on the recommendations of the mid-term review, the project was restructured in February 2010. The restructuring includes: (i) Modification of the project performance indicators; (ii) cancellation of part 4.2 in schedule 1 of the Financing Agreement

(innovative initiatives sub-component); (iii) expansion of the project scope including possible extension of the provision of HR for PWID to Farah and Nimroz provinces, where the HIV epidemic is believed to be high (based on the results of rapid assessments on PWID in these provinces); and (iv) extension of the Project Closing Date from December 31, 2010 to June 30, 2012.

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

VII. Monitoring and evaluation environment

HIV prevalence and epidemiological status: The data on cumulative reported HIV and AIDS cases is available until 2008-2009. Data on HIV estimates, such as adult HIV prevalence, estimated number of people living with HIV, and estimated AIDS deaths, is available only until 2005. In 2011, new estimates have been elaborated and will be published by end of 2012. HIV prevalence among PWID, sex workers, prisoners and long distance truck drivers are available from IBBS 2009 and will be updated through a second IBBS round in 2012. HIV prevalence among injecting drug users and sex workers are also available from the cross-sectional studies conducted in Kabul, Herat and Mazar (2007). HIV prevalence among pregnant women is not available.

Risks, vulnerability and HIV knowledge: Although UNGASS indicators on risks among PWID and sex workers are available, among MSM comparable data is very limited and only available from the *Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan*, with a a sample size of 100 conducted in 2009. Limited data is also available among other contexts of vulnerability, such as among women, migrants and in specific frontier districts requiring further assessments and research.

AIDS-related spending: Data on total reported domestic public and international expenditure (Million USD) is available for 2008 and 2009. AIDS spending by categories is also available for 2008 and 2009.

National response: ART and PPTCT coverage data are not available due to the lack of estimated size of the populations in need. Regarding HIV testing, for the general population, only VCT registration data is available. However, HIV testing and prevention coverage data is available for sex workers and PWID (IBBS 2009).

Strengths of the M&E system

There are currently officers in eight provinces that can help gather essential data through the Global Fund Round 7 until September 2013. Drug use surveys in Afghanistan by UNODC can provide information on drug users and PWID, who are key drivers of the epidemic in Afghanistan. Age-disaggregated data is available for HIV testing and prevention coverage among female sex workers and PWID. In the IBBS 2009, two potential 'bridge' populations in the Afghanistan context, i.e. truckers and prisoners, were also included.[8]

Weaknesses of the M&E system

- There is no HIV sentinel surveillance in place
- There is no case reporting system in place
- There is insufficient information on MSM
- Gender disaggregated data is limited
- No robust information exists on STI among general population and Key Affected Populations
- Up-to-date data on adult HIV prevalence and HIV knowledge among the general population is not available. Response data is also scarce and ART and PPTCT centers do not have a robust centralized monitoring system.
- Preparation of reports, such as the GARPR 2012, is problematic as there is no central repository of documents.

[8] AIDS Datahub, Afghanistan_key_data_issues_2011.Last accessed 20th March 2012.

ANNEXES

Annex I- Process of Report Preparation

The process of preparation of this report encompassed an initial consultation meeting between the NACP, UNODC, UNAIDS, Johns Hopkins University, and the designated consultants. A consultative meeting was called in March 04, 2012 to discuss the data required for GARPR. Dr. Bargami, acting manager of NACP informed all participants that NACP is going to submit the GARPR report due by March 31, 2012. The need of technical support was discussed and all participants agreed that there is need of technical assistance particularly for report w riting. In addition indicators were reviewed and consensus on indicator relevancy and method of data collection was disused. Details of discussion are available in meeting minutes attached to this annex. Civil society, community members as well as researchers were also consulted and contacted after which data collation and interviews for the NCPI were planned. More details are also attached as meeting minutes dated March 05, 2012. This effort was divided out amongst various stakeholders. Data collation took about two weeks. The first ever IBBS of Afghanistan was completed in 2009 and this data provided the main source of information on the relevant targets in this report. Using primary data from IBBS, interviews of the NCPI and funding matrix responses, and secondary data, the two consultants commissioned by UNAIDS, working closely with MoPH prepared the first draft of the report. This was presented to a wide variety of stakeholders, including the Government, civil society and researchers. The observations made during this second consultation on GARPR 2012 were incorporated. Overall, the NACP took the lead in data collation and has taken care to include all relevant stakeholders and information and had jointly planned and validated the data during March 25-26, 2012.

Minutes of Meeting of Global AIDS Response Progress Report
Date: March 04, 2012
Venue: NACP meeting hall
Participants:

No	Name	Title	Organization
1	Dr. Mohammad Younus Bargami	Acting Interim Manager and Vulnerability Advisor	NACP
2	Dr. Samarudin	Harm Reduction Advisor	NACP
3	Dr. Mohammad Nawroz Ibrahimi		UNICEF
4	Dr. Mohammad Ayoub		HPRO
5	Dr. Hussain Ali	M&E and Surveillance Advisor	NACP
6	Dr. Naweed Anwar	M&E and Surveillance Officer	NACP

7	Mr. Julian		Swasti
8	Ms. Harsheth Virk		UNODC
9	Dr. Lailuma		WHO
10	Dr. Ajmal Sabawoon		JHU
11	Dr. Mohammad Hashim Rahimi	Global Fund Project manager	NACP

Agenda:

1. Briefing on Global AIDS Response Progress Report
2. Technical Assistance Provision
3. Selecting Indicator relevant to country
4. Development of tentative action plan to produce report submitting to UNAIDS

Discussion:

First of all Dr. Mohammad Younus Bargami welcomed participant and shed light on importance of submission this report to UNAIDS and expressed that this is the second time that NACP is going to submit this report to UNAIDS. Then he asked Dr. Ajmal Sabawoon to precede the discussion on the preparation of the report.

First the need of technical assistance was discussed and three options were proposed as below;

1. Whole process should be sequel by technical assistance only,
2. The process should be accomplished by core group members, and
3. The process should be done by both technical assistance and core group members.

In conclusion all core group members agreed to select the third option and TA will contribute their effort in report writing and facilitating validation workshop.

Second, Dr. Ajmal briefly explain the process required for submission of Global AIDS Response Progress Report (GARPR) that aims to provide guidance to national AIDS programmes and partners actively involved in the country response to AIDS on use of core indicators to measure and report on the national response. Then all core members reviewed indicator one by one and agreed to on collecting indicators. Indicator those are selected or rejected are presenting as Annex 1.

Finally the process required for submission of report discussed as it is presented in figure 1 and translated into actions as presented in Annex 2.

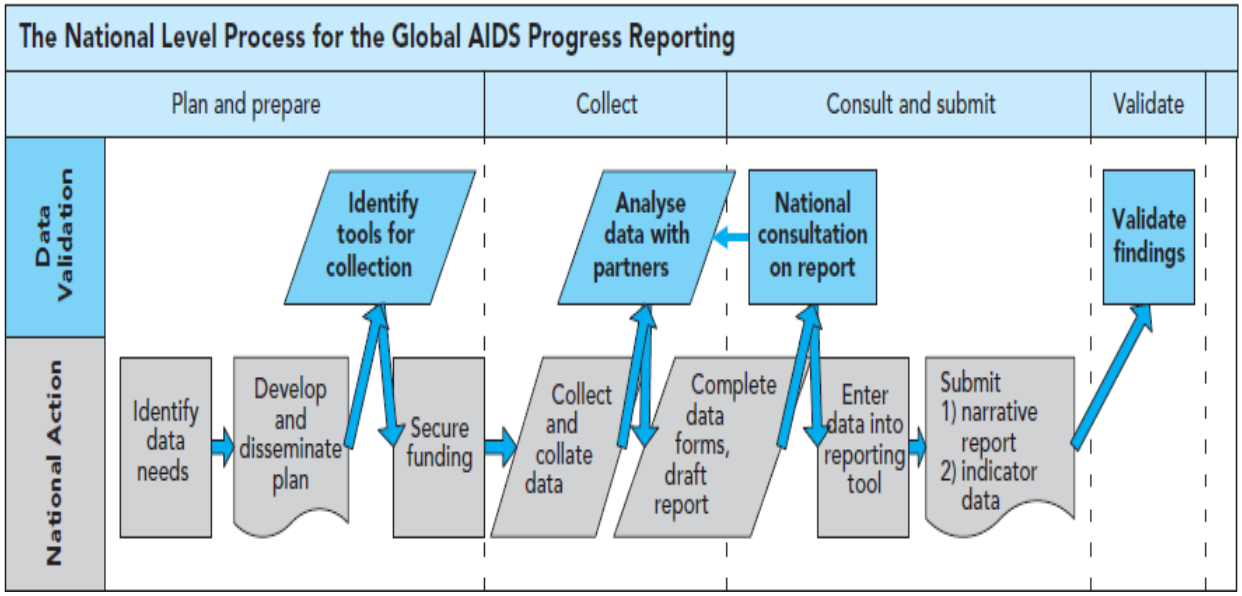


Figure 1: the national level process for the Global AIDS Progress Reporting

Indicator to collected for 2012 Global AIDS Response Progress Report, March 04, 2012

Target NO	Polulation		Indicator	Relevance to Afghan Context: Relevance	Relevance to Afghan Context: if not relevant, Rationla	Decision on data collection	Remark
Target 1							
Reduce sexual transmission of HIV by 50 percent by 2015	General Population	1.1	correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Not relevant	this is not generalized epidemic and data is not available so	No	
		1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not relevant	this is not generalized epidemic and data is not available so	No	
		1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in last 12 months	Not relevant	this is not generalized epidemic and data is not available so	No	
		1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercouse	Not relevant	this is not generalized epidemic and data is not available so	No	
		1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Not relevant	this is not generalized epidemic and data is not available so	No	
		1.6	Percentage of young people aged 15-24 who are living with HIV	Relvant but data is not available	this is not generalized epidemic and data is not available so	No	
	Sex Worker	1.7	Percentage of sex workers reached with HIV prevention programmes	Relevant	Since there is no updated survey so it would be better to use program data that cover at least 6 month. We also can requst	Yes	Program Data, IBBS
		1.8	Percentage of sex workers reporting the use of a condom with their most Recent client	Relevant	IBBS	Yes	HPRO, Program data
		1.9	Percentage of sex workers who have received an HIV test in the past 12 Months and know their results	Relvant	IBBS	Yes	
		1.10	Percentage of sex workers who are living with HIV	Relevant	IBBS	Yes	
	MSM	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Relevant but data is not available	denominator is difficult to obtain	No	In narrative we should expressed the obsoulate no from program data
		1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partners	Relevant	Male Vulnerability assessment, Naz Foundation	No	In narrative we may present some discription but data will is not available to enter
		1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Relevant		Yes	Program data, YHDO
		1.14	Percentage of men who have sex with men who are living with HIV	Relevant		Yes	UNAIDS should be asked to share spectrum published report

Target 2.						
Reduce transmission of HIV among people who inject drug by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Relevant		Yes	Program data, IBBS
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Relevant		Yes	IBBS
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Relevant		Collected	IBBS
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Relevant		Collected	IBBS but program data should also be considered
	2.5	Percentage of people who inject drugs who are living with HIV	Relevant		Collected	IBBS
Target 3.						
Eliminate mother-to-child transmission of HIV by 2015 and substanitially reduced AIDS related maternal deaths	3.1.	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother to child transmission	Relevant but data is not available	Data is not available and there is no estimated no. of pregrenant women in last 12 months	No	Progarm data should be used and we can reflect in narrative part
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Relevant but data is not available	Data is not available	No	Progarm data should be used and we can reflect in narrative part
	3.3	Mother-to-child transmission of HIV (modelled)	Relevant but data is not available	Data is not avialble	No	
Target 4.						
Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	relevant		Yes	Program data and spectrum for Den
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Relevant		Yes	Program data and spectrum for Den
Target 5.						
Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Relevant		Yes	Program data
Target 6.						
Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources	Relevant		Yes	with consulation of partner
Target 7.						
Critical Enablers and Synergies with Development Sectors	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace evaluation)programmes, stigma and discrimination and monitoring and evaluation)			Yes	NCPI tool will be applied
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Relevant but data is not available		No	Partners such MoWA and some human right organizations should be asked for this purpose. Need to have pharase in narrative part.
	7.3	Current school attendance among orphans and non-orphans aged 10–14	Not relevant		No	UNICEF will be asked to share MICS and if there is data we can reflect it in narrative report
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Not relevant	There is no either DHS or other national representating survey.	No	Zahid Hatam is more referenc peroson to contact at WB

Meeting Minutes, GARPR 2012

Date: March 05, 2012
Venue: NACP Meeting Hall
Agenda: Development of an action plan for collecting information required for NCPI
Participants:

No	Name	Title	Organization	email
1	Dr. AjmalSabawoon	Project Manager	JHU	sabawoonajmal@gmail.com
2	Dr. Ahadia Anis	Advocacy consultant	NACP	advcom.nacp@moph.gov.af
3	Dr. Hussain Ali	M&E and Surveillance consultant	NACP	msr.consult.nacp@gmail.com
4	Dr. Naweed Anwar	M&E and Surveillance Officer	NACP	dr.naweedanwar@yahoo.com

Discussion:

Based on the decision taken in meeting dated 4 March 2012 for the submission of GARPR, a team was assigned to work on indicator number 7.1 that is dedicated for Government HIV and AIDS policy. A meeting was organized and first of all a brief presentation given by Dr. Sabawoon. Then all the team members did work on actions required for collecting data from Government and other relevant organization such as human right, civil societies, UN, and bilateral organization. One of the concerns that were discussed is limited time for collecting this information since it was recommended by guideline that the process should start 6 month prior to submission of this indicator. In addition, under the methodology part, the guideline recommends to collect information using desk review and conducting interviews with relevant respondents. Though there is no doubt on importance of desk review, it requires time and for the time being it seems to be impossible to carry out this activity.
Agreed Decision:

1. Action plan should be developed during the meeting.
2. A meeting should be invited from wide range of relevant partner to agree on methodology proposed by the NCPI team.
3. Desk review is not required for this period of GARPR submission and we will only conduction interview with Government officials and other relevant stakeholders specified in action plan attached to this meeting minute.
4. Data will be validated in Validation workshop along with other indicators.

NCPI Action plan, March 05, 2012						
no	Activities	NCPI Target Group	Responsible	Time line	Action status	Remark
1	Designation of coordinator for Part A		Dr. Ahadia	5-Mar	Done	
2	Designation of coordinator for Part B		Dr. Naweed	5-Mar	Done	
3	Review of Part A and B tool		Dr. Ahadia	6-Mar		
4	Agree with stakeholders on the NCPI data gathering and validation process (invite rlevant key stakeholders to validate the methodology		Dr. Hussain Ali	7-Mar	Pending	A wide range of stakeholder will in invited and consensus will be taken on methodology
5	Data Collection					
5.1	Desk review of relevant documents		Dr. Hussain Ali		TBD in stakeholder validation workshop	Since the time is limitted and we may not manage to review all relevant documenrs.
5.2	Interviewing (or other ways of obtaining the information efficiently) key people most knowledgeable about the specific topic					
5.2.1	For Strategic Plan and Political Support sections (NACP manager or duputy manager)					
5.2.1.1	NACP manager	A	Dr. Ahadia	7-Mar		
5.2.1.2	Dr. Tawfiq Mashaal	A	Dr. Ahadia	10-Mar		
5.2.1.3	Heratt Provincial HIV and AIDS coordinator	A	Dr. Sabawoon	9-Mar		
5.2.2	M and E (NACP M&E officer, other ministry or oganization M&E)					
5.2.2.1	NACP M and E and surveillance consultant	A	Dr. Ahadia	10-Mar		
5.2.2.2	SPHP project manager	A	Dr. Ahadia	11-Mar		
5.2.3	Human Right organizations					
5.2.3.1	Afghanistan Human Right Watch	B	Dr. Hussain Ali	12-Mar		
5.2.3.2	UNAMA	B	Dr. Hussain Ali	11-Mar		
5.2.3.3	Afghanistan Independent Human right comission	B	Dr. Ahadia	12-Mar		
5.2.3.4	Local organization who work in field of human right	B	Dr. Hussain Ali	13-Mar		
5.2.4	Civil Societies					
5.2.4.1	IDUs Network	B	Dr. Naweed	11-Mar		
5.2.4.2	YHDO	B	Dr. Naweed	12-Mar		
5.2.4.3	OTCD	B	Dr. Ahadia	14-Mar		
5.2.4.4	SAF	B	Dr. Naweed	13-Mar		
5.2.4.5	AFGA	B	Dr. Ahadia	14-Mar		
5.2.4.6	SDO	B	Dr. Hussain Ali	13-Mar		
5.2.5	Prevention and Treatment, care and support section					
5.2.5.1	ART center	A	Dr. Hussain Ali	10-Mar		
5.2.5.2	MDM	B	Dr. Naweed	11-Mar		
5.2.6	UN and Bilateral Organization					
5.2.6.1	UNODC	B	Dr. Ahadia	12-Mar		
5.2.6.2	USAID	B	Dr. Ahadia	14-Mar		
5.2.6.3	UNICEF	B	Dr. Hussain Ali	14-Mar		
5.2.6.4	WHO	B	Dr. Hussain Ali	14-Mar		
6	Validation Workshop		TA	TBD		
7	Analyse and interprete data and narrative report		Dr. Sabawoon	14-26 March		
8	Enter and submit data		Dr. Sabawoon	29-Mar		

ANNEX 2: NCPI Report

Process

The GARPR core group meeting held in March 04, 2012assigned a team of three members to collect data required for NCPI. The team was oriented to the NCPI tool and action plan by the core group team leader. The team also managed to develop an action plan to roll out NCPI due to the time final report's due date.

Seven respondents were selected to be interviewed for Part A while 15 potential respondents were selected to be interviewed for Part B. Questionnaires were distributed to all respondents from March7 – 14, 2012. Out of seven participants for Part A, six responded. It is worth mentioning that one interview was deemed incomplete for part A since the respondent did not provide any explanations to the questions that required an example or explanation. Regarding Part B, out of the thirteen questionnaires that were distributed, twelve were completed. Similar to Part A, some respondents did not provide explanations or examples for questions that required additional information from the respondents.

After collecting the data, members from all relevant organizations were invited for data validation in March 25, 2012. A small portion of Part A was reviewed by participants at the validation workshop and in the end all participants agreed that there is a need to have an ad-hoc meeting the following day. Through a whole day workshop we completed the validation for Part B during the morning session and successfully accomplished validating the data of Part A by the afternoon.

Summary of Findings

Part A:

Strategic Plan

Almost all respondents agreed that the country has developed a multi-sectorial strategic plan for the term of 2011-2015. Most of the respondent felt that the new strategic plan has been developed based on a five- year experience and the ground reality was considered in its development process. This strategic plan, National Strategic Framework-II (NSF II), is target group oriented and prioritizes its target groups based on evidence. The Ministry of Public Health (MoPH) has the overall responsibility for the development and implementation of this strategy. The NSF-II strategizes education, health, labour, military/police, transportation, women, and young people sectors for HIV prevention. The Budget was determined for most of the sectors, except for labour, transportation and young people sectors. The participants also expressed that if there is no budget for such sectors, there would be no activities accordingly. The NSF-II addressed men who have sex with men(MSM); migrant/mobile populations; street orphans and other vulnerable children; people who inject drugs, commercial sex workers, transgendered people, women and girls; and prisoners as key and vulnerable populations. Prisons and schools were identified as

settings for intervention. The strategy also addressed stigma and discrimination, gender empowerment and/or gender equality, protection of human rights and the involvement of people living with HIV as cross-cutting issues. The participants' suggested that through assessment, mapping and studies it could be feasible to identify key populations. Currently, IDUs, MSM, FSWs and prisoners were identified as the key affected populations, while women, youth, uniformed personnel and street children were considered as vulnerable populations. However, although there was a National Strategic Plan as of end of 2011, it did not translate into an operational plan. Though NACP invited all relevant stakeholders to develop the strategy, some of organizations did not show up and those who attended die not actively participate. Therefore, most participants expressed that civil societies were involved moderately in the development of the strategy. The strategy has been endorsed by all external partners.

Afghanistan has developed its national development plan based on the MDG goals and has HIV integrated into its plan. In addition, HIV is also integrated in the routine country assessment /UN Development Assistance Framework and sector-wide approaches. Still, there is no strategy on poverty reduction. Specific areas that were included in the strategic plan are: HIV impact alleviation; reduction of gender inequalities as they relate to HIV prevention, treatment, care and support; reduction of stigma and discrimination; and social security.

As of the end of 2011 there was no impact evaluation of HIV and its socio-economic development for planning.

The Country has a strategy that addresses HIV-related issues among the national army, police and prison staff. Though the country followed the 2011 Political Declaration on HIV and AIDS, the budget was not revised accordingly.

As concerning the estimation of current and future need of ART for adults and children, all the participants agreed that the current need is an estimation and did not project future needs. It is worth mentioning that the HIV program coverage is being monitored and can be disaggregated by age and sex to monitor by target population, such as key affected and vulnerable population. Generated information, particularly IBBS, was identified as the basic source of information for designing responses and new strategic plan formulation. It is worth mentioning that the program is being monitored by geographic coverage at provincial level and again generated information were being used to design intervention and policy and planning formulation. There are some program and interventions, such as health system strengthening (HSS), basic package health services (BPHS) and essential package of hospital services (EPHS), revision and strengthening that has contributed to strengthen health system.

Overall all participants agreed to give grade 7 for the effort paid to strategic framework development as end of 2011. Since 2009, the key achievements were identified as completion of IBBS, development of NSF-II, the national HIV policy, and HIV case reporting. Still access to hidden populations, stigma and discrimination associated with HIV and AIDS, insecurity, insufficient funds and low awareness, were challenging successful implementation of HIV prevention programs.

Political Support and Leadership

All participants agreed that high level governmental official, such as the Minister of Public Health, and other sub-national level governmental officials, speak out on AIDS in the World AIDS Day observation both in 2010 and 2011. In addition, the President of the Islamic Republic of Afghanistan is being informed on OST scale-up challenges and asked his Cabinet to discuss the issue and find way to overcome such challenges. Currently, Parliament also had discussion on Methadone. Afghanistan has the officially recognized HIV coordination body called HIV and AIDS Coordination Committee of Afghanistan (HACCA) with specific terms of references and the Government leadership actively participates in its meetings. The HACCA is chaired by the Technical Deputy Ministers. It has 122 members from different civil society organizations, people living with HIV and private sectors. One of the task that the HACCA is responsible for is strengthening donor coordination to avoid parallel funding and duplication of effort in programming and reporting. HACCA also has mechanism to promote interaction between Government, civil societies and private sectors to the AIDS response. Almost 85 percent of budget was spent by civil societies. The spent budget was allocated for activities required for capacity development, coordination with other implementing partners, information on priority needs, procurement and distribution of medications or other supplies and technical guidance. It is worth mentioning that the country did not review national policies and laws to determine whether they are consistent with the National HIV Policies. Overall, participants agreed to give grade 8 for HIV program in 2011. However, participants acknowledged that while MoPH leadership is involved in the national AIDS program for HIV prevention and inter-ministerial strategy is in place but still working with leadership of line ministries is a challenge for the program.

Human Rights

Afghanistan has regulation that specify protection for people living with HIV, MSM, migrant/mobile population, orphan and other vulnerable population, PWID, prisoners, sex workers, women and girls, and young men and women. Most of these regulations are outlined through HIV related policies and strategies. In addition, Afghanistan's Constitution also has the statement that can reflect non-discrimination by saying every Afghan has the right to treatment. None of participants indicated that there is a policy or law that creates obstacle to effective prevention, treatment, care and support for Key Affected or other vulnerable population.

Prevention

There is a strategy and policy that promotes information, education and communication (IEC) on HIV for the general population. These policies emphasize avoidance of injecting drugs, commercial sex and inter-generational sex; being faithful to spouses, sexual abstinence and delaying sexual debut; engaging in safer sex; and fighting violence against women; greater acceptance and involvement of people living with HIV; greater involvement of men in reproductive health programmes; knowing one's HIV status; preventing mother-

to-child transmission of HIV; promoting greater equality between men and women; reducing the number of sexual partners, using clean needle and syringe, and using condom consistently. In the last year, NACP implemented activities to promote accurate reporting on HIV by the media. In addition NACP has a strategy to promote life skill based education for young people. HIV education is part of primary, secondary and teacher training curriculum. However, there are neither appropriate gender sensitive sexual and reproductive health elements nor an HIV education strategy for out –of-school young people.

Unlike out-of-school young people, there is a strategy to promote IEC for Key Affected Populations and other vulnerable population. NACP managed to develop key messages and defined proper communication channels. The strategy addresses IEC to PWID, MSM, sex workers, prisoners, reproductive age women and transport workers. These strategies include condom promotion, substitution therapy, voluntary testing and counseling (VCT), needle and syringe exchange, stigma and discrimination reduction and targeted information on risk reduction, and HIV education.

Overall, participants gave a grade 5 for policy efforts to support HIV prevention for the term of 2011. Multi-sectorial approach to increase awareness and expansion of coverage were the main achievements in prevention element. However, stigma and discrimination, low level of awareness in the general population and limited coverage still remain challenges for the program in order to ensure prevention.

The country has identified the need for programs such as capacity development, surveillance and data collection, advocacy and communication, and expansion of targeted interventions for Key Affected Populations.

On the implementation level, most participants agreed that people have access to blood safety, condom promotion, harm reduction for PWID, HIV prevention for out-of-school young people, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, sex workers, school-based HIV education for young people and universal precautions in health care setting. Three areas: HIV prevention in work place, prevention of mother-to-child transmission and risk reduction for MSM were those were participants disagreed that the majority of people from above-mentioned populations did not have access to services. Overall, efforts for implementation of HIV prevention program has rated as grade 8 in 2011.

Treatment, care and support

Needle and syringe program (NSP), Opioid Substitution Therapy (OST), anti-retroviral treatment (ART), STI management and opportunistic infections (OI) were identified as essential elements of a comprehensive package of HIV treatment, care and support services. There was conflicting opinions on whether the majority of people have access to treatment, care and support services. It was agreed that majority of people have access to ART, cotrimoxazole prophylaxis and HIV testing and counseling for people with TB, STI management, TB infection control in HIV treatment and care facilities, TB preventive

therapy for people living with HIV, TB screening for people living with HIV, and treatment of common HIV-related infections. However, it was disagreed that the majority of people have access to ART for TB patients, early infant diagnosis, HIV care and support in the workplace, HIV treatment services in the workplace or treatment referral systems through the workplace, nutritional care, pediatric AIDS treatment, post-delivery ART provision to women, post-exposure prophylaxis for non-occupational exposure (e.g. sexual assault), post-exposure prophylaxis for occupational exposures to HIV, and psychosocial support for people living with HIV and their families.

Though there was no strategy to support social and economic status of people living with HIV, there is a strategy on developing/using generic medications or parallel importing of medications for HIV. Afghanistan has access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications.

Overall the effort in the implementation of HIV treatment, care and support rated as grade 3. Since 2009, the scale up of ART, trained personnel on ART, availability of ART guidelines and medicines and equipment are achievements. Still limited geographical coverage and inadequate laboratory equipment are challenging implementation of treatment, care and support for people living with HIV.

It is worth mentioning that there is no strategy or policy in place to address the additional HIV related needs of orphan and other vulnerable children.

M and E

There is an M and E plan for the term of 2010 and was developed through participation of some partners. Low capacity of NACP, weak coordination among key staff and frequent turnover of staff are issues that challenge NACP to implement its M and E plan. M and E plan includes a data collection strategy and addresses behavior survey, evaluation/research studies, HIV surveillance, routine program monitoring, data analysis and dissemination strategies, a well-defined standardized set of indicators that includes sex and age dis-aggregation, and guidelines on tools for data collection. Budget was allocated to implement M and E plan and around 15 percent of the budget is allocated accordingly. There is an M and E unit located within MoPH. Low capacity, lack of analysis tools and insufficient routine data collection tools are obstacles to implement properly M and E plan. Currently, there are the following personnel: an M&E and surveillance consultant, a surveillance manager, two surveillance officers, and a monitoring specialist who work as full time.

A mechanism is in place to ensure that all key partners submit their M&E data/reports to the M and E Unit for inclusion in the national M&E system. All implementing partners submit their reports on monthly and quarterly basis. In addition BPHS implementers submit their report to health management and information system (HMIS). To monitor Key Affected Populations, IBBS is conducted every second year and, finally, national monitor checklist also provides some of indicators required in the M and E plan.

Still NACP is suffering from the lack of national HIV related data base. As mentioned earlier, there is an HMIS system within MoPH that collects health-related information from BPHS implementers. In addition, it is worth mentioning that there is lack of publications from collected information particularly from IBBS.

M and E data is usually used for program improvement, development and revision of national response, resource allocation and policy and strategy formulation. In last year, there was an M and E training at national level where five members were trained while there was no training held for the sub-national level. It is worth mentioning that members from civil societies also participated in such training.

II. Part B

Civil Societies Involvement

All participants from civil society, donors and Key Affected Populations acknowledged that civil societies were contributing to strengthening the political commitment of top leaders and national strategy formulation. They give grade 3 scores for their contribution level. In addition, they also expressed that these entities have been involved in planning and budgeting process for the NSF-II as well as the Global Fund proposal development. Civil societies are highly provided services in area of HIV prevention, treatment, care and support while their involvement in budgetary issues and national report writing was reported moderately.

As it concerns the development of national M and E plan development their contribution have shown as low by giving them grade 2 while their participation in M and E working group seems to be moderate. Civil societies also were less involved for using data for decision-making process. The representation of diverse civil societies in inclusive effort was reported as moderate and all respondent expressed that there is a good coordination. Key Affected Populations themselves participated in World AIDS Day Observation and speak out about their needs and have broken the silence. They also succeeded to establish Afghan drug user association and a group for people living with HIV. Civil societies are able to access financial and technical support to implement HIV prevention activities moderately. Most of them acknowledged that however there are funds available from different donors such as the World Bank, The Global Fund, UNODC, USAID and other donors, but still service provision is limited to few provinces. They also acknowledged that provision of technical support is weak to civil societies.

Above 75 percent of services, such as testing and counseling and stigma and discrimination reduction for MSM, PWID, and sex worker were provided by civil societies, while civil societies offering services for people living with HIV was indicated as 51-75 percent. Clinical services for ART and OI provided by civil societies was reported as 25-50 Percent, while civil societies involvement in home based care and program for orphan and other vulnerable children reported as below 25 percent.

Overall the effort increment of civil societies' participation in 2012 concluded as grade 7. Since 2009, there were achievements for civil societies listed below:

- Civil societies were included in policy formulation and decision-making processes.
- Most of service delivery offered by civil societies.
- Active participation from civil societies in HACCA meeting.
- Opportunity was provided to civil societies for international exposure visit to share best practices.

There are some changes for civil societies, such as insufficient availability of HIV testing services and limited accessibility. However, the coordination level has been increased but still it needs to be improved further. Insufficient funds for civil societies and capacity building are still challenging them. Finally approval of OST and harm reduction services in prison settings still remains as challenge to civil societies.

Political support and leadership

There are diverse opinions on the political support to programs, and fifty percent believed that there is no political support to implement HIV-related program. In the validation workshop, all participants agreed that Key Affected Populations, including people living with HIV, were involved in NSF-II development process and its endorsement.

Human Rights

There is a lack of non-discrimination regulations for specific populations - i.e. people living with HIV, MSM, migrant/mobile populations, orphan and other vulnerable populations, people who inject drugs, prisoners, sex workers and transgender population to protect themselves from contracting HIV, while for people living with disabilities, women and girls, and young women and men the regulations do exist. It is worth mentioning that the Afghanistan Constitution prohibits any kind of discrimination against Afghan citizens. The Ministry of Justice and several law enforcement agencies assure the implementation of laws, but the implementation level is poor and needs to be improved. In addition, there are still some laws, regulations and policies that create obstacles to provide services for MSM, PWID, sex workers and transgender population within Sharia law and the Afghanistan Constitution considers that these activities as criminal act. But Afghanistan has law, regulation and policy to reduce violence against women and expressed elimination of all kind violence against women. NSF-II and HIV policy mentioned that all Afghan have equal right to access to preventive, treatment and support services free of any kind of discrimination. All HIV related services offered to client without any charge or fee and NSF-II has addressed this issue. There is a mechanism to record cases that key population had experienced by some of organizations. NSF-II and HIV policy also ensure that women regardless of pregnancy and child birth context have equal access to HIV prevention, treatment, care and support services. In addition, NSF-II and HIV policy also expressed that all Key Affected Populations should have access to HIV prevention, treatment, care and support services.

There are some organizations, such as the Afghan Human Right Commission, Parliament, UN agencies and Human Rights Watch to ensure human right, but they do not have HIV-related performance indicators.
In the last two years, several training have been conducted to raise awareness for people living with HIV and Key Affected Populations as well as those who work for law enforcement organizations that has critical role in their capacity development. There is a mechanism in place to reduce HIV related stigma and discrimination such as program for health care workers and media.

Overall all respondent agreed to give a grade 4 for policies, laws and regulations that are in place to promote and protect human rights in relation to HIV in 2011. Training, development and airing of TV spots, involvement of human right commission and parliamentarian in HIV related activities are some of the achievement since 2009. Still there are some challenges regarding law and regulation that do not allow some of HIV related activities. In addition, the implementation of law and regulation rated as a 3. Since 2009, development of OST policy, prison health strategy, harm reduction strategy and drug demand reduction policy are the achievements while poor implementation remains as a challenge for program.

Prevention

Afghanistan through studies, assessment, monitoring visits and reports identified the need of HIV prevention programs. All participants agreed that the majority of people in need have access to blood safety, testing and counseling services, school based HIV education for young people and universal precautions in health care settings. Despite of having HIV interventions, still most of participant did not agree that majority of people in need have access to condom promotion, harm reduction for PWID, HIV prevention for out-of-school young people, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention for people living with HIV, reproductive health services including sexually transmitted infections, prevention and treatment, risk reduction for intimate partners of key populations, and risk reduction for MSM population. It is worth mentioning, that most participant strongly disagreed that majority of people in need do not have access to HIV prevention in workplace, prevention of mother-to- child transmission of HIV and risk reduction for sex workers.

Overall efforts in implementation of HIV prevention program in 2011 rated as grade 5. Since 2009, there were achievements as an OST program piloting, integration of HIV services into BPHS and HIV awareness campaign in schools. There are some issues that challenging HIV prevention program, such as OST implementation, harm reduction in prisons, adherence to treatment, program for drug users, vocational training for drug users, stigma and discrimination, low coverage of key affected population, and insufficient funding.

Treatment, care and support

NSF-II has identified the essential elements of comprehensive package of treatment, care and support such as ART, STI management, OI, and OST. It is worth mentioning that OST program has initiated for the first time here in Afghanistan and the ART program scaled-up

in Herat province. With regard to the program implementation, all participants agreed that the majority of people have access to cotrimoxazole prophylaxis and TB preventive treatment to people living with HIV, STI management and TB screening for people living with HIV while all participant did not agree that the majority people have access to ART, ART for TB patient, HIV testing and counseling for people with TB, pediatric AIDS treatment, psychosocial support for people living HIV and their family, TB infection control in HIV treatment and care facilities, and treatment for common HIV-related infection. In addition, most of participants strongly disagreed that majority people have access to early infection diagnosis, HIV care and support in workplace, HIV treatment services in workplace, nutritional care, post-delivery ART provision to women, and post exposure prophylaxis for non-occupational and occupational exposures.

Overall, all participants have rated the level of implementation of treatment, care and support services as grade 3. Since 2009, there are some achievement such as procuring one CD4 count machine, increment of ART coverage, increment of HIV case detection and ART guideline. Despite of having successful implementation, there are some challenges to the program. These challenges are: irregular drug supply, low ART coverage, drug resistance, low capacity for service delivery, lack of psycho-social support and drop out.

Though the adult's needs for comprehensive package of treatment, care and support services are being addressed, still orphan and children's needs were not addressed by NSF-II and HIV policy.

Recommendations

1. The process of preparation of the GARPR 2012 started late, while the process for data collection, analysis and validation requires more time so it would be better to plan data collection at least six month prior to submission of the final report. It is also recommended to allocate more time for NCPI data validation for the next GARPR round.

2. Though the NSF-II is in place for 2011-2015, till now there is no operational plan for its implementation. It is recommended to translate this strategy into an operational plan that would enable monitoring the level of implementation of the proposed strategies.

3. NACP was established in 2003. Since then efforts have been mobilized to implement HIV programs, but till now there is no impact evaluation. There is need to conduct impact evaluation of the HIV response and the socio-economic consequences of the epidemic for further planning purpose.

4. However, the AIDS program did pay special attention to reduce stigma and discrimination but still most of the participants in the NCPI process felt that much more effort are still required to overcome stigma and discrimination. It is also recommended that the awareness level should be increased to access hidden

populations. In addition, it was also suggested to mobilize more funds for implementation of HIV prevention programs.

5. Though the NSF-II and HIV policy documents, Afghanistan' now have articles that support HIV programs within the country but still there is need of a review of laws and regulations that could impede policy changes and this should be presented and adopted to decision makers as appropriate for the country.

6. For the time being, there are only two ART centers in the county and most of ART eligible people could not access them across provinces. Geographical expansion of ART and provision of adequate laboratory equipment to monitor progress in treatment and care for people living with HIV are a strongly felt need.

7. To monitor HIV programs, there is need for a robust M and E unit. Meanwhile, there are only four individuals working in this unit almost all of them newly hired to the program. It is recommended that much more attention should be paid to strengthen the M and E unit by hiring more staff. A plan should be developed to build their capacities as well. In addition, there is need of conducting national and sub-national level training. Through such training more staff would be able to improve data quality.

8. Most implementing partners and other relevant entities report to the M and E unit, but still this unit needs to store data in a data base. It is recommended to NACP to develop a proper data base for all data they receive.

Action plan for Global AIDS Response Progress Report, 2012				
No.	Activities	Responsible	Time line	Remarks
1	Communicate with UNAIDS on provision of TA	Dr. Bargami		There is need for technical support in report- writing and validation workshop
2	Identify data need		4-Mar	
3	Information-sharing			
3.1	FSW report and other related reports from HPRO	Dr. Ayoub	5-Mar	These document should be submitted to NACP (Dr. Bargami)
3.2	MICS	Dr. Mohammad Nowroz Ibrahimi	5-Mar	This document should be submitted to NACP (Dr. Bargami)
3.3	NRVA	Dr. Ajmal	5-Mar	
4	Percent of MSM who live with HIV should be requested from UNAIDS as some data exists ranging from coverage to HIV status	Dr. Bargami	5-Mar	No estimations have as yet been undertaken on MSM
5	Distribution of syringe/year/person should be collected in close coordination with relevant partners such AHAPP, SPHP, UNODC, and World Vision	Dr. Samarudin	8-Mar	
6	Indicator no.6.1	Dr. Hashim	12-Mar	
7	NCPI	Dr. Ahadia, NACP		
7.1	Training, orientation on NCPI instrument	Dr. Sabawoon	5-Mar	
7.2	Identify potential key respondents	Dr. Ahadia, NACP	5-Mar	
7.3	Make appointments with key respondents	TBD		
7.4	Conduct interviews	TBD		
7.5	Submit to core group focal point	TBD		
7.6	Collate and analysis of data			

8	Indicator no 7.2 should be asked from MOWA, NRVA to be cross-checked	TBD	12-Mar	
Action plan for Global AIDS Response Progress Report, 2012				
No.	Activities	Responsible	Time line	Remarks
9	Indicator no 7.3 should be derived from MICS	Dr. Ibrahim	5-Mar	
10	Indicator no 7.4: WB will be asked about this indicator	Dr. Bargami	12-Mar	Zahid Hatam is contact at WB
11	Identify relevant tools for data collection	Mr. Julian	4-Mar	
12	Collect and collate data in coordination with partner organizations from government, civil society and international agencies	Dr. Sabawoon	13-Mar	
13	Analyze data in coordination with partner organizations from government, civil society and international agencies	Dr. Sabawoon and core group		
14	Validation Workshop	Dr. Bargami	26-Mar	19 or 26 March (Mr. Joseph will confirm)
15	Draft Report 0	Dr. Angela Chaudhuri	18-Mar	
16	Disseminate to core group	Dr. Sabawoon	18-Mar	
17	Receiving comments	All core group	21-Mar	
18	Incorporating comments	Dr. Angela Chaudhuri	25-Mar	
19	Finalizing Report	Dr. Angela Chaudhuri	26-Mar	
20	Online Data entry	Dr. Sabawoon	27-Mar	
21	Foreword	H.E. Minister	26-Mar	NACP will facilitate the process