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AFGHANISTAN AT A GLANCE

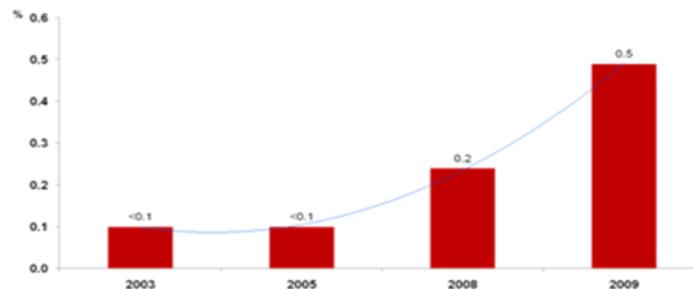
Total population	29,117 (2010) ²
Annual population growth rate	3.2% (2010-2015) ²
Population aged 15-49 (thousands)	13,333 (2008) ²²
Percentage of population in urban areas	23% (2010) ¹
Crude birth rate (births per 1,000 population)	46.5 (2008) ³
Under-5 mortality rate (per 1,000 live births)	257 (2008) ²⁰
Human Development Index (HDI) Rank/Value	155/0.349 (2010) ²¹
Life expectancy at birth (years)	44.6 (2010) ²¹
Adult literacy rate	28% ²³
Ratio of girls to boys in primary and secondary education (%)	57 (2008) ³
GDP per capita (PPP, \$US)	1,321 (2009) ³
Per capita total health expenditure (Int.\$)	83 (2007) ²⁰



HIV PREVALENCE & EPIDEMIOLOGICAL STATUS

Data on HIV prevalence is scarce, given the current state of rebuild of Afghanistan's health system. UNAIDS has estimated that, as of 2008, HIV prevalence among the general population is below 0.5%⁶ (Fig. 1). Given that no HIV surveillance system is in place, reported data originates from blood banks and VCT Centres. Data from the Central Blood Bank Kabul indicates that the detection of the first HIV positive case in Kabul was in 1989. Between 1989 and 2005, the Central Blood Bank reported a total of 67 cases of HIV infection out of 125,832 blood samples screened at central and provincial levels via rapid testing kits⁷. As of the end of 2009, 636 HIV-positive cases have been reported nationwide and the number of deaths due to AIDS was estimated to be fewer than 10⁸.

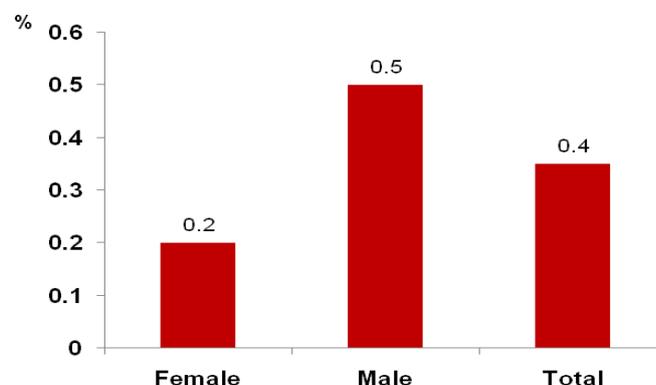
Figure 1. HIV prevalence among general population aged 15-49, 2003-2009



Sources: UNAIDS Report on the Global AIDS Epidemic, 2006; Afghanistan UNGASS Country Progress Report, 2010, used information from MIS Data of Afghan National AIDS Control Programme

During 2008-2009, of the 19,875 people who tested themselves at voluntary counselling and testing (VCT) centres, among whom 42 % were women⁸. Among those who were tested, 69 (0.4%) were HIV positive (Fig. 2). HIV prevalence was 0.5% among males who were tested and 0.2% among females who were tested⁸.

Figure 2. Percentage of HIV positive tests, by gender, at eleven VCT centres, 2008-2009



Source: Afghanistan UNGASS Country Progress Report, 2010 used information from MIS Data of Afghan National AIDS Control Programme

¹ MIS Data of Afghan National AIDS Control Programme.

Surveillance systems:

Afghanistan's monitoring and evaluation programme is still nascent and has been hindered by the security situation within the country in addition to other logistical constraints. However, several research studies have been commissioned in the past few years, including:

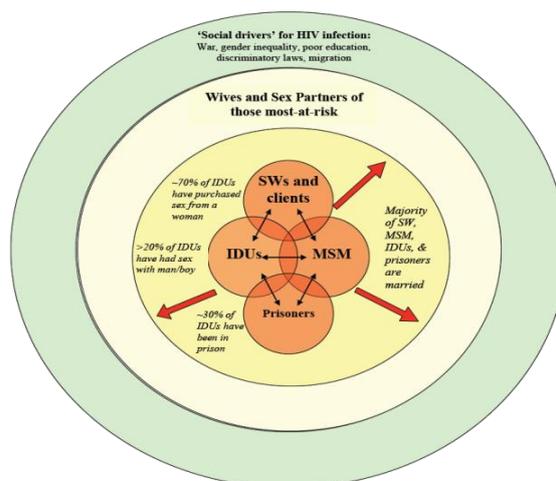
- The first Integrated Bio-Behavioural Surveillance was carried out among injecting drug users and female sex workers in 2009;
- A social mapping of high-risk groups was carried out by the University of Manitoba in Kabul, Jalalabad, and Mazar-i-Sharif in 2006;
- Naz Foundation completed a rapid assessment of men who have sex with men in 2009

WHO IS AT RISK OF HIV INFECTION IN AFGHANISTAN?

Due to the fact that there is no HIV surveillance system set up in Afghanistan, it is difficult to track the trend of the HIV epidemic amongst key populations at higher risk. Nonetheless, a number of studies have documented HIV prevalence and behaviours among certain key populations at higher risk.

While the HIV epidemic in Afghanistan is in its early stages, largely concentrated with the injecting drug user (IDU) population, risk behaviours and sexual networks are overlapping. As shown in Figure 3, 70% of IDUs have purchased sex from a woman; over 20% of IDUs have had sex with a male; 30% of IDUs have been in prison; and the majority of sex workers, men who have sex with men (MSM) and IDUs are married⁹.

Figure 3. Population interaction of most at risk populations in 4 cities, 2007-2008



Source: Todd CS et al_HIV, Hepatitis C and Hepatitis B infections and associated risk behavior in IDUs, Kabul. *Emerg. Infect. Dis.* 2007 Sep, 13(9):1327-1331.

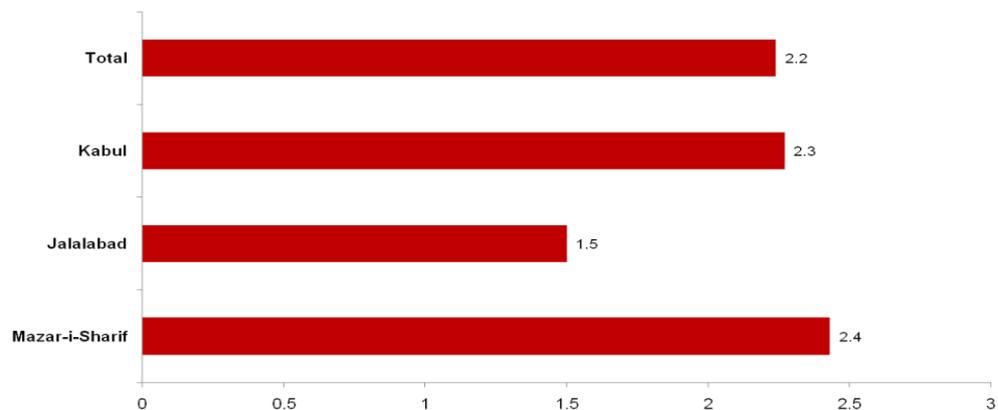
Injecting drug users

Afghanistan is the world's primary producer of opium¹⁰. In 2007, a total of 157,000 hectares of land was cultivated for opium in Afghanistan (down 19% from 193,000 hectares in 2007)¹⁰. It is estimated that there were 366,500 households or 2.4 million Afghan people involved in poppy/opium cultivation in 2009, which constitutes nearly 10% of the total population¹⁰. The increasing production of opium has resulted in the availability of a greater quantity of both opium and heroin in the local market. With increased access to and availability of drugs, many Afghan young people are vulnerable to risk behaviours, particularly injecting drug use.

The primary mode of transmission of HIV infection is injecting drug use⁸. A number of recent studies have sampled and surveyed IDUs in a range of cities.

In 2006, a social mapping study was conducted in three cities – Kabul, Mazar-i-Sharif and Jalalabad – which estimated that there were 2.2 IDUs per 1,000 urban adult men (the equivalent of 16,000 IDUs nationwide)¹¹. This estimate is slightly lower than the 19,000 estimated by a World Bank survey in 2005¹². The estimated number of IDUs per capita ranged from approximately 1.5 IDUs per 1,000 adult men (aged 15-49) in Jalalabad to 2.4 per 1,000 in Mazar-i-Sharif, with the estimate for Kabul falling between the other two cities (Fig. 4).

Figure 4. Estimated population size of IDUs per 1,000 adult men in 3 cities, 2006-07

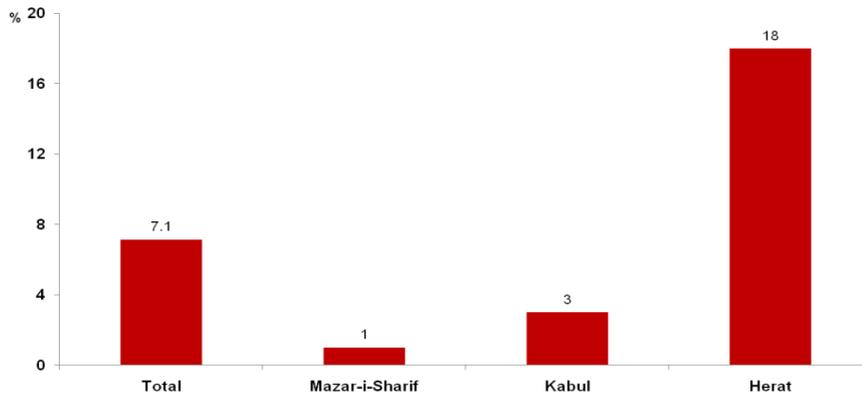


Source: . Afghanistan_The World Bank, Mapping and Situation Assessment of Key Populations at High Risk of HIV in Three Cities of Afghanistan, April 2008

Most recently, the 2009 Integrated Bio-Behavioural Surveillance (IBBS) – conducted in three cities – found that HIV prevalence among IDUs ranged from 1% in Mazar-i-Sharif to 3% in Kabul to 18% in Herat (Fig. 5)¹³. The national average of HIV prevalence among IDUs is thus 7.1% (N.B. this average is not fully representative of the whole country, but is an average over the three cities using all cases tested positive as the numerator and all cases tested as the denominator)⁸. In 2008, HIV prevalence in Herat was found to be 3.1%¹⁴. In 2007, HIV prevalence in Kabul was also found to be 3%⁹, and was 0% in Jalalabad and Mazar-i-Sharif¹¹.



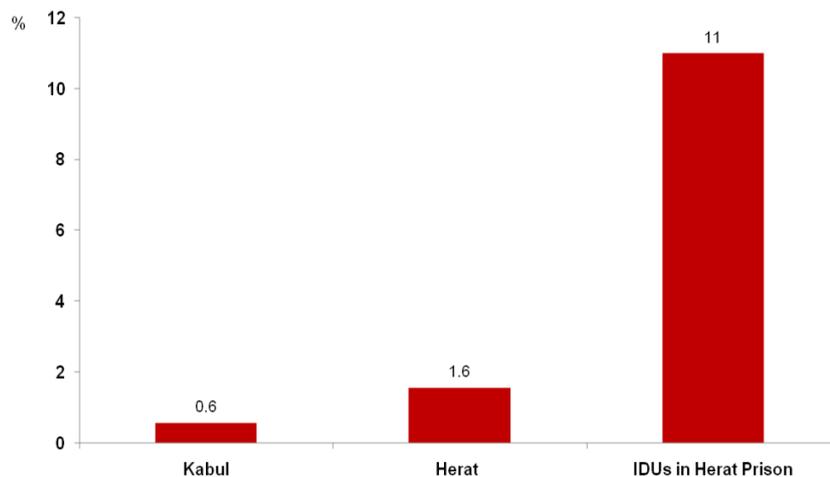
Figure 5. HIV prevalence among IDUs, selected cities, 2009



Source: Afghanistan_ Integrated Bio-Behavioral Surveillance-2009_Cited in Afghanistan UNGASS Country Progress Report, 2010

IDUs in prisons are a particular sub-population of concern in Afghanistan. Indeed, 17% of IDUs in Kabul reported having injected drugs in prison¹⁵. According to the IBBS 2009, HIV prevalence among prisoners was 0.6% in Kabul and 1.6% in Herat (11% in a Herat prison according to a 2008 study¹⁴) (Fig. 6)¹³.

Figure 6. HIV prevalence among prisoners and IDU prisoners, selected prisons, 2009



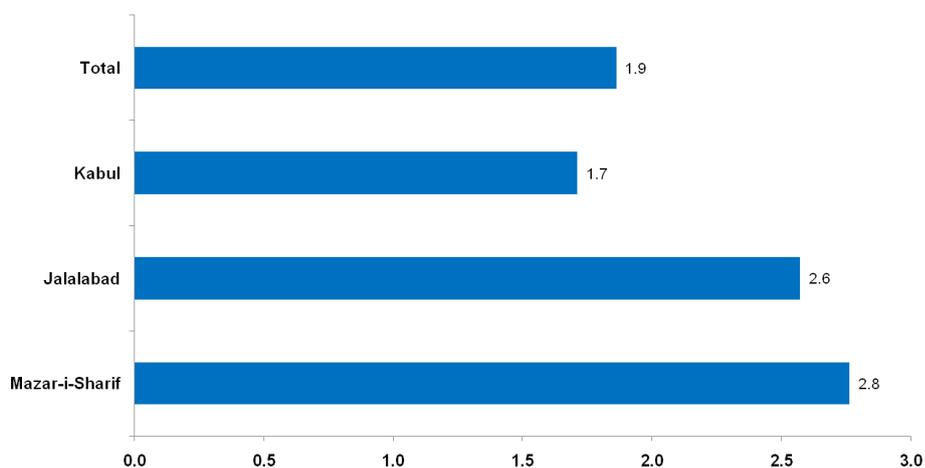
Sources: Afghanistan_ Integrated Bio-Behavioral Surveillance-2009_Cited in Afghanistan UNGASS Country Progress Report, 2010 ; The World Bank. Afghanistan HIV/AIDS Prevention Project Implementation Support Mission (June 1-9, 2008) Aide Memoire. 2008

Female sex workers

Overall HIV prevalence among female sex workers (FSWs) was 0%, according to the IBBS 2009¹³, slightly lower than the 2008 convenience-based sample in the three cities of Kabul, Jalalabad and Mazar-i-Sharif in which prevalence was found to be 0.2%.

Further to the 2006 mapping and situation assessment of high risk groups, there were an estimated 1,160 FSWs across the three cities, with the largest absolute number (898) being in Kabul. However, the highest number of FSWs per capita was in Mazar-i-Sharif, with approximately 2.8 FSWs per 1,000 adult women (aged 15-49) (Fig. 7)¹⁰. These figures are considered to be conservative estimates, given the cultural aspects making FSWs particularly hidden within society. Overall, there were an estimated 1.9 FSWs per 1,000 women across all three cities. In each of the cities, FSWs were present in all zones or districts. However, home-based sex work was more widely distributed than street-based sex work, particularly in Mazar-i-Sharif and Jalalabad – where street-based sex workers were only found in 4 of 10 and 2 of 5 districts, respectively. Street-based sex workers were more geographically widespread in Kabul.

Figure 7. Estimated population size of FSWs per 1,000 adult women in 3 cities, 2006-07



Source: Afghanistan_The World Bank, Mapping and Situation Assessment of Key Populations at High Risk of HIV in Three Cities of Afghanistan, April 2008

A study revealed that 39% of truck drivers surveyed reported that sex work was available where they stayed at night¹⁴. In addition, a 2007 study among Afghan university students reveals that 5% of all male respondents (N=743) and 10% of married male respondents (N=52) had visited a brothel in the past one year¹⁶.



Men who have sex with men

MSM are highly stigmatized in contemporary Afghan society, which could account for their presumably significant underreporting. As a result, HIV prevalence among this group remains unknown. Indeed, the World Bank study concluded that MSM activities are kept secret amongst small networks¹¹. Key informants reported that 100 or more MSM were selling sex in Mazar-i-Sharif with a frequency of about 3 clients per day, and that sexual behaviour would occur mostly in the homes of clients. Meanwhile, about 1-3% of the IDUs included in the IBBS 2009 had ever had sex with another man. This figure was significantly higher in the 2006 survey in two major cities, in which it was found that 20% of IDUs had had sex with a male during their lifetime (22% in Mazar-i-Sharif, 21% in Jalalabad)¹⁵.

Long distance truck drivers

Long distance truck drivers are another group at risk in Pakistan, given certain behaviours that put them at risk. It is estimated that there are approximately 60,000 truckers living and operating in Afghanistan and another 2,000 international truckers⁶. The IBBS 2009 found that HIV prevalence was 0% among the truck drivers surveyed, but a range of risk behaviours persist (see section on Vulnerability, Knowledge & Risk Behaviours, below).

VULNERABILITY, KNOWLEDGE & RISK BEHAVIOURS

Vulnerability factors

Afghanistan is considered a low- prevalence country, but vulnerability and risk factors for HIV infection are numerous, and include:

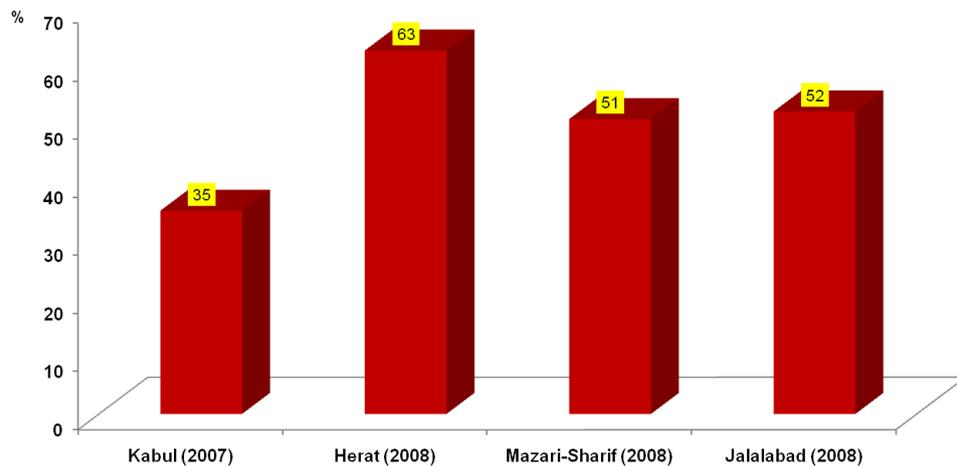
- Four countries bordering Afghanistan (Pakistan, Tajikistan, Uzbekistan and Iran) – which provided refuge to many of the 8 million Afghans who fled their homes during recent decades of conflict¹⁷ – are experiencing HIV epidemics among injecting drug users
- Nearly three decades of war and 5 years of drought have caused the population's health, social, and economic conditions to greatly decline¹⁷;
- Generally low levels of education and literacy¹¹: the literacy rate in the general population is 28% - and only 13% among women¹⁷;
- High levels of migration and mobility due to porous borders as well as extensive internal and external displacement of people¹¹;
- Massive production of drugs (opium) and illicit drug use constrains coverage of vulnerable groups¹¹;
- HIV knowledge and awareness are low;
- Limited health and social infrastructure¹¹;
- Only half of the country's donated blood units are screened for HIV in a quality-assured manner⁸.

² Based on data from Afghanistan Public Blood Bank Report

Injecting drug users

Various studies have demonstrated high levels of risk behaviours among IDUs in several cities, as summarized in Table 1. The IBBS 2009 revealed that the majority (94%) of IDUs used sterile needles in last injection, averaged over all three cities included in the study (Kabul, Herat and Mazar)¹³. Yet an earlier study in 2006 in Mazar-i-Sharif and Jalalabad found that only 53% reported using sterile injection equipment¹¹. Another study found that, in 2007-2008, 35% of IDUs in Kabul had ever shared needles or syringes, and over half had done so in Herat (63%), Mazar-i-Sharif (51%) and Jalalabad (52%) (Fig. 8)¹⁴.

Figure 8. Percentage of IDUs having ever shared needles or syringes in 4 cities, 2007-2008



Source: Todd, CS, UCSD/WRAIR/NAMRU Project, 2007 cited in Understanding HIV in Afghanistan: The Emerging Epidemic and Opportunity for Prevention, August 2008

According to the IBBS 2009, 55-70 % of the IDUs had ever bought sex from a sex worker; 9-12 % of the IDUs had bought sex in last six months. Among them, only 17-32 % of IDUs used condom in their last sexual encounter (in the last six months). Findings from the three-city study by the World Bank point to similar sexual risk behaviours among IDUs¹¹. Overall, three-fourths of IDUs from the two cities reported ever having sex with a woman, and almost half had ever paid a woman for sex. Condom use was very low, with over 80% of IDUs who had paid for sex reporting never having used a condom with FSWs.

Knowledge levels about HIV among IDUs remain very low (Table 1). The IBBS 2009 shows that only 29% of IDUs could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission (5% in Mazar-i-Sharif)¹³.

Table 1. Risk behaviours and HIV knowledge among injecting drug users in four urban centres: Kabul, Herat, Mazar-i-Sharif and Jalalabad

Indicator	Kabul	Herat	Mazar-i-Sharif	Jalalabad
IDUs having ever shared needles or syringes	35% (N=464); 2007*	63% (N=340); 2007*	51% (N=187); 2007*	52% (N=96); 2007*
IDUs having paid a woman for sex	76% (N=464); 2007*		74% (N=623); 2008*	
IDUs having had sex with men/boys	27% (N=464); 2005-2006*		23% (N=623); 2008*	
IDUs (14-49) having heard of HIV/AIDS	46% (N=464); 2005-2006*		n/a	
Comprehensive knowledge of HIV	29%; 2009 ^a			n/a
	n/a	n/a	5%; 2009 ^a	

* Todd, CS, UCSD/WRAIR/NAMRU Project, 2007 cited in Understanding HIV in Afghanistan: The Emerging Epidemic and Opportunity for Prevention, August 2008

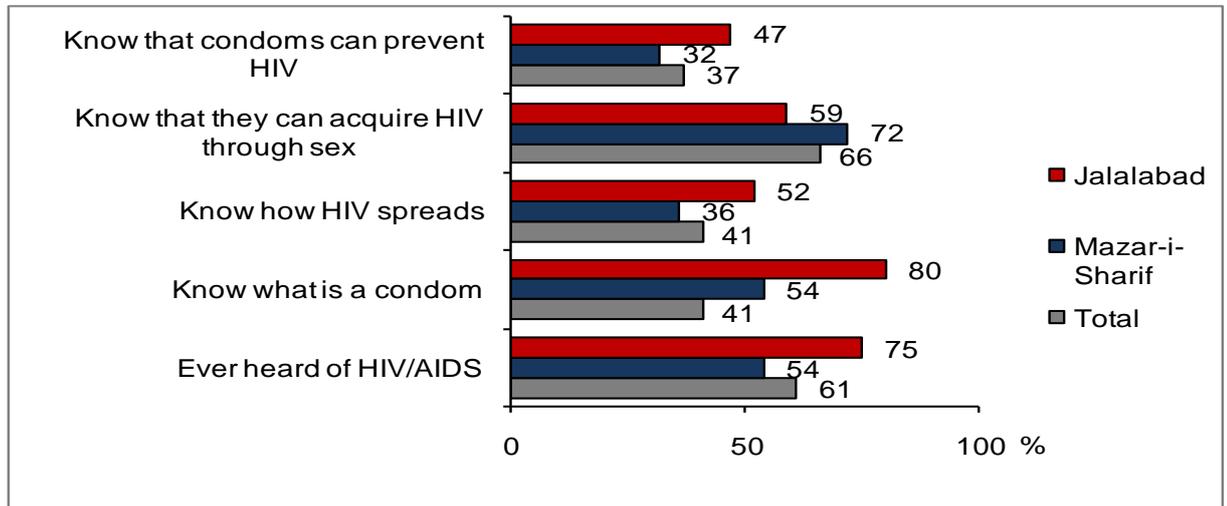
^a IBBS, 2009

Female sex workers

The IBBS 2009 found that knowledge levels of HIV among FSWs were extremely low¹³. Only 2 % could both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. This figure was even lower among younger sex workers, aged 18-24 years, at 0.7%.

In terms of knowledge about specific elements HIV transmission (as opposed to comprehensive knowledge), 2006 data shows that a majority of FSWs in Mazar-i-Sharif and Jalalabad reported knowing about condoms (Fig. 9). However, only a few of respondents reported using condoms "most of the time". Most FSWs had heard of HIV and AIDS and knew that it could be transmitted through sex. Very few (9%) had ever been tested for HIV. Figures pertaining to condom use were higher in 2009, according to the IBBS, although still only 58 % of FSWs report using a condom with their most recent client.

Figure 9. Percentage of FSWs with HIV and AIDS related knowledge, 2007-2008



Source: Afghanistan_The World Bank, Mapping and Situation Assessment of Key Populations at High Risk of HIV in Three Cities of Afghanistan, April 2008

A summary of recent findings pertaining to FSWs' HIV prevalence and risk-taking behaviours can be found in Table 2.

Table 2. HIV prevalence and risk behaviours among female sex workers in three urban centres: Kabul, Mazar-i-Sharif and Jalalabad

Indicator		Kabul	Mazar-i-Sharif	Herat	Jalalabad
Condom Use	Ever used condoms	n/a	40%; 2007-2008 ^b	n/a	29%; 2007-2008 ^b
	With client condom use "most of the time"	n/a	32%; 2007-2008 ^b	n/a	16%; 2007-2008 ^b
	With most recent client	58%; 2007-2008 ^b			
Average number of clients per month		84% had 1-2 clients per day; 2006 ⁺	10; 2007-2008 ^b	n/a	19; 2007-2008 ^b
		4.4; 2009 ^a			
Heard of HIV		<1%; 2005 ⁺	54%; 2007-2008 ^b	n/a	75%; 2007-2008 ^b

⁺ Data from Action Aid KAP Study, 2006

^a IBBS 2009, as cited by note 8.

^b Afghanistan_The World Bank, Mapping and Situation Assessment of Key Populations at High Risk of HIV in Three Cities of Afghanistan, April 2008

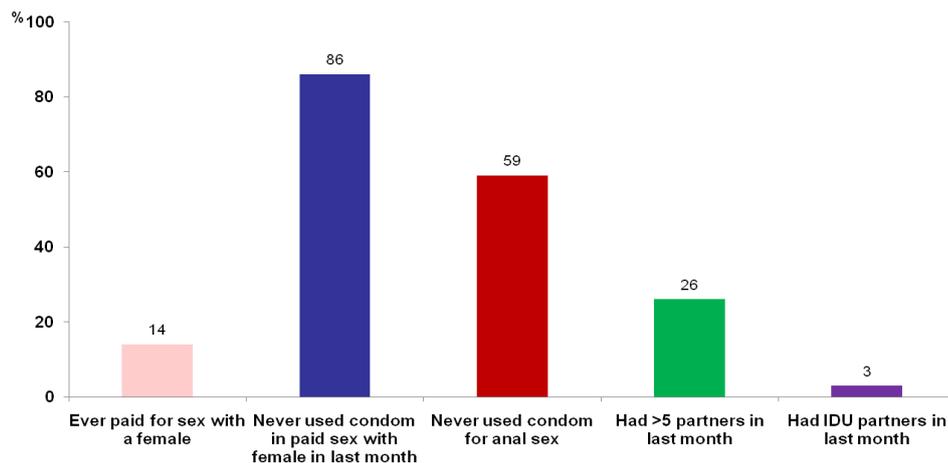
Men who have sex with men

MSM were not a population included in the IBBS 2009. Findings from a 2008 small rapid assessment of 100 adult MSM in the cities of Kabul and Mazar-i-Sharif are summarized in Table 3 and Figure 10¹⁸

Table 3. Risk behaviours among men who have sex with men in two urban centres

Behaviour	Responses
Sexual contact with females	<ul style="list-style-type: none"> • 23% were married; • 42% had had sex with a female (other than their wife, if married); • 14% had ever paid for sex with a female.
Injecting drug use	<ul style="list-style-type: none"> • 1% had injected drugs in the last month; • 3% had a sexual partner who injected drugs in the last month.
Multiple partners	<ul style="list-style-type: none"> • 75% had 1-5 different partners in the last month, 22% had 6-10 partners, and 4% had more than 10 partners.
Paid sex	<ul style="list-style-type: none"> • 100% had received money for sex with another male.
Condom use	<ul style="list-style-type: none"> • 13% used a condom for anal sex “every time”; 30% used a condom sometimes; and 59% never used a condom; • 18% used a condom at last paid sex.
Knowledge of HIV and AIDS	<ul style="list-style-type: none"> • 27% had ever heard of HIV; • 66% had ever heard of AIDS.

Figure 10. Percentage of MSMs with selected sexual behaviours in Kabul & Mazar-i-Sharif, 2009



Source: Khan S., et al. Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan, March 2009

Long distance truck drivers

The IBBS 2009 found that 23% of long distance truck drivers buy sex, among whom 51% use condoms. An earlier 2006 study by Action Aid found that 7% of long distance (n=390) truck drivers reporting having paid for sex in the previous 12 months, among whom less than a quarter used condoms⁴.

NATIONAL RESPONSE

*Governance*⁸

The National AIDS Control Programme (NACP) developed, through a comprehensive process with a wide range of stakeholders and development partners, an HIV and AIDS National Strategic Framework (2006-2010). The Framework outlines Afghanistan's broad vision and strategic objectives, which include: strengthening strategic information; ensuring development and coordination of a multi-sector response and institutional capacity building; raising public awareness about HIV and STI prevention and control; ensuring access to prevention, treatment and care services for high-risk and vulnerable populations; and strengthening the health sector capacity within the framework of a Basic Package of Health Services and Essential Package of Hospital Services. In 2007, the Afghanistan HIV and AIDS Coordinating Committee (HACCA) was established to address the multi-sectoral issues related to the HIV epidemic.

In September 2007, the Afghanistan HIV and AIDS Prevention Project (AHAPP) took effect, which sought to contribute to the national development goals of the Interim Afghanistan National Development Strategy (I-ANDS) of maintaining HIV prevalence below 0.5% in the general population and below 5% among vulnerable groups at high risk of infection. The project's development objectives are to slow down the spread of HIV and build up the national capacity to respond to the epidemic. To realize these, the project aims to target interventions for key populations at higher risk, and improve knowledge of HIV prevention as well as reduce stigma related to HIV. The Project has four components: communications and advocacy; strengthening of HIV surveillance; targeted interventions for high risk behaviours; and program management, capacity building and monitoring and innovation.

HIV prevention programmes

In 2008, the MoPH/NACP recently began to implement harm reduction activities among key populations at higher risk, including IDUs, sex workers, truck drivers and prisoners. Security and other internal factors have been cited as important constraints in the scaling up of prevention programs.

Figure 11 (a) shows the range in the percentage of key populations at higher risk tested for HIV in the last 12 months. According to the IBBS 2009, about 22% of the IDUs have ever been tested and know their HIV results¹³. Four percent of FSWs had been tested in the last 12 months and knew their results¹³. Earlier findings from the 2008 situation assessment found that 12% of FSWs in Mazar-i-Sharif and 4% in Jalalabad had ever been tested for HIV¹¹. Among the general population, in 2009, only 0.2% of women and men aged 15-49 received and HIV test in the last 12 months and knew their results, according to VCT data (showing that 19,875 people had been tested)⁸. The 2008 rapid assessment of 100 MSM found that 4% had ever been tested.

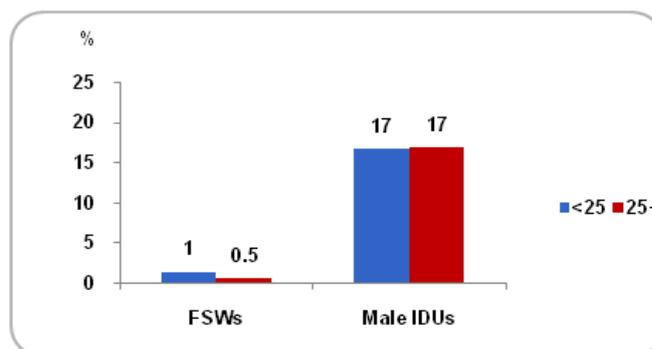
Figure 11 (a). Percentage of key affected populations tested for HIV in last 12 months, 2009



Source: Afghanistan, IBBS-2009 cited in Afghanistan UNGASS Country Progress Report, 2010

In 2009, 17% of IDUs were reached with HIV prevention programmes. It is important to note a possible reporting bias as data was collected in cities already providing prevention interventions¹³. Moreover, coverage was uneven across the three major cities included in the IBBS. The current service package available to IDUs consists of the provision of needles, condoms, STI treatment and referral to testing and counselling and an opioid substitution therapy policy has been developed⁸. Two clinics for sex workers have been established in Kabul and Mazar-i-Sharif, reaching 400 sex workers (amounting to a 0.1% coverage)⁸. MSM prevention coverage was not reported on.

Figure 11 (b) Percentage of key affected populations reached with HIV prevention programme by age group, 2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010 citing Afghanistan, IBBS, 2009

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

As of 2009, there were a total of 11 VCT centres in 8 provinces (up from 6 centres in 4 provinces in 2007)⁸. As recently as April and June, 2009, two ART clinics have been established in Kabul and Herat and ART was rolled out at the end of 2009⁸. In 2009, 95 cases of HIV were registered, of which 12 people were on ART.

Prevention of mother-to-child transmission services are not available in Afghanistan⁸.

Law and policy related issues

Legal and policy environments create impediments to generating size estimates of key populations at higher risk and in reaching them with prevention, treatment and care.

Drug use in Afghanistan is illegal and is associated with penalties of rehabilitation for a first offence or imprisonment for recurrent offenses¹⁵. Importantly, the Opioid Substitution Therapy (OST) Policy has been approved by the Consultation Group on Health and Nutrition – the Technical Advisory Group of the Ministry of Public Health. This paves the way for the scaling up of harm reduction programmes among IDUs⁸.

Sex work is illegal in Afghanistan, as is male-to-male sex. In fact, the *Penal Code of Afghanistan, 1976*, at Article 427(1), states that “[a] person who commits adultery or pederasty shall be sentenced to long imprisonment.” Pederasty, in this case, appears to refer to homosexual intercourse between males regardless of age¹⁹. Sharia law is also reportedly applied to regulate homosexual behaviour and carries the penalty of life imprisonment¹⁹.

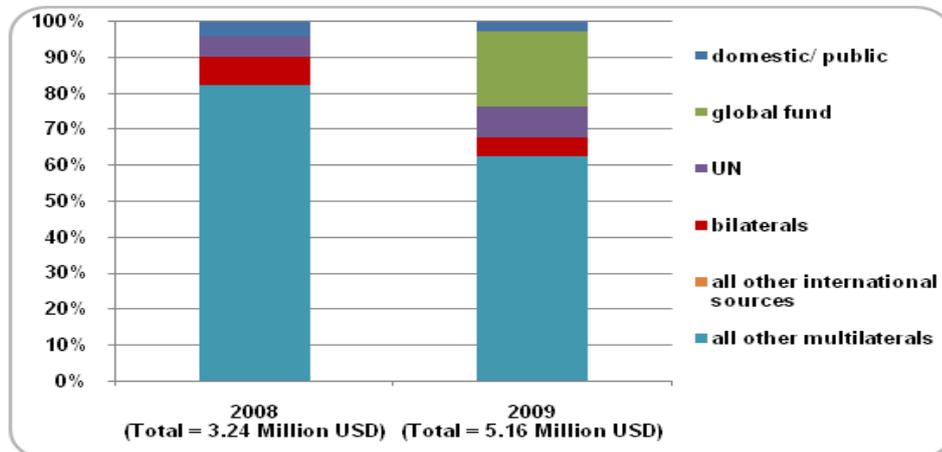
HIV FINANCING AND EXPENDITURE

In Afghanistan, there are more than 150 NGOs (both international and national) working in the health sector. Eighty percent of existing health facilities are either operated or supported by NGOs⁷. UN agencies such as UNICEF, UNFPA, WHO and the World Bank are technically and financially supporting Afghanistan’s effort in combating HIV and AIDS. Also, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) supports certain activities that aim to develop the infrastructure for HIV/TB/Malaria programming.

The budget allocation for HIV/AIDS programs both by governments and major donors was 5.2 million USD in the year 2009 (up from 3.2 million USD in 2008)²⁴ (Fig. 12). Of this, 2.6 % was financed by domestic and public sources, the Global Fund to Fight AIDS, Tuberculosis and Malaria (21.1 %), UN agencies (8.4%), bilaterals (5.5%) and 62.4% by other multilaterals in 2009²⁴. In terms of HIV expenditures by spending category in 2009, prevention received the most funding (2.46 million USD), followed by Programme Management and Administration (1.16 million USD), Human Resources (0.71 million USD) and research (0.65 million USD) The amount as little as 0.11 million USD was spent for care and treatment of PLHIV in 2009 (Fig. 13)²⁴. Of total HIV expenditures on prevention in 2009, 0.95 million USD was spent for HIV prevention interventions among key affected populations, up from 0.73 million USD in 2008, followed by VCCT (0.28 million USD), Communication for social and behavioural change (0.15 million USD) and PMTCT (0.02 million USD) (Fig. 14)²⁴.

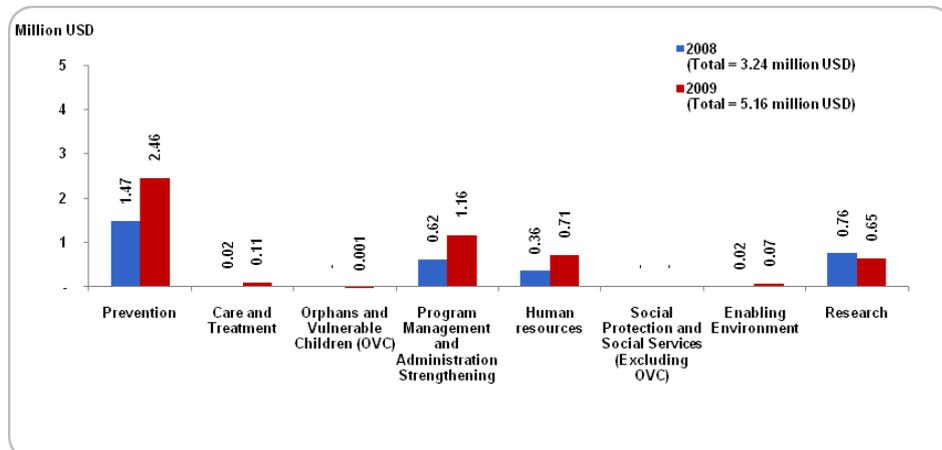


Figure 12. Percent distribution of total HIV expenditures by financing source, 2008 - 2009



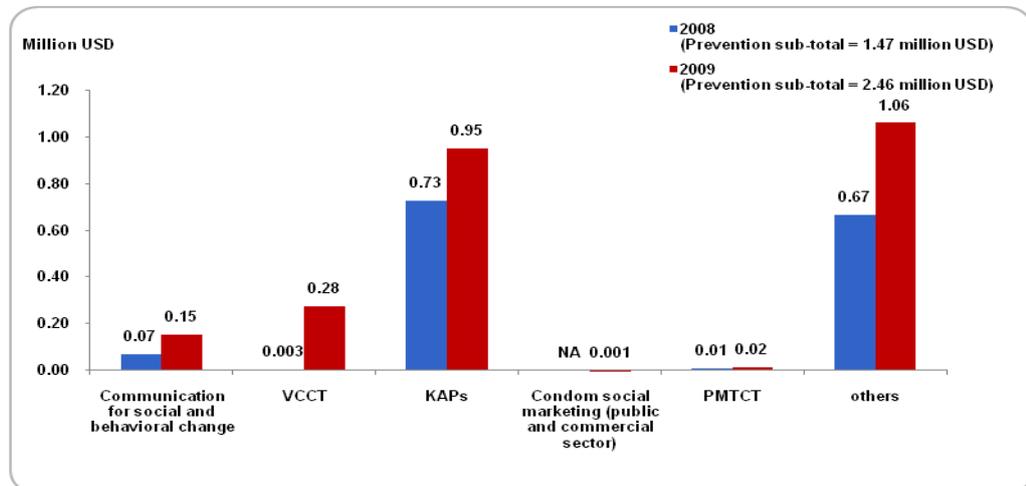
Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

Figure 13. Amount of total HIV expenditures by major spending category, 2008-2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

Figure 14. Amount of total HIV expenditures on prevention by service category, 2008 – 2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

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