PROGRAM OPERATIONAL PLAN IN SUPPORT OF THE AFGHANISTAN HIV/AIDS NATIONAL STRATEGIC FRAMEWORK (2006-2010)

NATIONAL AIDS CONTROL PROGRAM (NACP)
MINISTRY OF PUBLIC HEALTH (MoPH)

ISLAMIC REPUBLIC OF AFGHANISTAN

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ABBREVIATIONS AND ACRONYMS

ACBAR	Agency Coordinating Body for Afghan Relief
AIDS	Acquired Immune Deficiency Syndrome
ANASF	Afghanistan National Strategic Framework
ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CSO	Civil Society Organization
DFID	Department of International Development - UK
DGA	Development Grant Agreement
EPHS	Essential Package of Hospital Services
EU	European Union
FBO	Faith-Based Organization
FC	French Cooperation
FMS	Financial Management System
GCMU	Grants and Contracts Management Unit
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GoA	Government of Afghanistan
GTZ-IS	German Technical Cooperation International Services
HACCA	HIV/AIDS Committee of Afghanistan
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICB	International Competitive Bidding
ICRC	International Committee for the Red Cross
IDA	International Development Association
IEC	Information, Education, and Communication
ILO	International Labour Organization
KABP	Knowledge Attitudes Behavior and Practice Study
MDM	MedecinsDu Monde
M&E	Monitoring and Evaluation
MoCN	Ministry of Counter Narcotics
MoD	Ministry of Defense
MoDM	Ministry of Displaced and Martyred
MoE	Ministry of Education
MoF	Ministry of Finance
MoJ	Ministry of Justice
MoHE	Ministry of High Education
MoHRA	Ministry of Hadj and Religious Affairs
MoI	Ministry of Interior
MoICYA	Ministry of Information, Culture and Youth Affairs
MoLSA	Ministry of Labor and Social Affairs
MoPH	Ministry of Public Health
MoRR	Ministry of Returnees and Refugees
MoU	Memorandum of Understanding
MoWA	Ministry of Women Affairs
MTCT	Mother-To-Child-Transmission
NACP	National AIDS Control Program
NCB	National Competitive Bidding
NGO	Non-governmental organization
POP	Program Operational Plan
PAD	Project Appraisal Document
PCU	Project Coordination Unit
PHD	Provincial Health Director
PLWHA	Persons Living with HIV/AIDS
PHRD	Public Human Resource Development
PO	Procurement Officer
RFP	Request for Payment

SCA	Swedish Committee for Afghanistan
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
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
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counseling and Testing
WB	World Bank
WHO	World Health Organization
WFP	World Food Program

Program Operation Plan (POP) in the Support of Afghanistan National Strategic Framework for HIV/AIDS (ANASF) – 2006-2010

I. INTRODUCTION

1. The Government of Afghanistan (GoA) is aimed to take an aggressive multi-sectoral response to the HIV/AIDS epidemic with the financial support of international donor community and technical assistance of development partners, involvement of public and private sector stakeholders and wide participation of local and international NGOs, CBOs, FBOs, academia, and civil society at large. In October 2006, the GoA approved its National Strategic Framework for HIV/AIDS (ANASF) for 2006-2010 and thus is moving towards Universal Access for Prevention, Care and Treatment, and Mitigation of the HIV/AIDS epidemic. The Afghanistan National Development Strategy (ANDS) set a five-year goal ***to maintain a low prevalence (<0.5 percent) of HIV in the population and to reduce mortality and morbidity associated with the HIV/AIDS by Jaddi 1389 (end of 2010)***[1]. The key objectives of the ANASF (Box 1) will help the country achieve this goal.

BOX 1: KEY OBJECTIVES OF THE AFGHANISTAN NATIONAL STRATEGIC FRAMEWORK FOR HIV/AIDS (ANASF), 2006-2010

Objective 1: To Strengthen Strategic Information to Guide Policy Formation, Programme Planning and Implementation

Objective 2: To Gain Political Commitment and Mobilize Resources Necessary to Implement the National HIV/AIDS Strategy

Objective 3: To Ensure Development and Coordination of a Multi-Sectoral HIV/AIDS Response and Develop Institutional Capacity of All Sectors Involved

Objective 4: To Raise Public Awareness on HIV/AIDS and STI Prevention and Control, Ensure Universal Access to Behaviour Change Communication on HIV/AIDS, Especially Through Targeting High-Risk Groups and Vulnerable Populations

Objective 5: To Ensure Access to Prevention, Treatment and Care Services for High-Risk Groups and Vulnerable Populations

Objective 6: To Strengthen the Health Sector Capacity to Implement an Essential Package for HIV/AIDS (EPHA) within the Framework of Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS)

II. PROGRAM OPERATIONAL PLAN'S OBJECTIVES AND GOALS

2. The GoA has demonstrated its interest in translating the ANASF into a Program Operational Plan (POP). Accordingly, this POP has been designed as a roadmap for the National HIV/AIDS Control Program of Afghanistan (NACP) to implement the ANASF. The POP has been prepared in close collaboration and participatory consultations conducted in the country with key stakeholders, including: (a) policy makers, such as line ministries of the GoA, donors, and development partners; and (b) service providers, comprised of a wide range of international and local NGOs.[2] Activities proposed within the POP provide a comprehensive framework for the country to build a solid platform to fight the HIV/AIDS. It is desired that HIV/AIDS interventions will be developed and implemented in collaboration with key stakeholders and with a financial support of various donors.

3. The POP is intended to be the main mechanism for achieving the "Three Ones" (*one* agreed HIV/AIDS action framework to coordinate the work of all partners, *one* national HIV/AIDS coordinating authority with a broad-based multi-sectoral mandate, and *one* agreed country-level

[1] Afghanistan National Strategic Framework for HIV/AIDS (2006-2010), NACP, MoPH, October 2006
[2] List of stakeholders consulted is presented in Annex 1

monitoring and evaluation system)[3] and ensuring that external sources of financial and technical support are effectively coordinated and aligned around the country systems. The HIV/AIDS Coordinating Committee of Afghanistan (HACCA) has been recently established (February, 2007) and it is aimed to coordinate HIV/AIDS interventions proposed in the POP. The Afghanistan County Coordination Mechanism (CCM) has also indicated its intention to submit a proposal to the next round (Round 7) of the Global Fund (GFATM) that would be also formulated within the scope of the POP.

4. Specifically, the POP aims to: (i) create an enabling policy and institutional environment in Afghanistan, (ii) build management and technical capacity of the NACP and its implementing partners to launch the HIV/AIDS interventions, and (iii) target various segments of the country's population through customized packages of services of prevention, care and treatment, appropriate for a country of a concentrated epidemic[4]. The POP will help facilitate a successful execution of HIV/AIDS interventions, promote consistency and transparency in the areas of procurement, disbursement, financial reporting, and monitoring and evaluation (M&E) of the program's effectiveness.

III. OVERVIEW OF THE HIV/AIDS IN AFGHANISTAN

5. Afghanistan is among the countries of Central and South Asia that despite the reported low HIV prevalence faces serious threat of HIV/AIDS epidemic mainly due to the high incidence of injecting drug use (IDU) that partially intersects with sex work (SW)[5]. The absence of a surveillance system on HIV/AIDS and STIs, and therefore, current reliance on sporadic and unsystematic data available for some of the high-risk groups makes it difficult to: (a) determine the magnitude of the actual epidemic, (b) understand the dynamics of transmission, and (c) assess the potential for its further diffusion. To date, the officially reported number of HIV cases is believed to be 71, including 18 women and 53 men, detected only at three locations in the country - the Kabul City Central Blood Bank, Kabul and Herat VCCT centers - cumulatively between 1989-2007 among 125,800 persons. UNAIDS and WHO estimate a much higher prevalence of HIV-positive cases in Afghanistan ranging from at least 1,000 to 2,000[6]. It is known only that 24 out of the 71 HIV-positive individuals were injecting drug users (IDUs); no information is available about the remaining cases. This fact suggests a potentially higher prevalence of HIV/AIDS among other segments of the population, contrary to a common belief that IDUs are the only drivers of HIV/AIDS in Afghanistan. It also calls for an immediate action in establishing services for people living with HIV/AIDS (PLWHA).

6. No assessment of social, poverty, or gender determinants of susceptibility of the Afghanistan's population to HIV/AIDS has been conducted yet. However, the best available data indicate that the country exhibits key vulnerability factors that may fuel the HIV epidemic.[7] Almost 29 million people in Afghanistan suffered 25 years of war, conflict, displacement, tremendous human loss, and severe impoverishment. Approximately 7.8 million Afghans spent some time living abroad as refugees, primarily in Pakistan (6.1 million) and partially in Iran (1.7 million). Today, about 2 million widows, 2 million orphans, almost 2 million disabled, over 1.7 million returnees and 500,000 IDPs reside in Afghanistan, while almost 4 million Afghan refugees still live in Pakistan and Iran.

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[3] In April 2004, the UNAIDS co-sponsors, the Global Fund, the World Bank, OECD, and key bilaterals, including the U.K and the U.S.A agreed to endorse the agreement of Three Ones. For further details see: Coordination of National Responses to HIV/AIDS, Guiding Principles and National Authorities and their Partners UNAIDS, 2004

[4] According to the UNAIDS and WHO, *concentrated or low HIV epidemic* is an HIV epidemic in a country where 5 percent or more of individuals in groups with high-risk behavior, but less than 5 percent of women attending urban antenatal clinics, are infected; *generalized HIV* epidemic is an HIV epidemic in a country where 5 percent or more of women attending urban antenatal clinics are infected; and infection rates among individuals in groups with high-risk behavior are also likely to exceed 5 percent.

[5] AIDS in South Asia: Understanding and Responding to a Heterogeneous Epidemic, The World Bank, 2006; UNAIDS, 2006

[6] Afghanistan Epidemiological Fact Sheets on HIV/AIDS and STIs, UNAIDS, 2006

[7] UNAIDS, 2006, UNODC, 2005, ORA International, 2006, Action Aid, 2006

Poverty became extreme for the most part of the country while access to social services, including education, health, and basic infrastructure has substantially deteriorated. There is an indication that as a result, in some instances survival has become sexualized, especially for those who lost their family members to war (widows and orphan children) or were stripped off their social, economic and human rights as they fled the country in the search of a refuge (i.e. refugees in Pakistan). Serious gender and age discrimination, including gender segregation and low mobility of women, trafficking, violence against women, labor and sexual exploitation of girls and children have been also marked. As some of the available data suggest, sex has become a survival commodity while increasing drug dependency, including IDU has become a coping strategy for the physical and physiological trauma faced by some Afghan citizens.

7. Variety of other structural determinants or amplifiers of HIV have been also reported in Afghanistan, such as: (a) limited blood safety, (b) unsafe surgical practices and basic physical care; (c) limited awareness and correct knowledge about HIV/AIDS among the general population; (d) almost no use of preventive measures, including condoms; (e) extreme poverty; (f) high level of illiteracy, especially among women; (g) high prevalence of TB, malaria, Hepatitis A, B, and C in the context of (h) limited health care services and competing health priorities; (i) serious deterioration of key human development indicators. Additionally, lack of income-generating opportunities in the country resulted in a high mobility of population, including: (a) significant out-migration of rural population to urban areas; and (b) male seasonal and long-term migration, largely for the purposes of illegal and/or unregistered migrant work to Pakistan, Iran, and the countries of the Persian Gulf, the countries that exhibit higher HIV/AIDS prevalence rates and more widely available commercial sex and injecting drugs.

8. In the absence of an effective surveillance system and robust prevention programs, the transmission of HIV may become a serious threat among the country's *high-risk groups* also referred to as *groups of high-risk behavior,* such as: (i) injecting drug users (IDUs); (ii) sex workers (SWs), (iii) men who have sex with men (MSM), (iv) prisoners, and (v) sexual partners/clients of these populations. *Vulnerable populations* include: (i) seasonal and long-term migrant workers such as long-distance truck and bus drivers, (ii) mobile populations such as refugees, returnees and internally displaced populations (IDPs), (iii) persons in uniform (police and military). Among *general population,* the following groups are believed to be also particularly prone to the infection: (i) women; (ii) youth; and (iii) street children.

9. Therefore, Afghanistan has expressed its intention to act early through facilitating a rigorous and comprehensive multi-sector response to the HIV/AIDS epidemic and seize an opportunity to (a) prevent its spread within high-risk groups, (b) transmission of the virus to vulnerable groups, and (c) potentially general population while avoiding stigmatization of the high-risk groups and people living with HIV/AIDS (PLWHA).

DRUG USE IN AFGHANISTAN

10. Afghanistan is the world's largest producer of opium and a host to almost 1 million drug users, including 740,000 males, 120,000 females and 60,000 children.[8] Although most of the opium is consumed outside of the country, it is easily available at a relatively low-cost for local consumption, mainly in the major cities and areas where the drugs are produced. A considerable number of the estimated drug users are hashish users (520,000 people), opium uses (150,000 people), heroin users (50,000 people) with 15 percent of those who inject heroin (IDUs) and a significant number of pharmaceutical drugs users (180,000 people) and 200,000 users of combination drugs that are made from cannabis, opium, and solvents.

[8] Afghanistan Drug Use Survey, 2005, UNODC and Ministry of Counter Narcotics (MoNC) of the Islamic Republic of Afghanistan

11. In the country, injecting drug use (IDU) is associated with an intravenous injection of: (a) heroin, (b) pharmaceutical drugs, and (c) tranquilizers and painkillers that are often supplemented with other forms of substance abuse. There are approximately 19,000 IDUs in the country, including 7,000 of those who inject heroin and 12,000 of those who inject pharmaceutical drugs[9]. It is known that at least half of the heroin IDUs share needles, although it is very likely that this number could be much higher.[10] While historically hashish and opium smoking, chewing, or inhaling has been to a certain degree socially tolerated, and opium has been as considered a "household medicine" in some communities, injecting of heroin appeared first among the Afghan refugees in Pakistan and Iran and those who returned home, mainly into the urban areas and frontier provinces of the country. Cities of Kabul, Herat, Gardez, Farah and Jalalabad have become a home to most of the IDUs mainly comprised of adult males who acquired their drug-abusing habits at a much younger age (15 years and younger) and while in exile. Overall, it is believed that social and economic costs of tremendous physical and psychological distress associated with the war and conflict resulted in an increased drug dependency among both men and women (single and poly-drug use), initially reported among refugees, returnees and discharged soldiers.[11]

POSSIBLE INTERSECTIONS BETWEEN IDU, SEX WORK, AND MSM

12. Available data relevant for Kabul City[12]shows that almost all surveyed IDUs share needles and/or syringes with multiple and concurrent users, almost never use condoms and frequently have sex with female SWs, as well as men (MSM) - primarily young men and boys - either for money or drugs. Another recent study in Kabul (2006) among a sample of IDUs (462 persons)[13] showed 3 percent prevalence of HIV. The study also confirmed that IDUs are engaged in high-risk behavior such as (a) receptive and distributive sharing of needles; (b) have high prevalence of Hepatitis C (36 percent), and (c) unprotected sexual activity including women and more so with men (55 percent), predominantly minors; and (d) reported an urgent need for treatment.

13. There are also indications of a number of female IDUs, particularly among the SWs, thus pointing to the intersection of drug use and sex work that has serious implications for further spread of HIV/AIDS mainly to the clients of SWs and sexual partners of the IDUs. The former include long-distance truck drivers, migrant workers, students, police, and military. Women, youth, and children also represent a significant segment of the population that is potentially prone to the infection as they are largely in direct contact with those at risk (IDUs, SWs, MSM, migrant workers, police and the military) and thus are potentially on the "receiving end" of the HIV virus without having knowledge of such risks. Consequently, the possibility of single and multiple intersections within the high-risk groups and further out to the vulnerable populations increases the odds of HIV infection among these populations.

NATIONAL RESPONSE TO HIV/AIDS

14. The national response to HIV/AIDS up-to-date had focused on a number of activities that partially covered areas of: (a) policy, planning and institutional development; (b) HIV/AIDS programming for high-risk groups; (c) IEC awareness campaigns; (d) provision of STI services; (e) establishing linkages between the National TB Program and Reproductive Health; (f) establishing of VCCT centers; (g) blood safety; and (h) harm reduction.

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[9] Data provided by the Ministry of Counter Narcotics(MoNC), 2006
[10] UNODC, 2005, *Ibid*
[11] Afghanistan Drug Use Survey, 2005, *Ibid* and GTZ-IS, Integrated Drug Prevention and Rehabilitation Project in Afghanistan, 2006
[12] Community Drug Profile #5, An Assessment of Problem Drug Use in the Kabul City, UNODC, 2003, Prevalence of HIV, Viral Hepatitis, Syphilis, and Risk Behaviour among Injecting Drug Users in Kabul, Afghanistan, UCSD 2006
[13] UCSD 2006, *Ibid*

15. The key responses to HIV/ AIDS of the *Government of Afghanistan* include the following achievements:

- The MoPH has finalized and approved its National HIV/AIDS Strategic Framework 2006 – 2010 (ANASF) in October 2006
- A new NACP Director has been appointed in September 2006
- The MoPH has initiated the process of the preparation of the Program Operational Plan (POP) for the ANASF in December 2006
- The HIV/AIDS Coordinating Committee of Afghanistan (HACCA) has been established in March 2007
- The MoPH established 6 VCCT centers – Kabul (2), Jalalabad, Mazar-i-Sharif, Faizabad and Herat between 2003-2006
- The MoPH established an STI clinic in Herat
- University of Manitoba (UoM) had launched a study in Kabul, Herat, Jalalabad, and Mazar-i-Sharif among high-risk and vulnerable groups (Social Mapping of High-Risk and Vulnerable Groups) in 2006; the University of California at San Diego (UCSD) had also launched a sero-behavioral study on IDUs and SWs in the same locations in 2006-2007; the results of the studies are expected in May 2007 for UoM study and March 2008 for the UCSD study;
- MoPH had completed a study among TB patients (1,200 persons) in seven provinces, including HIV/AIDS testing; two TB patients were tested positive for HIV
- A Harm Reduction Strategy developed by the MoCN (Ministry of Counter Narcotics) and Drug Reduction Department of the MoPH in 2003
- MoCN has been coordinating joint activities of the MoPH and MoCN by establishing 3 working sub-groups (Prevention; Treatment, and Harm Reduction); and has been supporting Demand and Harm Reduction initiatives in the country in collaboration with the UNODC and GTZ-IS.
- The National Health Communications Policy and Strategy (2004-2007) has been developed by the MoPH includes a specific objective on HIV/AIDS.
- The National TB and Reproductive Health Strategies have integrated HIV/ AIDS into their programming.
- The Ministry of Youth Action Plan 2006 includes a component "Role of Youth Fighting against HIV/AIDS".
- Training of school teachers has been conducted and a draft teacher training module on HIV/AIDS developed.
- The Ministry of Public Health had included HIV/AIDS in the Basic Package of Health Services (BPHS) and EPHS. The BPHS aims to cover 80 percent of the population and is largely delivered by contracted NGOs.
- The MoPH has developed a comprehensive plan for strengthening access to safe blood in the country. As a result, the Blood Safety Program is currently under development with the financial support from the French Cooperation.
- The NACP reported procurement and distribution of 20,000 kits for HIV/ AIDS through the blood banks. First round of training of laboratory technicians, nurses and blood bank staff has also been conducted.

- The MoPH has completed draft National Guidelines on VCCT and trained one staff member on voluntary counseling in Iran; three lab technicians of the VCCT centers have been trained in India
- Twenty-two media workers have been provided training on HIV/AIDS in Kabul City
- The World's AIDS Day had been observed nation-wide since 2003 (annually)
- In selected provinces, the MoPH has initiated reproductive health and HIV/ AIDS activities specifically for out-of–school-youth by establishing youth information centers and youth-friendly services.
- HIV/AIDS agenda has been included in the national education curriculum for 4^{th}-12^{th} grade
- NACP has launched a number of HIV/AIDS awareness campaigns with a help of health workers, religious leaders, and community leaders (the elderly) between 2003-2005
- The World Bank HIV/AIDS Prevention Project is under preparation
- The NACP and CCM submitted the Six-Round Proposal for GFMAT in 2006
- The NACP has started the process of preparation of the seventh round proposal for GFTAM

16. A number of international NGOs and their local counterparts have been also active in reaching out to some of the high-risk populations through peer-education and community outreach programs. They focused in urban areas (Kabul, Herat, Jalalabad, Mazar-i-Sharif) and included: (a) harm reduction programs, e.g. safe needle exchange programs for IDUs –GTZ-IS, Medecins Du Monde, WADAN, Nejat, and Zindagi Naween; (b) HIV/AIDS awareness for IDUs, SWs, MSM, truck drivers, and mobile workers – ORA International, KOR, ActionAid, GTZ-IS, Medecins du Monde, WADAN, and Zindagi Naween. More specifically, the contribution of *international and local NGOs* includes the following:
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- ORA International (Orphans, Refugees and Aid International) had conducted a survey on behavior and practices among high risk and vulnerable populations (SWs, IDUs, truck drivers) in 2005 (Survey of high risk groups in Kabul city) and initiated a small program for sex workers in selected districts of Kabul; ORA International has established of a drop-in centre with counseling and health facilities in Kabul for CSWs, hotel workers, truck drivers, school teachers; it has been also promoting HIV/AIDS awareness and counseling for prisoners (Puli-Charhi Prison and the Governor's House in Kabul), including women prisoners; provides support to community health workers in Kabul.

- KOR (Katiz Organization for Rehabilitation) has been closely collaborating with GTZ-IS in the cities of Kabul and Jalalabad, including training on (a) HIV/AIDS; (b) demand reduction for NGOs and the GoA; KOR had established a resource centre and is considering an opening of a de-toxication center in Badakhshan ; KOR has an HIV testing and counseling center in Kabul city (District 5); and produces a bi-monthly magazine on HIV/AIDS and drugs in Dari and Pashto

- Action Aid has undertaken research into HIV/ AIDS risks among vulnerable groups (truck drivers, SWs, drug users, migrant workers, and returnees in four (4) cities in Afghanistan in 2006; conducted a KABP study among high-risk groups (truck drivers, IDUs, FSWs, refugees, health professionals, students) and collaborated with the University of Manitoba (Canada) and University of California at San Diego (USA) on social mapping if high-risk groups. Action Aid conducted training on (a) basic research, (b) peer-education among mullahs and medical students on HIV/AIDS; and (d) networking and HIV/AIDS advocacy through media

- GTZ-IS- SI (ASIA) in close collaboration with the Ministry of Counter Narcotics (MoCN), UNODC and Drug Reduction Department of the MoPH has been providing advisory services to partner NGOs by building their organizational capacity for the planning and delivery of quality services. GTZ-IS has been promoting HIV/AIDS awareness in the context of the IDU through school-based drug education, drug education at workplace campaigns, and mobile exhibitions. GTZ-IS has launched campaigns to reduce stigma associated with drug use and HIV in a number of communities through training of social multipliers (provision of information to high school teachers, community leaders, religious leaders, police/local authorities) and advocacy for clients' rights for care and support; provided drug education at prisons (40 jail workers and 240 inmates in Herat) and has been implementing safe syringe/needles programs (e.g. 10,000 syringes were distributed in 1,5 month); supported 5 treatment centers for IDUs and other drug addicts; GTZ-SI has been running 5 community based drug prevention, treatment and rehabilitation projects on drug and HIV/AIDS counseling; GTZ-IS is considering to finance a treatment and counseling center in Herat prison; GTZ-IS staff provided support to various local NGOs (SHRO, WADAN, KOR, and Zindagi-Naween) in planning, supervision, documenting, M&E of their activities
- SCA (Swedish Committee for Afghanistan) has been providing assistance to the MoPH, and training of school teachers on HIV/AIDS; SCA staff trained 1,200 people on HIV/AIDS; SCA financed a production of an educational film on HIV/AIDS
- IFRC (International Federation of Red Cross) has a program on STI prevention and is providing syndromic treatment in their clinics as well as training service providers
- ARCS (Afghanistan Red Crescent Society) has been collaborating with the MoE to develop a Memorandum of Understanding (MoU) to reach out to 9,000 students through its awareness program in 2007; more than 38,000 community health volunteers, including 18,000 first aid volunteers for welfare and community development programs throughout rural and urban areas of the country; ARCS has 20,00 youth volunteers
- AMI (Aid Medicale Internationale) has provided HIV testing kits at Maiwand hospital and training of laboratory technicians
- WADAN in collaboration with the UNODC and GTZ-IS has been involved in demand reduction activities; providing awareness training on HIV/AIDS to mullahs and teachers; distribution of syringes; drug treatment, rehabilitation and drop-in center in Herat.
- Colombo Plan has been working closely with the MoCN and Drug Reduction Department of the MoPH in Loghar and Nangrahar provinces participated in awareness training on HIV/AIDS to 25 mullahs, translated of life skills curriculum for students and teachers of the Training Directorate of Afghanistan; established a Teaching and Documentation Center for the MoCN
- Medecins du Monde (MDM) has been working in Kabul city with a number of IDUs (under 100 persons), providing basic medical aid, shelter, food and clothing. MDM is also providing information about risks associated with the drug use and HIV/AIDS.

17. UN agencies have also provided considerable support to the MoPH and the NACP, as a part of the national response to the HIV/AIDS. Specific activities of *the UN agencies* in Afghanistan in this regard include the following:

- UNODC has been providing technical assistance to the MoPH, MoCN and MoE since 2003. The staff of the UNODC had managed programs on drug abuse and rehabilitation of IDUs in six provinces (Balkh, Badakhshan, Kabul, Kandahar, Herat and Nangrahar); financed a drop-in-center for Afghan IDUs and opium dependant returnees from Iran in Ghazni; UNODC had launched motivational courses for IDUs on switching from IDU to chewing, smoking or eating of opium; prevention program in Pouli-Charhi prison in Kabul city, including women, and juveniles; established a clinical lab with the HIV/AIDS testing facility in the Mental Health Hospital in Kabul city; UNODC has been supporting production of IEC materials on HIV/AIDS and IDU; it funded a drug-abuse treatment center together with the ARCS; UNODC has established partnerships with AFRE (Afghanistan Research and Evaluation Group), WADAN, UNHCR, and GTZ-IS.

- UNDP has been providing technical assistance to the MoPH since 2005. The assistance includes (a) procurement of IT equipment, furniture, and a financial support for the operational costs of a resource centre and a prefab office of the NACP; (b) financing of the VCCT in the city of Jalalabad (including renovation of the building, IT and laboratory equipment, and lab consumables); (c) inputs of the preparation of the ANASF and GFMAT Round 6 Proposal. UNDP also supported NACP to launch the HIV/AIDS awareness campaigns for the World AIDS Day (2005-2006); it also financed training costs on the staff of the VCCT centers in Herat and Jalalabad; UNDP provides on-going advisory, technical and programmatic inputs to NACP; and facilitates coordination and networking among HIV/AIDS focal points of the line ministries, UN agencies and NGOs/CBOs working on HIV/AIDS

- UNFPA has been providing technical assistance to the MoPH since 2003. This assistance includes: (a) providing inputs for the ANASF; (b) facilitation of consultations for the preparation of the ANASF; (c) financial support for three VCCT centers; (d) training and condom supply for the VCCTs in Mazar-i-Sharif and Jalalabad; (e) providing financial support for NACP operational costs; (f) coordination and support to NACP on the World's AID Day; (g) collaboration with other departments of MoPH (e.g. Youth Advocacy Department); and (h) HIV/AIDS awareness among young people (in and out of school students)

- UNESCO has been providing technical assistance to the MoPH and MoE since 2003, including (a) supporting the HIV/AIDS Advocacy Project, (b) translating of a HIV/AIDS tool kit into Dari and Pashto; (c) preparing posters and pamphlets on HIV/AIDS; (e) conducting training of trainers (ToT) for teachers on HIV/AIDS; (f) developing a guide for teachers (40 pages) in Dari and Pashto; (g) and supporting HIV/AIDS awareness campaigns through schools. Recently (March 2007), UNESCO formulated a draft outline for the HIV/AIDS Communication Strategy for the NACP.

- UNICEF has been provided technical assistance to the MoPH since 2003, including (a) inputs of the preparation of the ANASF; (b) training, operational costs; and (c) preparation of an outline for a communication strategy on HIV/AIDS;

- UNIFEM has been provided technical assistance to the MoPH, MoCN and MoE since 2003Participation in the World AIDS Day in Herat, Kandahar, Panjsheer, Ghazni, Parwan, and Kapisa

- ILO has been provided technical assistance to the MoPH and Ministry of Labor and Social Affairs (MoLSA) since 2005, including (a) translation of the ILO Code of Practice on HIV/AIDS at Workplace into Dari and Pashto; (b) printing of 1000 copies, ready for dissemination;

- WFP conducted (a) training for truck drivers in Kabul City and (b) launched a food security survey among PLWHA

18. Despite the progress made up-to-date in Afghanistan, there is a need *to scale-up the HIV/AIDS interventions*, through the following:

(a) building a comprehensive harm reduction program for IDUs, including heroin and pharmaceutical IDUs, as well as prisoners who are IDUs,

(b) designing an appropriate community outreach programs for SWs, given the sensitivity of the subject in the country;

(c) designing special programs for vulnerable groups long-distance truck drivers, and migrant workers, refugees, returnees, and IDPs;

(d) develop programs for PLWHA, including nutrition, ART, individual and family support by providing home-based care, treatment, and counseling

(e) designing sound programs for the general population, with a special attention paid to women, youth and street children

19. At the same time, a *comprehensive multi-sector approach* is needed given the current nature of the epidemic that would require an active involvement and support from a number of line ministries, such as MoCN, MoHRA, MoWA, MoE, MoHE, MoJ, MoDLSA, and MoRR, as well as the private sector, civil society, NGOs, CBOs, and religious organizations.

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IV. SUMMARY OF THE PROGRAM OPERATIONAL PLAN

20. The POP has been developed within the overall concept of the ANASF and to ensure maintaining "***a low prevalence (<0.5 percent) of HIV in the population and to reduce mortality and morbidity associated with the HIV/AIDS by Jaddi 1389 (end of 2010)***." The POP includes a detailed description of the Program activities, formulated through six (6) components presented in Box 2. The document provides: (a) detailed description of proposed activities; (ii) inputs, costing, time-line and implementation arrangements required; (iii) procurement plan; (iv) M&E and reporting system, (v) organizational responsibilities, and (vi) funding arrangements.

BOX 2: ELEMENTS OF THE PROGRAM OPERATIONAL PLAN

PART 1: BUILDING AN ENABLING POLICY AND INSTITUTIONAL ENVIRONMENT FOR HIV/AIDS INTERVENTIONS

COMPONENT 1: DEVELOPING NATIONAL HIV/AIDS/STI SURVEILLANCE AND M&E SYSTEMS

COMPONENT 2: ADVOCACY AND POLICY DEVELOPMENT FOR HIV/AIDS INTERVENTIONS

COMPONENT 3: INSTITUTIONAL CAPACITY BUILDING FOR PROGRAM MANAGEMENT

COMPONENT 4: NATIONAL HEALTH SECTOR CAPACITY TO IMPLEMENT HIV/AIDS/STI INTERVENTIONS

PART 2: TARGETED HIV/AIDS INTERVENTIONS

COMPONENT 5: TARGETED INTERVENTIONS FOR HIGH-RISK GROUPS, VULNERABLE POPULATIONS, AND PLWHA

COMPONENT 6: TARGETED INTERVENTIONS FOR GENERAL POPULATION

21. The estimated cost of the proposed POP is 37.1 MLN USD. At the moment, the mobilized funds include 10 MLN USD IDA grant from the World Bank and USD 6.8 million from the French Cooperation.

Table A: Cost Summary of POP Components – 2007-2010 (4 years) - in USD

All Components	Estimated Cost	Mobilized Funds	Source of Funding[14]	Gap in Funding
COMPONENT 1:	3,570,000	1,600,000	WB	1,970,000
COMPONENT 2:	1,510,000	300,000	WB	1,210,000
COMPONENT 3:	2,489,250	2,100,000	WB	389,250
COMPONENT 4:	14,585,200	6,840,000	FC	7,745,000
COMPONENT 5:	14,060,000	5,000,000	WB	9,060,000
COMPONENT 6:	1,000,000	1,000,000	WB	----
TOTAL	**37,124,450**	**16,840,000**	**WB/FC**	**20,374,250**

21. The IDA grant will finance activities proposed under the World Bank HIV/AIDS Prevention Project. The French Cooperation will finance activities within the proposed Blood Bank System Program. The POP will be implemented over a four-year period as a phased operation. Activities proposed in the POP will be launched in the order of priority, including:

- Phase 1 (a) - first 6-months from the start-up of the POP (March 1–September 31, 2007)
- Phase 1 (b) - first year (March 1, 2007- March 21, 2008[15])
- Phase 2 - second year (March 22, 2008- March 21, 2009)
- Phase 3 - third year (March 22, 2009- March 21, 2010)

[14] WB- The World Bank, FC – French Cooperation
[15] In Afghanistan, a fiscal year starts on March 22

- Phase 4 - fourth year (March 22, 2010 – March 21, 2011)

22. The primary implementing agency of the POP will be National AIDS Control Program (NACP) at the Ministry of Public Health (MoPH). A number of line ministries will participate in the activities under various components/sub-components of the POP. The roles and responsibilities of each of the participating ministries and departments will be defined according to agreements reached between the NACP/MoPH and those ministries and formulated in respective memorandums of understanding (MoUs). The preliminary list of participating ministries includes:

- Ministry of Counter Narcotics (MoCN)
- Ministry of Hadj and Religious Affairs (MoHRA)
- Ministry of Interior (MoI)
- Ministry of Justice (MoJ)

23. It is likely that other ministries will also take part in the activities proposed under this POP, including the following:

- Ministry of Defense (MoD)
- Ministry of Women Affairs (MoWA)
- Ministry of Social and Labor Affairs (MoSLA)
- Ministry of Returnees and Refugees (MoRR)
- Ministry of Education (MoE)
- Ministry of Higher Education (MoHE)
- Ministry of Finance (MoF)
- Ministry of Information, Culture and Youth Affairs (MoICYA).

24. Several departments of the MoPH will also get involved in the activities proposed under the POP, including:

- Drug Demand Reduction (DDR)
- Information, Education and Communication (IEC)
- Reproductive Health (RH)
- Youth Health (YH)
- Grants and Contracts Management Unit (GCMU)
- Monitoring and Evaluation (M&E)

25. Local and international NGOs, community-based and religious organizations will participate in the implementation of the activities proposed under the POP as sub-contractors, according to Terms of Reference (TOR) defined for each of the activities. The NACP/MoPH will initiate a competitive selection process (call for proposals) that will include review of: (a) technical and financial proposals of candidates; and (b) relevance of the candidates' qualifications. The contracts will be awarded to those organizations whose technical and financial proposals will meet the criteria set by the NACP/MoPH.

26. All contracts will be executed and managed by the Grants and Contracts Management Unit (GCMU) of the MoPH, under the supervision of the NACP.

27. HIV/AIDS Coordinating Committee of Afghanistan (HACCA) will provide assistance to the NACP by coordinating the effective implementation of the HIV/AIDS interventions within the framework of the POP.[16] HACCA has been formed in March 2007 as a multi-sectoral structure that

[16] Terms of Reference of the HACCA is presented in Annex 2

aims to facilitate a consolidated response to HIV/AIDS via sound partnership between the GoA, local and international NGOs, civil society and development partners. Chaired by the Deputy Minister for Technical Affairs of the MoPH, and represented by a wide range of local and international stakeholders, HACCA is aimed to be a broad-based and effective mechanism of technical oversight to NACP. HACCA would ensure involvement of representatives of all provinces by facilitating information and knowledge sharing, coordination and partnership among all stakeholders. HACCA will provide inputs to the NACP by reviewing the POP implementation on a routine basis (semi-annually and annually), providing assistance for the formulation of a national HIV/AIDS policy, facilitate resource mobilization, foster HIV/AIDS advocacy within the government's structures, as well as among development partners and the donor community.

V. DETAILED DESCRIPTION OF THE PROGRAM OPERATIONAL PLAN

PART 1: BUILDING AN ENABLING POLICY AND INSTITUTIONAL ENVIRONMENT FOR HIV/AIDS INTERVENTIONS

BOX 3: COMPONENTS OF PART 1

COMPONENT 1: DEVELOPING NATIONAL SECOND GENERATION HIV/AIDS/STI SURVEILLANCE AND M&E SYSTEMS
COMPONENT 2: ADVOCACY AND POLICY DEVELOPMENT FOR HIV/AIDS INTERVENTIONS

COMPONENT 3: INSTITUTIONAL CAPACITY FOR PROGRAM MANAGEMENT
COMPONENT 4: NATIONAL HEALTH SYSTEM CAPACITY TO IMPLEMENT HIV/AIDS/STI INTERVENTIONS

28. Afghanistan's policy and institutional environment for the HIV/AIDS response needs substantial improvement. Activities proposed within four components (presented in Box 3) will allow building an enabling policy and institutional environment in the country that is much needed for the successful implementation of HIV/AIDS interventions in Afghanistan. The details of these activities are summarized below and are also presented in a detailed cost-table (See Section XII).

COMPONENT 1: DEVELOPING NATIONAL SECOND GENERATION HIV/AIDS/STI SURVEILLANCE AND M&E SYSTEMS

29. There is a need for Afghanistan to develop a comprehensive surveillance system for HIV/AIDS/STI that will constitute of a second-generation surveillance that is appropriate for countries of low HIV/AIDS prevalence and with an epidemic that is predominantly found in high-risk groups, e.g. injecting drug users (IDUs) or sex workers (SWs)[17]. Therefore, the key objectives of the second-generation surveillance in Afghanistan will be to: (a) monitor trends and emerging pockets of HIV infection among *high risk groups,* and (b) develop a national estimate for HIV prevalence.

30. Overall, establishing the National Second Generation Surveillance System for HIV/AIDS/STI and M&E System to support it will provide quality data much needed on the HIV/AIDS/STI prevalence and behavioral patterns over time (4 years) measured across various geographic areas (8 major cities of the country) and diverse populations (high-risk groups and vulnerable populations) to guide informed decision-making and planning at the national and sub-national levels. It will help establish the early implementation of a strategic information system that will enable evidence-based planning and management of program activities. The initial strategic information system will consist of a minimal set of standardized national indicators, reflecting the programmatic priorities of the NACP and enable overall tracking of the progress of the POP. Key data sources for these indicators will include: (a) the HIV surveillance system, (b) routine program monitoring systems, and (c) implementing unit level service quality assessments. Process monitoring systems for each program area will complement the national M&E framework and will be developed by the lead implementing partners, in conjunction with the NACP M&E officer and respective program area lead.

[17] Initiating Second Generation HIV Surveillance System: Practical Guidelines, UNAIDS, WHO, 2002

SPECIFIC ACTIVITIES OF COMPONENT 1

NATIONAL INDICATORS FOR COMPONENT 1:

- Availability of annual NACP progress reports and action plans based on analysis of surveillance and program monitoring data.
- % of provinces w/ annual mapping and size estimation of high risk groups and especially vulnerable populations.

31. **Sub-Component 1.1: Establishing of a National-Level Logical Framework and Strategic Information System:** This sub-component will support two main activities that aim at building a foundation for the development of the National 2nd Generation HIV/AIDS Surveillance System in Afghanistan. They include: (a) establishing a set of national-level logical framework and strategic information system, (b) establishing a multi-disciplinary technical HIV/AIDS/STI surveillance working group, and (c) developing a strategy and implementation plan for the HIV/AIDS/STI surveillance system.

32. The NACP will benefit from the early implementation of a strategic information system that will enable evidence based planning and management of program activities. The initial system will consist of a minimal set of standardized national indicators, reflecting the programmatic priorities of the POP and enable overall tracking of the progress of the POP. Key data sources for these indicators include the HIV surveillance system, routine program monitoring systems, and implementing unit level service quality assessments. The process monitoring systems for each program area will complement the national M&E framework and will be developed by the lead implementing partners, in conjunction with the NACP M&E officer and respective program area lead.

Table 1: Activities Proposed Under Sub-Component 1.1

Activities of Sub-Component 1.1	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Develop an agreed set of National Indicators for the NACP	National Indicators Developed	NACP M&E officer, International M&E Consultant, and national stakeholders	Nation-wide	March 2007	1 set of indicators
2 Document data sources & flow for the collection of national indicators	Data sources & flow documented	NACP M&E officer, national M& E Consultant to NACP	Nation-wide	Rolling, as program activities are launched	Monthly reports (48 reports)
3. Create standardized data collection/entry formats and data base for the routine monitoring system for each program area	NACP M&E manual and database	NACP M& E Officer, national M& E Consultant to NACP, International M&E Consultant	Nation-wide	March-July 2007	1 M&E manual and 1 database = 2
4. Training of Staff involved in data collection, entry, and Supervision of Routine Monitoring Indicators	Complete and timely routine reports from all implementation units (annually)	NACP M& E Officer, national M& E Consultant to NACP, and International M&E Consultant (at the initial stage)	Nation-wide	Rolling, as program activities are launched	4 Reports
5.Establishing of a system & schedule for annual implementing unit service quality assessments	Completed Service Quality Assessment Reports for all implementation units.	NACP M& E officer, national consultant to NACP	Nation-wide	Annually	4 reports
6. Collection and analysis, and dissemination of national indicator data through reports and regularly scheduled review meetings of NACP stakeholders	Reports of national indicators disseminated to NACP stakeholders and accessible to the public	NACP M& E officer, national consultant to NACP	Nation-wide	Quarterly & Annually	12 quarterly and 4 annual = 16 reports

Sub-Component 1.2: Developing National Second Generation HIV/AIDS Surveillance System

33. Afghanistan National Second Generation Surveillance System for HIV/AIDS/STI will be designed with these considerations and constitute of: (a) periodic sentinel HIV sero-prevalence surveys, (2 rounds within 4 years), (b) behavioral surveillance (studies) conducted among high-risk groups (2 rounds within 4 years), and (c) annual mapping and size estimation of high-risk groups and vulnerable populations (4 rounds within 4 years). The system will be built on the existing routine sentinel sites (6 VCCT centers in the country) through improving their technical and human capacity. The existing capacity and effectiveness of the VCCT centers will be also assessed in order to consider alternatives to the VCCT, if necessary (e.g. blood banks, general diagnostic facilities). HIV/AIDS surveillance system will also benefit from HIV/AIDS/ STIs data provided from other routine reporting system within the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS). Finally, information on the prevalence of Hepatitis B/C, TB and malaria will be also used and integrated within the existing national system of infectious diseases surveillance (IDS) and overall Health Management Information System (HMIS).

34. It is likely that a phased approached for development of the Second Generation Surveillance System for HIV/AIDS/STI will be required. The level of sophistication and coverage (geographical location and size) is expected to expand as national technical capacity and programmatic rapport with high-risk groups grows. Where the existing baseline information does not exist, an implementation plan for gathering a minimal baseline data during the first six months of the Program will be developed. At this stage, the national HIV/AIDS/STI surveillance will target some of the *high-risk groups,* including: (i) IDUs and their sexual partners; (ii) female sex workers (FSW) and their clients; and (ii) prisoners; as well as some of the *vulnerable populations,* including: (i) migrant workers; (ii) long-distance truck/bus drivers; (iii) refugees, returnees and IDPs. *High-risk groups* will be targeted through (a) periodic sentinel HIV sero-prevalence surveys, and behavioral studies, and (b) annual mapping and size estimation.

Table 2: Activities Proposed Under Sub-Component 1.2

Activities of Sub-Component 1.2	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Establishing a Multi-Disciplinary Technical HIV/AIDS/STI Surveillance Working Group (SWG)	Multi-Disciplinary Technical HIV/AIDS/STI Surveillance Working Group (SWG) established	NACP & MoPH		March-April 2007	1 group
2. Developing a Strategy & Implementation Plan for the National 2nd Generation HIV/AIDS/STI Surveillance System	Strategy and Implementation Plan for the National 2nd Generation HIV/AIDS/STI Surveillance System developed	SWG/NACP; MoPH will provide formal approval of the Strategy and Implementation Plan		May-June 2007	1 strategy
3. Induction Training on 2nd Generation HIV/AIDS Surveillance System	Training Course launched	International Consultant, together with NACP, MoPH and WHO	Nation-wide representation	September 2007	1 training course
4. Conducting HIV/AIDS/STI Surveillance Surveys & Behavioral Surveillance Studies	(a) Sentinel HIV Sero-Prevalence Surveillance Surveys among high-risk groups conducted	International/local NGOs	Gradual expansion from 4 major cities to 8 and potentially rural areas	August-December 2007 (1st round); March- October 2009 (2nd round)	2 studies
4. (continues)	(b) KABP Studies among high-risk and vulnerable groups	International/local NGOs		August 2007-August 2008	3 studies
4. (continues)	(c) Poverty, Gender & Social Assessment of HIV/AIDS	International /local NGOs		August 2007-July 2008	1 study
4. (continues)	(d) Mapping and Size Estimation of high-risk groups	International/local NGOs		Annually	3 studies
5. Integration of the HIV/AIDS/STI data into the National System of IDS and HMIS	(a) Report on HIV/AIDS/STI data analysis	NACP, SWG, and NGOs participating in surveillance studies	Nation-wide	Annually	4 reports
5. (continues)	(b) Report Dissemination	NACP, SWG, and NGOs	Nation-wide	Annually	4 reports

	Workshops	participating in surveillance studies			
	(c) Assessing the quality & improving the HIV/AIDS/STI Surveillance Surveys and KABP Studies	NACP M&E staff with assistance from the M&E Department of the MoPH and SWG		Quarterly and annual reports of 4 years as a part of the M&E reports	12 quarterly and 4 annual = 16 reports
	(continues as above)	External M&E specialists (2 persons)		Annual reports of 4 years as a part of the M&E reports	4 reports
5. (continues)	HIV/AIDS/STI data is integrated into IDS and HMIS	NACP, SWG		January 2008-June 2010	

35. **Establishing a Multi-Disciplinary Technical HIV/AIDS/STI Surveillance Working Group (SWG):** The SWG will be established within a period of approximately 2-months and will comprise of key partners involved in HIV/AIDS/STI surveillance (local and international experts) to advise and support the NACP to develop the Second Generation HIV/AIDS Surveillance System. Members of the SWG will be selected by the NACP and HACCA on a competitive basis and according to the specific qualifications required for the implementation of the tasks formulated in Terms of Reference for SWG (Annex 3). The Deputy Minister for Technical Affairs of the MoPH will provide final approval of the SWG membership. The proposed composition of the SWG will include 6 persons: 3 local and 3 international experts, representing NACP, HACCA, and research groups.

36. **Developing of a Strategy and Implementation Plan for the National 2nd Generation HIV/AIDS/STI Surveillance System:** This activity will include an assessment of the existing HIV/AIDS/STI prevalence data, and information of patterns of behavior of high-risk groups The objective of the assessment will be to review data provided from several sources up-to-date including, but not limited to: (a) HIV sero-prevalence and Behavior study by the University of California at San Diego (UCSD); (b) Knowledge, Attitudes, Behavior and Practice Study (KABP) by Action Aid, (c) Situation Assessment and Social Mapping Study by University of Manitoba; and (d) Survey of Groups and High-Risk at Contracting STIs and HIV/AIDS in Kabul by ORA International. The assessment will be consist of a description of (a) the current understanding of the HIV epidemic; (b) current surveillance and research capacity in the country; (c) a gap analysis, and (d) recommendations put forward on the design of the second generation HIV/AIDS/STI surveillance system in Afghanistan given the context of current constraints of infrastructure, technical capacity, and hidden nature of the epidemic. The assessment will also provide a clear division of responsibilities among organizations, institutions, and individuals to be involved in building the HIV/AIDS/STI Surveillance System. The Strategy and Implementation Plan for the National 2nd Generation HIV/AIDS/STI Surveillance System will include: (a) scope of work; (b) surveillance protocols, (c) implementation arrangements; (d) capacity building plan; and (e) M&E framework on how to track and evaluate surveillance activities. An assessment of priority interventions will be used to establish baseline measures of the impact and outcome level indicators as presented in the POP logical framework. Where the existing baseline information does not exist, the SWG will develop an implementation plan for gathering minimal baseline data during the first six months of the POP implementation.

37. **Induction Training on 2nd Generation HIV/AIDS Surveillance System:** This activity will aim at building/strengthening the capacity of the local professionals in developing and implementing HIV/AIDS surveillance by providing knowledge and practical skills development on how to launch surveillance activities. The training course will be based on a curricula developed for the participants who will come from different professional backgrounds and experiences. The training course will include 1 week of intensive, face-to-face workshop sessions (lectures) and 1 week of practical training (case studies based on field and lab work).

38. **Conducting the HIV/AIDS/STI Surveillance Surveys and Behavioral Surveillance Studies among High Risk Groups and Vulnerable Populations:** The activity will include implementation of

periodic sentinel HIV sero-prevalence surveys, and behavioral surveillance (KABP studies) among high-risk groups and vulnerable populations, as well as an assessment of social, poverty and gender determinants of their vulnerability to HIV/AIDS. It will include: (a) 2 rounds (once in 2 years) of sero-prevalence surveys and behavioral studies; (b) a nation-wide social, poverty, and gender assessment; and (c) annual mapping and size estimation studies. It is expected that coverage for this activity will be based on a gradual expansion from 4 major cities to the remaining 4 cities (8 total within 4 years), and potentially selected provinces covering major rural areas.

39. **Integration of the HIV/AIDS/STI data into the National System of Surveillance of Infectious Diseases and HMIS:** This activity will include several tasks that will facilitate collection, analysis, and management of the HIV/AIDS/STI data that will be integrated into the existing National System of Surveillance of Infectious Diseases (IDS) and HMIS. NACP and SWG will be responsible for the coordination of collection and analysis of the HIV/AIDS/STI surveillance data and to ensure its adequate integration into the IDS and the HMIS.

40. **Assessing Quality and On-Going Strengthening of the HIV/AIDS/STI Surveillance Surveys and KABP Studies:** This activity will include a number of important tasks that will allow developing a robust M&E system of the implementation of the surveillance surveys and studies. It will focus on: (a) ensuring sufficient staffing for managing and supervision of surveillance activities; (b) developing budgets and protocols (time-table, implementation and reporting) for conducting quality assurance of the surveillance system to assess the results (quality, gaps and recommendations to improve in the next round of surveillance surveys and KABP studies). In order to accomplish this activity, technical capacity of the NACP (at the national and provincial levels) will be built to operate, monitor and provide supportive supervision of the HIV/AIDS/STI Sentinel and Behavioral surveillance activities, including: (a) hiring of a national consultant to the NACP (M&E specialist); (b) providing training of the new NACP M&E staff by the senior staff of the M&E Department of the MoPH.

COMPONENT 2: ADVOCACY AND POLICY DEVELOPMENT FOR HIV/AIDS INTERVENTIONS

KEY INDICATORS FOR COMPONENT 2:

- # of sectors for which expressions of commitment at national level have been signed and disseminated (presidential, parliamentarians, religious leaders, military officials, media/cultural leaders) by December 2007.

41. **Component 2** will support activities aimed at developing an enabling policy framework for the HIV/AIDS interventions in Afghanistan. They will include: (a) raising HIV/AIDS awareness at the top political and national leadership; (b) providing assistance to NACP to coordinate the HIV/AIDS interventions through establishing an HIV/AIDS Coordinating Committee of Afghanistan (HACCA); and (c) developing key policy documents for HIV/AIDS interventions, such as a national policy on HIV/AIDS and HIV/AIDS communication and advocacy strategy.

42. International experience demonstrates that *commitment of a political and national leadership* is instrumental in the fight against the HIV/AIDS. Some national governments successfully have been the "driving force" behind the fight focusing on the need for laying groundwork for political, religious and community dialogue. Governments, as well as national leaderships that have been consistent over time in their commitment to the HIV/AIDS agenda contributed to a successful response. Maximum use of existing political and social structures can help provide correct information and adequate services to the population.

43. In many countries, the greatest obstacle to HIV/AIDS prevention has been opposition, or even the fear of opposition from religious authorities. Prescribing abstinence and mutual monogamy in the face of overwhelming evidence that there behaviors are not always the norm has been seen worldwide[18]. The fear of offending religious constituencies has created gridlock in some instances. Nevertheless, international experience shows that religious leaders that actively promote family, behavioral and sexual norms can play a significant role in limiting the spread of the HIV.

44. In Afghanistan, like in many Islamic societies, most social activity is organized around religious organizations which can be used as active development partners, including the health and education sectors. Religious organizations, both formal and informal can become important partners in a dialogue between public health officials and communities. It is desired that HIV will be included into the messages conveyed through appropriate channels (e.g. Friday prayers, madrassas) and appropriate language, as well as provide support, compassion and tolerance for PLWHA; and encourage equal access to correct knowledge about HIV/AIDS within most suitable context (e.g. within the madarassas' teaching on sexual and reproductive health). It is expected that strong political and national commitment to HIV/AIDS agenda will be sustained at all levels.

45. *Strategic communication and advocacy* is considered to be a promising tool in the HIV/AIDS response since it combines a series of important elements and is designed to stimulate positive and measurable behavior change[19]. Communication of evidence-based information is critical to any efforts to slow the rate of transmission of the HIV virus and to ensure that PLWHA and their families are treated with respect and in accordance with fundamental human rights. In Afghanistan, developing a communication and advocacy strategy is important for the following reasons: (a) need for community mobilization; (b) need for comprehensive approaches to prevention and the use of communication in reducing stigma and discrimination associated with the HIV/AIDS; (c) need for communication programs tailored to the needs

[18] Acting Early to Prevent AIDS: The Case of Senegal, UNAIDS, 1999
[19] Strategic Communication in the HIV/AIDS Epidemic, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, 2004

and interests of for a wide range of varying audiences including policy makers, national leadership, service providers, high-risk groups, vulnerable populations; (d) the role of communication in support of health/clinical and social services; (e) selection of communication and advocacy approaches with considerable potential including entertainment-education, audio/video and pictorial means, telephone hotlines and digital communication, as applicable.

46. Sub-Component 2.1: Raising HIV/AIDS Awareness at the Top Political, Religious and Military Leadership: This sub-component will focus on mainstreaming HIV/AIDS agenda by increasing awareness of the top political and national leadership (military and religious), including the Office of the President, National Parliament, line ministries dealing with religious affairs, interior and justice. It will also include non-governmental religious leadership that has strong influence at the community level. Activities proposed under this component will aim at sensitizing this stakeholder group on the issues of HIV/AIDS prevention, treatment, care, and reducing stigma and discrimination of high-risk groups and PLWHA, and consequently, facilitating their public expression of commitment. It will provide an opportunity to incorporate the HIV/AIDS into the national development agenda and also support the process of formulation and endorsement of a national policy on HIV/AIDS that will provide basis for protecting the rights of PLWHA.

47. To achieve this task, the NACP will identify two individuals with a strong record of advocacy work and outstanding ability to work with top level political, religious and military leadership. It is recommended that the lobbying at the Office of the President will be a responsibility of the Minister of Pubic Health himself. Other activities will be delegated to a new NACP staff – an advocacy advisor- selected on a competitive basis. The expected deliverables of the described activities will be the provision of formal Expressions of Commitment from the President of Afghanistan (1), religious and military leadership (2, 3), and other influential media individuals in an appropriate format.

Table 3: Activities Under Sub-Component 2.1

Activities of Sub-Component 2.1	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Lobbying the HIV Agenda at the Office of the President	Expression of Commitment from the Office of the President formulated	NACP, MoPH, and relevant HACCA members	Kabul	July 2007 – December 2007	1 document
2.Training for Parliamentarians	Expression of Commitment from the National Parliament formulated	NACP, MoPH, and relevant HACCA members	Kabul	July 2007 – December 2007	1 document
3. Training for Imams and Mullahs	Expression of Commitment from the Religious Leadership formulated	NACP, MoPH, MoHRA, and relevant HACCA members	Nation-wide	July 2007 – December 2007	1 document
4. Training Military Leadership (commanders, staff of the MoJ, MoD, MoI)	Expression of Commitment from the Military Leadership formulated	NACP, MoPH, HACCA members (MoJ, MoI, MoIYCS), UNFPA	Selected provinces	July 2007 – December 2008	1 document
5. Training for Other Influential Individuals (Media Owners, Editors, Journalists, Writers/Poets)	Expression of Commitment formulated	NACP, MoPH, and relevant HACCA members, UNFPA	Nation-wide	July 2007 – December 2008	1 document

48. Sub-Component 2.2: Assistance of the HACCA to NACP to Coordinate HIV/AIDS Interventions: The goal of HACCA is to contribute to effective implementation of HIV/AIDS interventions by providing advisory and coordinating assistance to the NACP. HACCA will also play an instrumental role in (a) coordination, M&E and institutional capacity development of the NACP; and (b) harmonizing and aligning resource mobilization to ensure efficient use of funds that will be made available for the HIV/AIDS interventions from the various donors (international, public and private). In order to achieve this goal, HACCA will develop a resource mobilization strategy (RMS) with specific guidelines and protocols for allocation and utilization of resource to establish/strengthen mechanism to streamline the allocation of such resources. HACCA will be also responsible for reviewing an M&E report of the utilization of resources according to established guidelines and protocols. Bottlenecks in fund flow will be identified by the HACAA and members responsible for coordinating their agencies' role in clearing such bottle necks. To ensure continuity and a smooth functioning HACCA, member agencies will designate specific focal persons to represent the agency at HACCA meetings.

49. HACCA will include representatives of the following agencies: MoPH, MoCN, MoHE, MoE, MoDMLSA, MoF, MoD, MoJ, MoI, MoICYA, MRR, the UN agencies (UNODC, UNDP, UNFPA, UNICEF, UNFEM, UNESCO, WHO, UNHCR), the World Bank, French Cooperation, GTZ-IS, EU, USAID, ACBAR Network, ActionAid, SCA, WADAN, ORA International, KOR, AFGA, Zindagi Naween, Nejat, and Medecins Du Monde. The Chair of HACCA will be the Deputy Minister for Technical Affairs of the MoPH.

Table 4: Activities Proposed Under Sub-Component 2.2

Activities for Sub-Component 2.2	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. HACCA's Assistance to the Implementation of HIV/AIDS Interventions, including:	HACCA established and functional	NACP	Nation-wide	February 2007	1 Committee
1. (continues)	Review of POP	HACCA	Nation-wide	Annually	4 reports
1. (continues)	Resource Mobilization Strategy for POP (RMS)	HACCA	Nation-wide		1 RMS
1. (continues)	Regional representatives Meeting on POP implementation	HACCA	Nation-wide	Semi-annual for 4 years	8 meetings
1. (continues)	Review of M&E Reports section on the utilization of resources for the POP	HACCA	Nation-wide	Annual for 4 years	4 reports

Sub-Component 2.3: Developing Key Policy Documents for HIV/AIDS Interventions

50. This sub-component will include activities that will support preparation of two key policy documents on HIV/AIDS in Afghanistan, such as: (a) national HIV/AIDS Communication and Advocacy Strategy and (b) national policy on HIV/AIDS. Several local and international institutions, as well as individual experts will participate in the preparation of these documents. The NACP will take the lead in coordinating the process; the newly appointed international HIV/AIDS consultant to NACP will be responsible for production of these documents. It is also expected that UNICEF, UNFPA, USAID, UNAIDS will provide assistance to the NACP and Department of Information, Education and Communication (MoPH) in the preparation of the first drafts. Line ministries such as MoHRA, MoE, MoHE, MoWA, will also provide their inputs (peer-review, recommendations) for draft policies. Series of stakeholder consultations will be held during the preparation of the National Policy on HIV/AIDS and the National Communication and Advocacy Strategy. The National Policy on HIV/AIDS will become effective as the MoPH and MoJ approves it. The National Communication and Advocacy Strategy will be approved by the MoPH.

51. **Developing of a National HIV/AIDS Communication and Advocacy Strategy:** This activity will include the preparation of the National HIV/AIDS Communication and Advocacy Strategy by utilizing communication and advocacy methods that are culturally and linguistically appropriate (considering high level of illiteracy, religious sensitivity and lack of conventional media tools) to start-up/scale up information on HIV/AIDS. Communication and Advocacy Strategy will include components that will aim at raising awareness and knowledge about the HIV/AIDS, ways of transmission and prevention, including socioeconomic and gender implications of the epidemic among all key stakeholder groups (target audiences), such as: (a) GoA and the National Parliament; (b) development partners, including UN agencies; (c) private sector; (d) civil society and academia, (e) local NGOs, CBOs, (f) media professionals, institutions and organizations; (g) professional educators; (h) religious and community leaders, (i) a wide spectrum of the beneficiaries, including *high-risk groups, vulnerable populations,* and *general population.*, including those in refugee communities, people receiving formal education; people accessing non-formal education and community

information. The Communication Strategy will integrate four elements: (i) information dissemination, (ii) advocacy, (iii) behavior change communication (BCC), (iv) and education into all policy relating to HIV and AIDS, and into the strategy of the National AIDS Control Program and will be grounded in a rights-based approach to enable access to information, health and education.

52. **Developing of a National HIV/AIDS Policy:** This document will provide a basis for an integration of HIV/AIDS agenda into program management of the GoA, formal and informal education and research curriculum, workplace policies for public, private and civil society organization, as well as create a supportive environment for people living with HIV/AIDS (PLWHA) and reduce stigma against HIV/AIDS, high-risk groups, and PLWHA. The National HIV/AIDS Policy will provide the direction and general principles in the prevention, care and support for PLWHA and their families. It will help address the complex social, ethical, legal, cultural and economic aspects of the HIV/AIDS epidemic and challenges that will emerge over time. The Policy will provide basis for: (a) prevention of transmission HIV/AIDS; (b) HIV testing; (c) treatment and care for PLWHA, (d) sectoral roles and responsibilities, including financing and accountability, (e) legislative and regulatory measures to address legal and ethical issues associated with the HIV/AIDS and those affected by the epidemic (PLWHA and their families) at a community level and society at large.

Table 5: Activities Proposed Under Sub-Component 2.3

Activities for Sub-Component 2.3	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
Developing Key Policy Documents					
1. Developing a National Policy on HIV/AIDS	National Policy on HIV/AIDS formulated and approved	International HIV/AIDS Consultant to NACP, HACCA, NACP/MoPH, MoJ		September 2007	1 Policy
1. (continues)	Stakeholder workshop for the preparation of the National Policy		Nation-wide	April - September 2007	2 workshops
2. Developing a National Communication and Advocacy Strategy on HIV/AIDS	National Communication Strategy on HIV/AIDS formulated and approved	NACP/MoPH, IEC HIV/AIDS/STI Working Group, UNESCO, UNICEF, UNDP, UNFPA		June 2007	1 Strategy
2. (continues)	Stakeholder workshop for the preparation of the Communication and Advocacy Strategy		Nation-wide	April - June 2007	2 workshops
	Dissemination of the National Communication and Advocacy Strategy, including:			September-October 2007	
	(a) Translation into Dari and Pashto				
	(b) Printing				
	(c) shipping/transportation costs				
Developing IEC Material for Target Groups					
3. Developing and/or Expanding IEC material on HIV/AIDS in the context of high-risk behavior, including:			Nation-wide		
(a) IDU	IEC Materials developed	UNODC, UNESCO, selected NGOs, NACP		April - September 2007	X number of IEC materials
(b) SW	IEC Materials developed	NACP, UNESCO, selected NGOs		April - September 2007	X number of IEC materials
(c) Prisons	IEC Materials developed	UNODC, UNESCO,, selected NGOs, NACP		April - September 2007	X number of IEC materials
4. Developing and/or expanding IEC material for vulnerability associated with:	IEC Materials developed				
(a) Migrant work	IEC Materials developed	ILO, UNESCO, NACP, selected NGOs		January -March 2008	X number of IEC materials

(b) Long-distance mobile work	IEC Materials developed	ILO, UNESCO, NACP, selected NGOs		January -March 2008	X number of IEC materials
5. Developing and/or expanding IEC material in the context of conflict and emergency, including:			Nation-wde	January -March 2008	X number of IEC materials
(a) Refugee context	IEC Materials developed	UNHCR, UNESCO, NACP, selected NGOs		April-September 2008	X number of IEC materials
(b) Returnee context	IEC Materials developed	UNHCR, UNESCO, NACP, selected NGOs		April-September 2008	X number of IEC materials
(c) IDP context	IEC Materials developed	UNHCR, UNESCO, NACP, selected NGOs		April-September 2008	X number of IEC materials
6. Developing and/or expanding IEC material on HIV/AIDS and women, including issues of:				April-September 2008	
(a) Reproductive health (b) STIs (c) MTCT	IEC Materials developed	UNESCO, NACP, IEC HIV/AIDS/STI Working Group, MoWA, UNIFEM,UNFPA, UNICEF, selected NGOs		April-September 2008	X number of IEC materials
7. Developing and/or expanding IEC material on HIV/AIDS and youth, including:			Nation-wide	April-September 2008	
(a) Sexual behavior (b) reproductive health of youth and adolescents	IEC Materials developed	UNESCO, NACP, IEC HIV/AIDS/STI Working Group, MoYCS, UNIFEM,UNFPA, UNICEF, selected NGOs		April-September 2008	X number of IEC materials

COMPONENT 3: INSTITUTIONAL CAPACITY BUILDING FOR PROGRAM MANAGEMENT

NATIONAL INDICATORS FOR COMPONENT 3:

- % of contracted/sanctioned implementation units with uninterrupted fund flow and service delivery (by line ministry)
- % of designated implementation units with full complement of proposed staff after 6 months of contracting (by a line ministry)

53. **Component 3** aims to support a number of activities that would allow facilitation of an effective and coordinated response to HIV/AIDS through wide participation of multi-sector stakeholders within the principles of the Three Ones: (i) *one* National HIV/AIDS Strategic Framework: and Plan; (ii) *one* Strong Coordinating Body with a Multi-Sectoral Mandate; and (iii) *one* M&E System. Multi-sector participation in Afghanistan will include vertical and horizontal involvement of public agencies (health and non-health sectors), the private sector, civil society, local and international NGO community, multilateral, bilateral donors and development partners. NACP will be responsible for the facilitation of this multi-sectoral response with the coordinating and advisory assistance of the HACCA. Activities presented below will help achieve this goal.

52. **Sub-Component 3.1: Institutional Capacity Building of the NACP to Coordinate the Multi-Sectoral Response to HIV/AIDS:** This sub-component will support activities that will strengthen program management and capacity building of the NACP through: (a) provision of short-term and long-term consultant technical assistance (TA); (b) financial support for training and other learning activities to the NACP staff (central and provincial level); (c) hiring of national consultants to the NACP; and (d) procurement of additional equipment, supplies for the NACP offices. These activities will build capacity of the NACP to implement, manage, coordinate, and M&E of HIV/AIDS interventions.

Table 6: Activities Proposed Under Sub-Component 3.1

Activities for Sub-Component 3.1	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Assistance to NACP	TA for the Preparation of GFMAT Proposal – Round 7	UNAIDS		March-July 2007	
	TA for Preparation of HIV/AIDS Dictionary	UNIFEM		June- August 2007	
	TA for Preparation of Communication & Advocacy Strategy	UNESCO/UNICEF		April –June 2007	
		UNDP			
		UNFPA			
		UNHCR			
		ILO			
		WFP			
	TA for Preparation of National HIV/AIDS Policy	USAID		June-September 2007	
		SCA			
		GTZ-IS			
2. Distance-Learning for 4 NACP staff on HIV/AIDS from LSTMH	Degrees Earned	NACP, WBI		January 2008-March 2010	4 persons
3.Training Course for the NACP coordinators/officers (34 persons)	Training Course Completed	TBD	Nation-wide	January 2008-September 2008	34 persons
4. Hiring of National Consultants to NACP (6 positions)	National Consultants Hired: (i) Surveillance and M&E Consultant; (ii) IEC Consultant; (iii) Harm Reduction Consultant;	NACP, MoPH	Nation-wide	March-April 2007	7 persons

	(iv) Procurement Consultant; (v) Targeted Interventions Consultant (vi) Accountant				
5. Refurbishing/Establishing NACP regional-level offices and Kabul Office (8 locations)	(a) Equipment and furniture for 8 NACP offices, including:		8 major cities	July 2007-March 2008	8 NACP office established and operational
	Rent				
	Computers				
	Printers/Photocopiers				
	Generators				
	Fuel				
	Other consumables				
	(b) Salaries for 8 regional offices new staff (45 persons)				

54. **Sub-Component 3.2: Developing and Strengthening the Institutional Capacity of Public, Private Sector, and Civil Society Stakeholders on HIV/AIDS:** This task will include interventions aimed at sensitizing and facilitating the involvement of key national stakeholders on the HIV/AIDS, such as: (a) line ministries of the GoA and other public agencies, (b) private businesses; (c) academia and civil society institutions; (d) NGOs, CBOs, and FBOs (mosques and madrassas). The activities under this sub-component will support development of multi-sectoral planning capacity to design appropriate, cost-effective interventions that would target high-risk groups, effect their behavior, promote education and knowledge about HIV/AIDS to the Afghan society at large.

55. The list of participating stakeholders will be as inclusive as possible and represent a wide range of constituencies and various sectors of Afghan society. It is important that private sector and religious organizations are given special attention and not excluded from the HIV/AIDS policy interventions. Also, academia and students of line academic institutions should be invited into the design, implementation, and monitoring of the proposed interventions; they can both provided with technical expertise, as well as contribute their knowledge and skills necessary for the multi-tasked activities that require considerable human capacity, will and commitment. Such approach will be used as an effective mechanism of coordinated and targeted community outreach. This sub-component will provide support to the national stakeholders in the areas of proposal development, program management and implementation, and M&E of performance. It will also allow development of an effective multi-sectoral coordination and partnership building under the mandates of the NACP and HACCA. Sensitization and involvement of public and private sector, and civil society will be achieved through activities presented in a table below.

Table 7: Activities Proposed Under Sub-Component 3.2

Activities for Sub-Component 3.2	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Dissemination of the National Strategic Framework on HIV/AIDS/STI and Program Operational Plan (POP) to Key Stakeholders	ANASF and POP translated into Pashto and Dari	NACP, MoPH (IEC Department)		March-April 2007	4 documents
	ANASF and POP Dissemination Workshops	NACP, MoPH (IEC Department)	Nation-wide	April 2007- May 2007	2 workshop
2. Training on HIV/AIDS for Key Stakeholders (Staff Training)			Nation-wide		
	Training for NGOs/CBOs	NACP		September 2007	2 workshops
	Training for line ministries	NACP, UNAIDS, TBD		October 2007	2 workshops
	Training for private business	NACP, ILO, MoLSA,		November 2007	2 workshops
	Training for Universities	NACP, MoHE		December 2007	2 workshops
	Training for Vocational Institutions	NACP, MoHE		December 2007	2 workshops
	Training for Urban Schools	NACP, MoE		January 2008	2 workshops

	Training for Rural Schools	NACP, MoE		February 2008	2 workshops
	Training for Academia	NACP		March 2008	2 workshops
3. Integration of HIV/AIDS into Workplace Policies	Developing TA	NACP, ILO	Nation-wide	January 2008-March 2010	
4. Streamlining HIV/AIDS into Education, Research & Training Curriculum	Curriculum Developed for Research Institutions	NACP, MoHE, MoE, UNESCO, selected NGOs	Nation-wide		
	Curriculum Developed for Students of Vocational Institutions				
	Curriculum Developed for School Teachers				
	Curriculum Developed for Students (Primary Education)				
	Curriculum Developed for Students (Secondary Education)				
5. Facilitation of Involvement of Staff and Students of Academic Institutions into Operational Research and Activities	Staff and students contracted for specific activities	NACP, MoHE, selected NGOs	Nation-wide		
6. Expanding Participation of Public, Private and Civil Society Organizations in Implementing HIV/AIDS Interventions	Number of organizations contracted for specific activities of the POP	UNESCO, NACP	Nation-wide		
7. Technical Assistance to CBOs/NGOs to Develop Proposals and Access Funding for HIV/AIDS Interventions	Proposals, TORs developed	NACP, UNDP, UNFPA, UNIFEM	Nation-wide		

COMPONENT 4: STRENGTHENING OF THE HEALTH SYSTEM CAPACITY TO IMPLEMENT HIV/AIDS/STI INTERVENTIONS

NATIONAL INDICATORS FOR COMPONENT 4:

- % of transfused blood units screened for HIV
- % of facilities with sufficient supply of infection prevention consumables
- % of facilities where all health care providers and support staff trained to implement infection prevention procedures
- % of provinces with voluntary confidential HIV counseling and testing facilities
- # of persons who voluntarily seek confidential HIV counseling and testing at the existing VCCT centers

56. Given the current low numbers of people who have been diagnosed with or who are aware of their potential risk of HIV infection the priorities of health sector capacity strengthening will consist of (a) reducing the probability of transmission of HIV and other blood borne infections through unsafe medical injections and transfusions; and (b) training health care providers on how to provide sensitive, high quality HIV services for high risk and vulnerable groups. The health sector must be capacitated to respond by increasing access to quality HIV testing and clinical care for PLWHA.

57. Sub-Component 4.1: Building a Safe Blood Bank System and Safe Blood Transfusion: This sub-component will include activities that will target service providers in regards to blood transfusion. Proposed activities will help to build an institutional and technical capacity of the health sector for provision of safe blood transfusion.

Table 8: Activities Proposed Under Sub-Component 4.1

Activities for Sub-Component 4.1	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Finalizing National Guidelines on Safe Blood Transfusion	National Guidelines on Safe Blood Transfusion finalized	MoPH, WHO, French Cooperation, Central Blood Bank	Nation-wide	September 2007	1 document
2. Integration of HIV/AIDS in the National Infection Prevention (IP) Guidelines	HIV/AIDS included in the National Infection Prevention (IP) Guidelines	MoPH, WHO	Nation-wide	October 2007	1 document
3. Training of Medical Personnel of Safe Blood Transfusion	Medical Personnel Trained	MoPH, French Cooperation, Central Blood Bank, WHO, selected NGOs	Nation-wide with first priority given to personnel of facilities with greater volume of patients and transfusions	September 2007- March 2009	7 cycles of training per year for 250 persons
4. Training of medical personnel on the Infection Prevention (IP) Guidelines and Post Exposure Prophylaxis (PEP)	Medical Personnel Trained	MoPH, WHO	Nation-wide	March 2007- March 2010	X number of medical personnel
5. Upgrading/Establishing of 8 Regional branches of the Central Blood Bank (CBB)	8 blood banks upgraded/ established	MoPH, French Cooperation	Nation-wide expanding from 6 regional blood banks to 2 additional regional	March 2007- March 2010	8 blood banks
6. Expansion of medical equipment and consumables for blood safety and infection prevention	Medical equipment and consumables procured	MoPH, French Cooperation	Nation-wide	March 2007- March 2010	X number of consumables for 8 regional banks
5. Screening of blood for HIV/AIDS and STIs	100 percent screening of blood for HIV/AIDS and STIs		Nation-wide	March 2007- March 2010	8 regional banks

58. Sub-Component 4.2: Developing IEC Materials for General Population on Blood Safety, Infection Prevention and Safe Injection Practices: This sub-component will include activities that will target general population. The activities will help raise awareness and correct knowledge of the public in regards to safe blood transfusion and safe medical practices as a whole, including information about the risks and promoting the demand for safe blood transfusion, as well as voluntary blood donation through community health facilities. As the NACP rolls out its Communication and Advocacy Strategy and intervention programs, general population will gain awareness of their risk for HIV through unsafe blood and the importance of preventing blood transfusion and blood transmission infections.

Table 9: Activities Proposed Under Sub-Component 4.2

Activities for Sub-Component 4.2	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Development of IEC Materials for General population on Blood Safety	IEC Materials for general population developed	MoPH, French Cooperation, Central Blood Bank, WHO, UNESCO	Nation-wide	September 2007 – March 2010	IEC Materials (X number of brochures, leaflets, posters)
2. Training of Trainers (TOT) for Dissemination of Safe Blood, IP and Safe Injection Practices	Workshops on Blood Safety launched for selected NGOs	MoPH, French Cooperation, Central Blood Bank, WHO, UNESCO	Nation-wide	September 2007 – March 2010	X number of workshop

59. Sub-Component 4.3: Building National Clinical Expertise on HIV/AIDS and STI: This sub-component will support activities that will provide a solid basis to build national clinical expertise on HIV/AIDS and STI in Afghanistan. The activities will include developing a training course for health care professionals and health workers on: (a) HIV/AIDS Epidemiology; (b) Prevention; (c) Care and Treatment; (d) IEC; (e) Stigma and Discrimination. It is expected that this training course will be launched for a period of 3 months by international and locally available experts on HIV/AIDS. The training course will be based in Kabul city as well as with a short-trip outside of the country to one-two neighboring countries of Central and South Asia for practical training. The course will be designed for both general as well as specialized training for a group of doctors, nurses, medical technicians, pharmacists, etc. and will be tailored to their specific needs.

Table 10: Activities Proposed Under Sub-Component 4.3

Activities for Sub-Component 4.3	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Identification of trainees for training on HIV/AIDS and STI prevention and care within the existing BPHS & EPHS staff	Training of Trainers (1 month cycle)	MoPH, BPHS and EPHS NGOs	Nation-wide	September 2007- October 2007	68 doctors (2 per a province) 34 nurses 34 medical technicians 34 pharmacists = 170 persons
2. Identification and Hiring of HIV/AIDS/ STI Trainers from BPHS and EPHS staff	2 international teaching professors; 2 local specialists	MoPH	International hire Local hire	June 2007- September 2008	2 international professors; 2 local specialists
3. Developing Curriculums on: (a) HIV/AIDS Epidemiology; (b) Prevention; (c) Care and Treatment; (d) EIC; (e) Stigma and Discrimination	Curriculums developed and approved	International and local teaching professors, MoPH		September 2007 – December, 2007	5 curriculums
3. (continues)	Production of HIV/AIDS modules for training program	International and local teaching professors			X number of training modules
3. (continues)	Purchase of teaching materials	NACP			X number of teaching materials
4. Launching of HIV/AIDS Courses		International and local teaching professors	Nation-wide	September 2007 – March 2008 (2 semesters, including practical training)	1 course

60. **Sub-Component 4.4: Development and Expansion of the National Capacity for Quality HIV Testing:** National capacity for HIV testing will require development of both facilities offering quality diagnostic testing for HIV upon health care provider referral, as well as those providing testing in the context of quality pre- and post-test counseling for persons who may be asymptomatic and want to know their HIV status. Many sites will need to offer both types of testing services. National guidelines should address quality standards for both testing scenarios and ensure protection of clients' confidentiality of results in all settings. The operational plan includes (refresher) training for staff of existing and new testing sites. In addition, the MoPH will design and implement an Environmental Management Plan (EMP) that would guide proper handling of wastes in blood banks, VCCTs, and needle/syringe exchange programs. Staff of the facilities of the blood banks, VCCTs and participating NGOs, i.e. those operating within the BPHS and EPHS, will be provided with training on the EMP and its guidelines and necessary materials on proper handling of bio-hazardous wastes.

Table 10: Activities Proposed Under Sub-Component 4.4

Activities for Sub-Component 4.4	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Adoption of Standardized National VCCT and Diagnostic Testing Guidelines	National VCCT and diagnostic testing guidelines finalized	MoPH, VCCT Working Group, NACP	Nation-wide	June 2007	1 document
2. Training of medical personnel of all HIV testing facilities on VCCT and BPHS/EPHS NGOs and diagnostic guidelines	Medical personnel and BPHS/EPHS staff trained	MoPH, WHO	Nation-wide	July 2007 – March 2008	6 Training Workshops
3. Developing and Dissemination of Promotional VCCT material	Promotional VCCT material developed and disseminated	NACP, MoPH, IEC/VCCT Working Groups, participating NGOs	Nation-wide	September 2007- March 2008	X number of materials
4. Developing National Guidelines for Laboratory Diagnosis of Opportunistic Infections and Monitoring of HIV/AIDS Disease Progression	National Guidelines for Laboratory Diagnosis of Opportunistic Infections and Monitoring of HIV/AIDS Disease Progression Developed	NACP, MoPH, WHO	Nation-wide	March 2007 – September 2007	1 document
5. Training of lab personnel on Diagnosis and Monitoring of HIV/AIDS and Associated Opportunistic Infections	Lab personnel trained on a monthly basis for one year	NACP, MoPH, WHO	Nation-wide	March 2008 – September 2008	6 training sessions
6. Strengthening Capacity of Medical Waste Management	(a) Training of medical personnel	MoPH, WHO, MoEnv[20]	Nation-wide	March 2008 – September 2008	6 training sessions
6. (continues)	(b) Training of technicians	MoPH, WHO, MoEnv	Nation-wide	March 2008 – September 2008	6 training sessions
6. (continues)	(c) Training of lab personnel	MoPH, WHO, MoEnv	Nation-wide	March 2008 – September 2008	6 training sessions

61. **Sub-Component 4.5: Coordination of HIV/AIDS/STI and TB Joint Interventions:** This sub-component will help establish mechanisms for collaboration between HIV/AIDS and TB interventions within the existing and potentially future programs of the relevant departments and directorates of the MoPH. It is expected that carrying out joint HIV/AIDS and TB will improve the effectiveness of the diagnosis, prevention, control of HIV/AIDS and TB, as well as provide basis for adequate and timely care and treatment of opportunistic diseases for PLWHA. Overall, this will facilitate TB and HIV patients to have access to comprehensive TB/HIV services.

Table 11: Activities Under Sub-Component 4.5

Activities for Sub-Component 4.5	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Developing National Guidelines on Coordination in the Diagnosis, Prevention and Control of TB and HIV/AIDS	National Guidelines Developed	NACP, MoPH, WHO, BPHS NGOs	Nation-wide	September 2007	1 document
	Training of BPHS NGOs	MoPH, WHO	Nation-wide	March 2008 – September 2008	12 training sessions
2. Screening for TB of the HIV Positive Patients	Screening of 100 percent of diagnosed HIV patients for	NACP, MoPH, WHO, BPHS NGOs	Nation-wide	September 2007 – September	80 percent of TB patients

[20] MoEnv – Ministry of Environment

	TB completed			2010	screened for HIV
3. Screening for HIV among active TB Patients	Screening completed among 50 percent of TB patients	NACP, MoPH, WHO, BPHS NGOs	Nation-wide, starting from major cities	September 2007 – September 2010	100 percent of HIV positive patients identifies screened for TB
4. Establishment of a Home & Community-based Training Program for the Care and Support of HIV/AIDS and TB clients	Home and Community-based Training Program Established	NACP, MoPH, WHO, BPHS NGOs	Nation-wide	March 2007 – March 2010	X number of home-bases programs

PART 2: TARGETED HIV/AIDS INTERVENTIONS

BOX 5: COMPONENTS OF PART 2
COMPONENT 5: TARGETING HIGH-RISK GROUPS, VULNERABLE POPULATIONS, AND PLWHA
COMPONENT 6: TARGETING GENERAL POPULATION

COMPONENT 5: TARGETING HIGH-RISK GROUPS, VULNERABLE POPULATIONS, AND PLWHA

62. Targeted interventions will be designed to address HIV prevention among high-risk groups, vulnerable populations, and PLWHA (priority target groups) to acquiring and/or transmitting HIV. High-risk populations include IDUs, SWs, and prisoners. Adoption of harm reduction practices and safe sexual behaviors will be the primary goal of these priority prevention services. The role of MSM, truckers, and migrants in transmission dynamics in Afghanistan will be explored through early surveillance activities and the need for targeted interventions for these groups will be assessed.

63. Targeted prevention services for the priority target populations will roll-out in a phased manner, based on scaling-up the scope and coverage of the existing interventions launched by a number of agencies, such as UNODC, GTZ-IS, Nejat, WADAN, Colombo Plan, Medecins du Monde, Action Aid, ORA International and others. Those will start in urban areas where large numbers of priority population members are identified through mapping. Regular efforts to map and estimate the size of high risk and especially vulnerable groups will be conducted at the provincial level and be the basis for planning the roll-out of additional sites.

64. For each target population a guideline for the common minimum package of prevention services will be developed to enable NACP to set standards and monitor the quality of the interventions. Based on these guidelines call for proposals (CFP) will be developed and NGOs contracted through a competitive selection process.

65. Early prevention programming for the priority populations will be designed to provide an initial *basic service package of services* via peer-based outreach and distribution of commodities (e.g. needles/syringes, condoms, etc.). Where feasible (i.e. where sufficient numbers of priority population are found, security considerations, etc.), drop-in centers or other safe spaces for congregation will be established to enable meetings of self help and support groups as well as to hold group behavior change communication sessions. These centers will also serve as sites to provide other important clinical services for the priority populations, such as treatment of abscesses and as required STI management. Local advocacy to create an enabling environment for the adoption of harm reduction and safe sex practices will be a part of these services. For the IDU population pilots of drug substitution therapy will be considered (methadone, buprenorphine, opium registration or medical opium)

66. As more numbers of PLWHA are diagnosed, particularly those among marginalized groups, community based care and support services will be provided to ensure services are sensitive and appropriate for the social contexts of these populations, including home-based services

67. Sub-Component 5.1: Providing Customized Packages of Services for IDUs: This sub-component will support a number of activities designed and implemented through peer education and community outreach provided via local and international NGOs and CBOs that have extensive experience in working with IDUs. The proposed activities will target various segments of the IDU population, including heroin and pharmaceutical IDUs, street IDUs, home-based IDUs, women-IDUs, youth and children among them. The activities will be build largely by scaling-up the on-going in the country interventions (e.g. GTZ-IS, UNODC, Medecins du Monde), as well as designing new programs that will suit the varying interests and needs of the IDUs (based on gender, age, degree of addiction, willingness to participate in the activities, etc).

They will include (a) harm reduction services, such as needle/syringe exchange programs, (b) behavior change interventions such as raising awareness and correct knowledge about HIV/AIDS and adoption of safe injecting practice and safe sex; (c) preventive measures, including condom/lubricant distribution; (d) improving access to STI and VCCT services; and (c) piloting of substitution treatment. Special attention will be paid to ensuring confidentiality and equal access to services by the IDUs by focusing on major urban areas and gradually expanding to rural areas, if necessary. Scope and type of interventions that will be also refined as the Program rolls based on the results of the social mapping and size estimation of the IDUs.

Table 12: Activities Proposed Under Sub-Component 5.1

Activities for Sub-Component 5.1	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Syringe/Needle Exchange Programs	Needle/Syringe Exchange Programs Developed	WB, UNODC , MoCN, MoPH, selected NGOs	In urban areas with high concentration of the IDUs – 8 major cities	July 2007-March 2010	X number of syringes/needles distributed
2. Condom/lubricant Distribution Programs	Condom/lubricant Distribution Programs	WB, UNODC, MoCN, MoPH, selected NGOs	In urban areas with high concentration of the IDUs – 8 major cities	July 2007-March 2010	X number of condoms/lubricants distributed
3. Access to STI and VCCT services	(a) Number of IDUs visited STI centers (b) Number of IDUs visited VCCTs	MoCN, MoPH, selected NGOs	In urban areas with high concentration of the IDUs – 8 major cities	July 2007-March 2010	X number of IDUs visited X number of STI centers and VCCTs
4.Raising HIV/AIDS awareness and correct knowledge, including behavior change communication (BCC)	IEC Campaigns launched	UNODC, MoCN, MoPH, selected NGOs	In urban areas with high concentration of the IDUs – 8 major cities	July 2007-March 2010	X number of IEC campaigns launched among X number of IDUs and X number of communities
5. Piloting of Substitution Treatment	Pilot programs launched	WB, UNODC, MoCN, MoPH, selected NGOs	Kabul City and potentially Herat	July 2007-March 2010	2 pilot programs
6. Training for Trainers (TOT) to Carry –Out Services for IDUs	Selected NGOs trained	UNODC, MoCN, MoPH	In urban areas with high concentration of the IDUs – 8 major cities	July 2007-September 2007	X number of NGOs
7. Peer-Education	Peer-education conducted among IDUs	UNODC, MoCN, MoPH		July 2007-March 2008	X number of peer-educators from former IDUs

68. **Sub-Component 5.2: Providing Customized Packages of Services for FSWs and Their Clients:** This sub-component will support a number of activities designed and implemented through peer education and community outreach provided via local and international NGOs and CBOs that have extensive experience in working with female sex workers (FSWs) and with consideration of high sensitivity of the issue of sex work and stigma associates with the occupation. Activities will include (a) condom/lubricant distribution programs, (b) behavior change interventions such as raising awareness and correct knowledge about HIV/AIDS and adoption of safe sex practices; (d) improving access of the FSW to STI and VCCT services, including potentially home-based STI services; and (c) promotion of alternative livelihoods. Special attention will be paid to ensuring confidentiality and equal access to services by the FSWs by focusing on major urban areas (including those along the main transport routes) and gradually expanding to rural areas, if necessary. Social mapping and size estimation will determine the scope and type of interventions that will be refined as the Program rolls.

Table 13: Activities Proposed Under Sub-Component 5.2

Activities for Sub-Component 5.2	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. STI Services	(a) Access to STI centers made available to FSWs (b) Potentially home-based STI services established	MoPH, selected NGOs	In urban areas with high concentration of the SWs – 8 major cities and along the transport routes	July 2007-March 2010	X number of SWs visited STI centers X number of home-based STI services established X number of SWs attended home-based STI services
2. Access to VCCT services	Access to VCCT centers made available to FSWs	MoPH, selected NGOs	In urban areas (6 VCCTs available) and along the transport routes	July 2007-March 2010	X number of SWs visited VCCT centers
3.Raising HIV/AIDS awareness and correct knowledge, including behavior change communication (BCC)	IEC campaigns launched among FSWs	MoPH, selected NGOs	In urban areas with high concentration of the SWs – 8 major cities and along the transport routes	July 2007-March 2010	X number of IEC campaigns launched among FSWs
4. Promotion of Alternative Livelihoods	Life-skills development sessions launched among FSWs	MoPH, selected NGOs	In urban areas with high concentration of the SWs – 8 major cities and along the transport routes	July 2007-March 2010	X number of FSWs reached X number of FSWs changed their profession
5. Condom and Lubricant Distribution	Condoms/lubricants distributed among FSWs	MoPH, selected NGOs	In urban areas with high concentration of the FSWs – 8 major cities and along the transport routes	July 2007-March 2010	X number of condoms/lubricants distributed among X number of FSWs
6. Training for Trainers (TOT) to Carry –Out Services for FSWs	Selected NGOs trained	MoPH, selected NGOs	In urban areas with high concentration of the FSWs – 8 major cities	July 2007-March 2010	X number of NGOs
7. Peer-Education	Peer-education conducted among FSWs	MoPH, selected NGOs		July 2007-March 2010	X number of peer-educators FSWs

69. **Sub-Component 5.3: Providing Customized Packages of Services for Prisoners:** This sub-component will support a number of activities designed and implemented through peer education and community outreach provided with assistance from local and international NGOs and CBOs that have extensive experience in working with prisoners. Activities will include: (a) condom/lubricant distribution programs, (b) raising awareness and correct knowledge about HIV/AIDS, including behavior change communication (BCC); (c) STI and VCCT services; (d) promotion of needle/syringe exchange programs, and (e) safe blood-exchange information campaigns. These activities will be build largely by scaling-up the on-going in the country interventions (GTZ-IS, UNODC, Medecins de Monde), as well as designing new programs that will suit various sub-groups of prisoners (based on age, gender, willingness to participate in the activities, etc).

Table 14: Activities Proposed Under Sub-Component 5.3

Activities for Sub-Component 5.3	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. STI Services	STI services established in prisons	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of STI services established
2. VCCT services	VCCT services established in prisons	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of VCCT services established in X number of prisons;
3.Raising HIV/AIDS awareness and correct knowledge, including behavior change communication (BCC)	IEC campaigns launched	UNODC, MoCN, other selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of IEC campaigns launched in X number of prisons
4. Condom and Lubricant Distribution	Condoms/lubricants distributed in prisons	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of condoms/lubricants distributed in X number of prisons
6. Needle/Syringe exchange Programs	Needle/Syringe exchange Programs launched in prisons	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of needles/syringes distributed in X number of prisons
7. Safe blood-exchange practices information campaigns	Safe blood-exchange practices information campaigns launched in prisons	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of IEC campaigns launched in X number of prisons
8. Training for Trainers (TOT) to Carry –Out Services for Prisoners	Selected NGOs trained	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number prisons/prisoners reached
9. Peer-Education	Peer-education conducted among Prisoners	UNODC, MoCN, MoPH, selected NGOs	Kabul, Herat with gradual expansion to other regional-level and provincial prisons	July 2007-March 2010	X number of peer-educators from prisoners

70. Sub-Component 5.4: Providing Customized Packages of Services for PLWHA: This sub-component will support interventions that will target PLWHA in Afghanistan provided through community outreach and peer-education via local and international NGOs and CBOs that have extensive experience in working with prisoners. Despite the fact that the officially reported cases of HIV are known to be 71 (cumulative between 1989-2007) and only drawn from two locations in the country, no information is available on their current status, location or needs. Therefore, as an initial step, the Program will aim to identifying all of the 71 PLWHA and provide preferably home-based services to them, including (a) raising their awareness about HIV/AIDS, including prevention of mother-to-child-transmission (PMTCT); (b) counseling through support groups and NGOs, (c) procurement of ARV drugs and provision of the ART to the identified PLWHA and potentially their children; (d) distribution of condoms/lubricants. At a policy level, this sub-component will support developing of the National ART Guidelines, and supporting procedures, such as training modules for the medical personnel regarding the provision of care and treatment for PLWHA. The activities will roll as a phased operation and will be fine-tuned as more PLWHA will be identified.

Table 15: Activities Proposed Under Sub-Component 5.4

Activities for Sub-Component 5.4	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1. Identification of all existing PLWHA	Identification assessment	NACP, MoPH, selected NGOs,	Nation-wide	July-December 2007	All PLWHA identified
2. Raising HIV/AIDS awareness and correct knowledge among PLWHA	IEC Campaign	NACP, MoPH, selected NGOs	Nation-wide	July 2007-March 2010	X number of IEC Campaigns launched among X number of PLWHA
3. Provision of ART , including:	ART Program	NACP, MoPH, selected NGOs	Nation-wide		1 Program
(a) Developing ART Guidelines for PLWHA	ART Guidelines Developed	NACP, MoPH, WHO, UNAIDS	Nation-wide	July 2007-March 2008	1 document
(b) Procurement of ARV drugs	ART Procured	NACP, MoPH		September 2007- March 2010	X number of ART purchased for X number of PLWHA
(c)Training of medical personnel on ART	Training completed	NACP, MoPH, WHO	Nation-wide	July 2007-March 2010	
(d) Provision of ART to PLWHA	ART provided	NACP, MoPH, selected NGOs	Nation-wide	July 2007-March 2010	All identified PLWHA receive ART
4. Counseling	Counseling provided	Selected NGOs	Nation-wide	July 2007-March 2010	All identified PLWHA receive counseling
5. Provision of home-based supportive care for PLWHA and their families	Supportive Care Program Developed and Operational	Selected NGOs	Nation-wide	July 2007-March 2010	All identified PLWHA and their families receive supportive care
6. Condom and Lubricant Distribution	Condoms/lubricants distributed among PLWHA	Selected NGOs	Nation-wide	July 2007-March 2010	All identified PLWHA receive condoms/lubricants
6. Training for Trainers (TOT) to Carry –Out Services for PLWHA	Selected NGOs trained	UNODC, MoCN, MoPH	In urban areas with high concentration of the FSWs – 8 major cities	January 2008-March 2010	X number of NGOs
7. Peer-Education	Peer-education conducted among PLWHA	UNODC, MoCN, MoPH	Nation-wide	January 2008 March 2010	X number of peer-educators from PLWHA

71. **Sub-Component 5.5: Providing Customized Packages of Services for Vulnerable Populations:** This sub-component will support interventions targeting vulnerable population, including migrant workers, long-distance mobile workers, refugees, returnees, internally displaced populations (IDPs), as well as uniformed personnel, e.g. military and police. Activities will support a number of activities designed and implemented through peer education and community outreach specifically for each of the sub-groups among the vulnerable population. Activities will include: (a) raising awareness and correct knowledge about HIV/AIDS, including behavior change communication (BCC); (c) encouraging access to STI and VCCT services and/or potentially establishing new STI/VCCT services; and (d) condom/lubricant distribution programs. These activities will be built largely on designing new programs that will suit each of the sub-groups among the vulnerable populations.

Table 16: Activities Proposed Under Sub-Component 5.5

Activities for Sub-Component 5.5	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
Migrant Workers, Long-Distance Mobile Workers, Refugees, Returnees, IDPs					
1. Access to STI Services for:					
(a) Migrant workers	Information about STI services is provided to migrant workers	ILO, NACP/MoPH selected NGOs,	Provinces along transport routes, border provinces	July 2009-March 2010	X number of migrants workers visited STI clinics
(b) Long distance mobile workers	Information about STI services is provided to mobile workers	ILO, NACP/MoPH selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of long-distance mobile workers visited STI clinics
(c) Refugees	Information about STI services is provided to refugees camps	UNHCR, NACP/MoPH, selected NGOs	Selected locations (refugee camps) in Pakistan and Iran	July 2009-March 2010	X number of refugees visited STI clinics
(d) Returnees	Information about STI services is provided to returnees	UNHCR, NACP/MoPH, selected NGOs	Selected provinces at check-points of return and host communities	July 2009-March 2010	X number of returnees visited STI clinics
(e) IDPs	STI Services for IDPs established in IDP camps/communities	UNHCR, NACP/MoPH, selected NGOs	Selected provinces high concentration of IDPs		X number of IDPs visited STI clinics
2. Access to VCCT services for:					
(a) Migrant workers	Information about STI services is provided to migrant workers	ILO, NACP/MoPH, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of migrants workers visited VCCT centers
(b) Long distance mobile workers	Information about STI services is provided to mobile workers	ILO, NACP/MoPH, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of long-distance mobile workers visited VCCT centers
(c) Refugees	Information about STI services is provided to refugees camps	UNHCR, NACP/MoPH, selected NGOs	Selected locations (refugee camps) in Pakistan and Iran	July 2009-March 2010	X number of refugees visited VCCT centers
(d) Returnees	Information about STI services is provided to returnees	UNHCR, NACP/MoPH, selected NGOs	Selected provinces with high concentration of returnees	July 2009-March 2010	X number of returnees visited VCCT centers
(e) IDPs	STI Services for IDPs established in IDP camps/communities	UNHCR, NACP/MoPH, selected NGOs	Selected provinces high concentration of IDPs	July 2009-March 2010	X number of IDPs visited VCCT centers
3.Raising HIV/AIDS awareness and correct knowledge					
(a) Migrant workers	IEC campaigns launched among migrant workers	ILO, NACP/MoPH, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of migrant workers reached
(b) Long distance mobile workers	IEC campaigns launched long-distance mobile workers (truck/ bus, taxi drivers) at main transport routes	ILO, NACP/MoPH, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of mobile workers reached
(c) Refugees	IEC campaigns launched among X number of refugee camps	UNHCR, NACP/MoPH, selected NGOs	Selected locations (refugee camps) in Pakistan and Iran	July 2009-March 2010	X number of refugees in X number of refugee camps reached
(d) Returnees	IEC campaigns launched among X number of	UNHCR, NACP/MoPH, selected NGOs	Selected provinces with	July 2009-March 2010	X number of returnees reached

	communities of returnees		high concentration of returnees		in X provinces
(e) IDPs	IEC campaigns launched among X number of communities of IDPs	UNHCR, NACP/MoPH, selected NGOs	Selected provinces high concentration of IDPs	July 2009-March 2010	X number of IDPs in X number of IDP camps
4. Condom and Lubricant Distribution				July 2009-March 2010	
(a) Migrant workers	Condoms/lubricants distributed among migrant workers	ILO, NACP, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of condoms/lubricant have been distributed among X number migrant workers
(b) Long distance mobile workers	Condoms/lubricants distributed among long-distance mobile workers (truck/ bus, taxi drivers) at main transport routes	ILO, NACP, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of condoms/lubricant have been distributed among X number of mobile workers
(c) Refugees	Condoms/lubricants distributed among X number of refugee camps	UNHCR, NACP, selected NGOs	Selected locations (refugee camps) in Pakistan and Iran	July 2009-March 2010	X number of condoms/lubricant have been distributed among X number of refugees in X number of refugee camps
(d) Returnees	Condoms/lubricants distributed among X number of communities of returnees	UNHCR, UNODC, NACP, selected NGOs	Selected provinces with high concentration of returnees	July 2009-March 2010	X number of condoms/lubricant have been distributed among X number of returnees in X provinces
(e) IDPs	Condoms/lubricants distributed among X number of communities of IDPs	UNHCR, NACP, selected NGOs	Selected provinces high concentration of IDPs	July 2009-March 2010	X number of IDPs in X number of IDP camps reached
5. Training for Trainers (TOT) to Carry –Out Services for:			Provinces along transport routes, border provinces	July 2009-March 2010	
(a) Migrant Workers	Selected NGOs trained	NACP, ILO, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of migrants reached
(b) Long-Distance Mobile Workers	Selected NGOs trained	NACP, ILO, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of long distance workers reached
(c) Refugees	Selected NGOs trained	NACP, UNHCR, selected NGOs	Selected locations (refugee camps) in Pakistan and Iran	July 2009-March 2010	X number of refugees reached
(d) Returnees	Selected NGOs trained	NACP, UNHCR, selected NGOs	Selected provinces with high concentration of returnees	July 2009-March 2010	X number of returnees reached
(e) IDPs	Selected NGOs trained	NACP, UNHCR, selected NGOs	Selected provinces high concentration of IDPs	July 2009-March 2010	X number of IDPs reached
6. Peer-Education					
(a) Migrant Workers	Peer-education conducted among migrant workers	NACP, ILO, selected NGOs	Provinces along transport routes, border	July 2009-March 2010	X number of peer-educators from migrant workers

			provinces		
(b) Long-Distance Mobile Workers	Peer-education conducted among mobile workers	NACP, ILO, selected NGOs	Provinces along transport routes, border provinces	July 2009-March 2010	X number of peer-educators mobile workers
(c) Refugees	Peer-education conducted among refugees	NACP, UNHCR, selected NGOs	Selected locations (refugee camps) in Pakistan and Iran	July 2009-March 2010	X number of peer-educators from refugees
(d) Returnees	Peer-education conducted among returnees	NACP, UNHCR, selected NGOs	Selected provinces with high concentration of returnees	July 2009-March 2010	X number of peer-educators from returnees
(e) IDPs	Peer-education conducted among IDPs	NACP, UNHCR, selected NGOs	Selected provinces high concentration of IDPs	July 2009-March 2010	X number of peer-educators from IDPs
Uniformed Personnel (Police and Military					
1. Encouraging Police and Military to use STI/VCCT Services					
	Policemen/women visited STI clinics	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of policemen/women visited STI clinics
	Policemen/women visited VCCT centers	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of policemen/women visited VCCT centers
	Police schools/academy reached	Selected NGOs ILO,, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of police schools/academy reached
	Military bases reached	Selected NGOs, ILO, MoPH, MoWA, MoD	Nation-wide	July 2009-March 2010	X number of military bases reached
	X number of military schools reached	Selected NGOs, ILO, MoPH, MoD, MoWA, MoHE	Nation-wide	July 2009-March 2010	X number of military schools reached
2.Raising HIV/AIDS awareness and correct knowledge		Selected NGOs, ILO, MoPH, MoI, MoWA		July 2009-March 2010	
	IEC campaigns launched	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	IEC campaigns launched among X number policemen/women
	IEC campaigns launched	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	IEC campaigns launched among X number of military staff
3. Condom and Lubricant Distribution	Condoms and lubricants distributed	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of condoms and lubricants distributed among policemen/women
	Condoms and lubricants distributed	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of condoms and lubricants distributed among military staff
4. Training for Trainers (TOT) to Carry –Out Services for Police and Military	Selected NGOs trained	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of NGOs
5. Peer-Education	Peer-education conducted among policemen/women	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of peer-educators from police
	Peer-education conducted among military	Selected NGOs, ILO, MoPH, MoI, MoWA	Nation-wide	July 2009-March 2010	X number of peer-educators from military

COMPONENT 6: TARGETING GENERAL POPULATION THROUGH RAISING AWARENESS AND KNOWLEDGE ABOUT HIV/AIDS

- % of general population (disaggregated by male and female) who have correct knowledge of routes of HIV transmission
- % of general population (women, youth, and children) who have correct knowledge of routes of HIV transmission
- % of general population who have had an injection in the last 12 months, who insisted on new needles/syringes
- # of communities (disaggregated by location –urban/rural) with correct knowledge of routes of HIV transmission

72. This component will support interventions that are aimed at general population, including (a) raising awareness and correct knowledge about HIV/AIDS and risks associated with it and (b) reducing discrimination and stigma against PLWHA and vulnerable populations.

73. **Sub-Component 6.1: Raising HIV/AIDS Awareness and Correct Knowledge, and Reducing Discrimination of and Stigma Against PLWHA and High-Risk Groups Among General Population:** This sub-component will focus on interventions HIV/AIDS/STI prevention awareness campaign among general population. This task will be guided by the Communication and Advocacy Strategy. The interventions will be designed and launched though community outreach via assistance of local and international NGOs, CBOs and religious organizations (shura, ulema, mosques, madrassas). They will include (a) IEC campaigns providing correct knowledge about HIV/AIDS and risks and vulnerabilities to the virus; (b) encourage access to STI services; (c) information about availability of VCCT centers, (d) condom distribution. This sub-component will be also based on expanding mass media campaigns to improve the social value of and encourage compassion, tolerance and sensitivity for PLWHA and high-risk groups.

Table 17: Activities Proposed Under Sub-Component 6.1

Activities for Component 6.1	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1.Raising HIV/AIDS awareness and correct knowledge among general population					
(a) In urban communities	IEC campaigns launched in 8 major cities	NACP, selected NGOs	8 major cities	July 2008-March 2010	8 major cities
(b) In rural communities	IEC campaigns launched in rural communities	NACP, selected NGOs	Provinces along transport routes, border provinces	July 2008-March 2010	X number of rural communities
2. Raising awareness of general population to reduce discrimination of high-risk groups and PLWHA					
	(a) IEC campaigns launched in 8 major cities	NACP, selected NGOs	8 major cities	July 2008-March 2010	8 major cities
	(b) IEC campaigns launched in rural communities	NACP, selected NGOs	Main provinces	July 2008-March 2010	X number of rural communities in X number of provinces
3. Condom Distribution	Condom distribution launched	NACP, selected NGOs	8 major cities/X number of provinces	July 2008-March 2010	X number of persons received condoms
4. Access to STI Services	Access to STI services made available	NACP, selected NGOs	8 major cities/X number of provinces	July 2008-March 2010	X number of persons visited X number of STI services

5. Access to VCCT Services	IEC campaigns launched in 8 major cities	NACP, selected NGOs	8 major cities	July 2008- March 2010	8 major cities
	Access to VCCT services made available	NACP, selected NGOs	8 major cities/X number of provinces	July 2008- March 2010	X number of persons visited X number of VCCT centers
3. Training for Trainers (TOT) to Carry –Out Services	Selected NGOs trained	MoPH, MoWA, MoD	Nation-wide	September 2009 – December 2009	X number of NGOs
4. Community Outreach	Outreach workers training conducted	Selected NGOs, MoPH, MoWA, UNFPA, UNICEF, UNDP, UNIFEM, UNESCO	Nation-wide	September 2009– December 2009	X number of peer-educators from

74. **Sub-Component 6.2: Raising HIV/AIDS Awareness and Correct Knowledge Among Specific Groups:** This sub-component will support interventions that will target women, youth and children. The interventions will be designed and launched though community outreach via assistance of local and international NGOs, CBOs and religious organizations (mosques, madrassas) working with women, youth and children. They will include (a) IEC campaigns providing correct knowledge about HIV/AIDS and risks and vulnerabilities to the virus; (b) encourage access to STI services; (c) information about availability of VCCT centers, (d) condom distribution among women and youth. These campaigns will be launched among women organizations (gender clubs, RH services), youth organization (youth clubs, sports clubs, schools, colleges), as well as children organizations and schools, as appropriate.

Table 18: Activities Proposed Under Sub-Component 6.2

Activities for Component 6.2	Deliverables	Implementing Partners	Coverage	Timeline	Quantity of Deliverables
1.Raising HIV/AIDS awareness and correct knowledge among specific groups:			Nation-wide	July 2008- March 2010	
(c) women	IEC campaigns launched among women organizations (gender clubs, RH services)	NACP,UNFPA, UNICEF, UNDP, UNIFEM, UNESCO, MoWA, selected NGOs	Nation-wide	July 2008- March 2010	X number of women
(d) youth	IEC campaigns launched among youth organization (youth clubs, sports clubs, schools, colleges)	NACP, UNDP, UNFPA, UNIFEM, UNICEF, MoYCS, MoWA, UNESCO, selected NGOs	Nation-wide	July 2008- March 2010	X number of youth
(d) children	IEC campaigns launched (children organizations, schools)	NACP, UNICEF, UNFPA, UNIFEM, UNESCO, selected NGOs	Nation-wide	July 2008- March 2010	X number of children
2. Raising awareness and inciting the general population to demand infection prevention and safe injection practices	IEC Materials for general population developed and distributed	MoPH, French Cooperation, Central Blood Bank, WHO, selected NGOs/CBOs	Nation-wide	September 2007 – March 2010	IEC Materials (X number of brochures, leaflets, posters)
2. (continues)	Workshops on IP and safe injection launched	MoPH, French Cooperation, Central Blood Bank, WHO, selected NGOs, CBOs	Nation-wide	September 2007 – March 2010	34 provincial workshops
	IEC campaigns launched for CBOs		Nation-wide		X number of campaigns
3. Training for Trainers (TOT) to Carry –Out Services for	Selected NGOs trained (NGO providing services for women, youth and children)	MoPH, MoWA, MoD	Nation-wide	September 2009 – December 2009	X number of NGOs
4. Peer-Education	Peer-education conducted among women	Selected NGOs, MoPH, MoWA, UNFPA, UNICEF, UNDP, UNIFEM, UNESCO	Nation-wide	September 2009– December 2009	X number of peer-educators from women
	Peer-education conducted among youth	Selected NGOs, MoPH, MoWA, MoYCS, UNFPA, UNICEF, UNDP, UNIFEM, UNESCO	Nation-wide	September 2009- December 2009	X number of peer-educators from youth

	Peer-education conducted among children	Selected NGOs, MoPH, MoWA, MoYCS, UNFPA, UNICEF, UNDP, UNIFEM, UNESCO	Nation-wide	September 2009-December 2009	X number of peer-educators from children

VI. PROGRAM IMPLEMENTATION ARRANGEMENTS

IMPLEMENTATION MECHANISM OF THE PROGRAM OPERATIONAL PLAN

75. The primary implementing agency will be National AIDS Control Program (NACP) at the Ministry of Public Health (MoPH). **At the central level**, NACP will have the overall responsibility for program oversight and supervision. The NACP Director will be the Program Manager and will have responsibility for the POP implementation and will be the focal point for coordination of activities.

76. The HIV/AIDS Coordinating Committee for Afghanistan (HACCA) will provide assistance to the NACP for the effective implementation of the HIV/AIDS interventions within the framework of the POP. Chaired by the Deputy Minister for Technical Affairs of the MoPH, and represented by a wide range of local and international stakeholders, HACCA is aimed to be a broad-based and effective mechanism of technical oversight to NACP. HACCA would ensure involvement of representatives of all provinces by facilitating information and knowledge sharing, coordination and partnership among all stakeholders. HACCA will provide inputs to the NACP by reviewing the POP implementation on a routine basis (semi-annually and annually), providing assistance for the formulation of a national HIV/AIDS policy, facilitate resource mobilization and alignment, foster HIV/AIDS advocacy within the government's structures, as well as among development partners and the donor community.

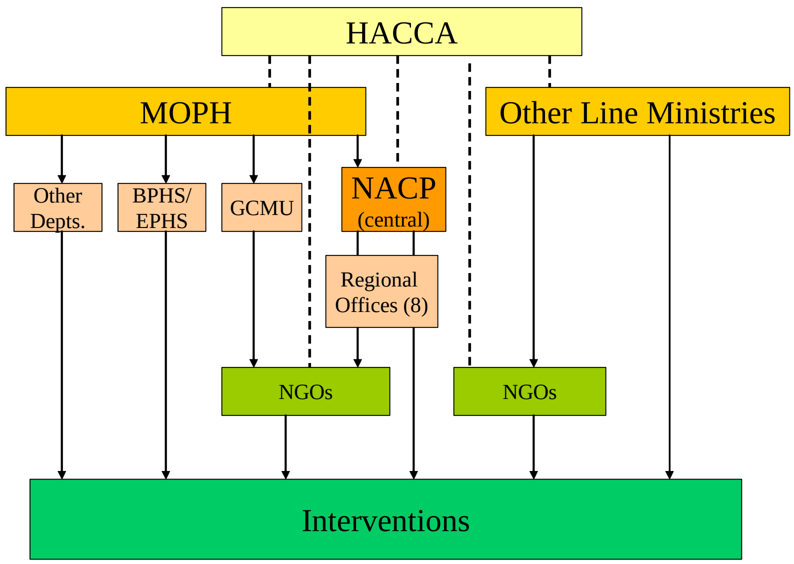
77. **At the provincial level,** NACP regional coordinators (8 persons) and provincial officers (27 persons) will be responsible for ensuring coordination and monitoring of the specific Program activities. Figure 1 illustrates the overall coordination arrangements for the implementation of the POP.

78. A number of line ministries will participate in the implementation of various components/sub-components of the POP, such as Ministry of Counter Narcotics (MoCN), Ministry of Hadj and Religious Affairs (MoHRA), Ministry of Interior (MoI), and Ministry of Justice (MoJ) – **implementing partners**. Other ministries will also participate in activities proposed under this POP. These ministries will include: Ministry of Defense, Ministry of Women Affairs (MoWA), Ministry of Social and Labor Affairs (MoSLA), Ministry of Returnees and Refugees (MoRR), Ministry of Education (MoE), and Ministry of Higher Education (MoHE), Ministry of Finance (MoF), Ministry of Information, Culture and Youth Affairs (MoICYA). Several departments of the MoPH will also participate in the implementation of the POP, including: Department of Drug Demand Reduction, Department of Information, Education and Communication, Department of Reproductive Health, Department of Youth Health, Grant Contract Management Unit (GCMU), and M&E Department - **other participating agencies.**

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

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

FIGURE 1: IMPLEMENTATION ARRANGEMENTS



RESPONSIBILITIES OF IMPLEMENTING AGENCIES AND PARTNERS

81. Local and international entities will be involved during the Program Operation Plan implementation phases as follows:

RESPONSIBILITIES OF THE NACP

82. NACP was established in 2003. The NACP has been coordinating the implementation of the HIV/AIDS interventions its establishment, and will be responsible to coordinate the implementation of the POP. The NACP would be also responsible for administration of the POP, procurement, financial management and for liaison with implementing agencies within and outside the MOPH for all other activities, as well as coordinating M&E of the entire POP.

83. The NACP would (i) ensure coordination between the Program, MoPH, and other agencies; (ii) coordinate the activities of different donors in order to increase the efficient use of resources (iii) maintain program records and prepare regular implementation reports; (iv) prepare terms of reference (TORs) for consultants who would assist Program implementation, and supervise their work; (v) coordinate processing of POP activities, submitted by the implementing partners and participating NGOs; (vi) ensure compliance with the Program Operational Plan; (vii) ensure the executing agencies comply with IDA, the Government, the GFATM and other donor procurement guidelines.

COMPOSITION OF NACP

84. The NACP is headed by a Director and will be composed of the following staff and national/international consultants:

NACP Staff:

- **Director**
- **Surveillance Officer**
- **IEC Officer**
- **Harm Reduction Officer**
- **M&E Officer**

NACP Consultants:

- **International HIV/AIDS Consultant**
- **M&E Consultant (Local)**
- **IEC Consultant (Local)**
- **Harm Reduction Consultant (Local)**
- **Targeted Interventions Consultant (Local)**
- **M&E Consultant (Local)**
- **Accountant (Local)**

BRIEF JOB DESCRIPTION AND RESPONSIBILITIES OF NACP STAFF

85. Full job description of NACP national consultants is presented in Annex 4. This section describes jobs and responsibilities of NACP key staff and local consultants, namely: (a) Director, (b) Surveillance Officer, (c) IEC Officer; (d) Harm Reduction Officer, (e) M&E Officer in regards to the implementation of the POP.

Responsibilities of the NACP Director:

86. NACP Director will be responsible for: (i) representing the MoPH at all donor concerning general arrangements; (ii) supporting the NACP staff on planning and coordinating HIV/AIDS activities; (iii) authorizing and signing contracts for the supply of goods and services required by the Program; (iv) signing disbursement applications as one of two authorized signatories; (v) signing tender documents and evaluation reports and authorize advertisements for procurement of goods and services in accordance with agreed procurement plans; (vii) revise and approve all POP reports for public dissemination; (viii) recruit, evaluate and replace staff whenever will be necessary.

87. The NACP will have an overall responsibility of the implementation of the POP. The NACP staff together with a number of national consultants to the NACP (six positions) made available for the entire program cycle will focus on the monitoring, coordination, quality control and management of various activities proposed by the POP. Specific responsibilities of each of the consultants are presented below.

Responsibilities of the International HIV/AIDS Consultant

88. The international HIV/AIDS consultant will work closely with the NACP manager and report to the Deputy Minister through the Director General for Primary Health Care. He will be responsible for the following:

- Review the current composition and position of the NACP within MoPH and recommend necessary adjustments (changes in NACP structure; skills development, etc.) to ensure strong coordination of NACP both at national and provincial level;

- Assist the NACP in developing a two years operational plan and budget, and in preparing proposals for external partners. Specifically,
  - instruct and assist NACP staff in proposal writing and facilitate relations with donors and external collaborators;
  - assist the NACP in the preparation of possible projects to be funded by the Government and other interested parties;
  - work collaboratively with NACP manager and staff, development partners, the MoPH (including the GCMU) to allocate the NACP budget.
- Assist the NACP in advocacy efforts both at national and provincial level
- In collaboration with NACP staff and other ministries, develop a national policy, protocol, and guidelines for VCCT, HIV reporting, harm reduction and other targeted interventions for high risk groups;
- Develop capacity of NACP central staff with selected training events inside and outside Afghanistan;
- With the assistance of central NACP staff, train regional NACP officers in technical and program management areas required for HIV/AIDS-related activities;
- Support the NACP in selecting NGO partners to execute desired projects..
- Assist the NACP to develop one national M&E system and support the development of the national capacity to sustain the system.
- Assist the NACP in the development of a national HIV/AIDS surveillance system, in collaboration with the senior advisory group and HMIS department of MoPH;
- Liaise with other agencies/institutions involved in surveys, collating results of HIV-related behavioral and prevalence studies within designated high-risk and sentinel groups;
- Assist the NACP to ensure that mapping and KAP studies are carried out among injecting drug users (IDUs), men having sex with men (MSMs), female sex workers (FSWs) and other high risk groups;
- Assist the NACP staff in the development of a national baseline database, integrating inputs from external consulting bodies as needed.

Responsibilities of the M& E and Surveillance Consultant

89. The HIV/AIDS M&E Consultant will be a member of the core technical staff of the NACP and report directly to the NACP Director. She/He will be responsible for directing the coordination of the HIV/AIDS M&E program. She/he will be expected to build on and work with the technical capacity of the participating line ministries and other government entities, NGOs, CBOs, the private sector, PLWHA groups and stakeholders. Other responsibilities of an M&E consultant will include the following tasks:

- Establish a surveillance committee consisting of all stakeholder and partners.
- Developing a detailed action plan for surveillance.
- Developing /adopting appropriate tolls for surveillance (e.g. reporting format).
- Develop adopt standard case definition and treatment protocols and guidelines for HIV/AIDS/STI in collaboration with relevant partners.
- Establish adopt a general strategy for HIV/AIDS surveillance.
- Develop/adopt training material for second generation surveillance.
- Develop a training plan and conduct training on surveillance to the staff members and involved people.
- Establish a sentinel site surveillance system for HIV/AIDS/STI.
- Initiate facilitate and support the design and implementation of sero-prevalence surveys, behavior studies.
- Prepare schedule of activities, mapping and assessments.

- Coordinate all surveillance activities with relevant departments, agencies and institutions.
- Data analysis and feed back to all relevant bodies.
- Collect, analyze and interpret all information from VCCTS and blood banks
- Assist in the establishment of surveillance system in the country
- Assist and monitor all the studies carried out in the field of HIV/AIDS
- Monitor and assist all research activities in the field of HIV/AIDS
- Design a standard reporting system for VCCTs and blood banks
- Collaborate closely with HMIS and M&E departments of MoPH
- Design a standard case detection and reporting protocol
- Facilitate meetings, workshops and trainings in the field of surveillance
- Design M&E Tool kits for Monitoring and Evaluation

Responsibilities of the Harm Reduction Consultant

90. The Harm Reduction Consultant will be a member of the core technical staff of the NACP and report directly to the NACP Director. She/He will be responsible for directing the coordination of the Harm Reduction program. She/He will be expected to build on and work with the technical capacity of the participating line ministries and other government entities, NGOs, CBOs, the private sector, PLWHA groups and stakeholders. Other responsibilities of the Harm Reduction Consultant will include the following tasks:

- Lead the development of an action plan for overall Harm Reduction strategy, which takes into action the activities and action of other participants. On behalf of the NACP, coordinate the strategy and action plan, seeing to its implementation and monitoring;
- Under the direct supervision of NACP Director in collaboration with other donors, participating line ministries and other Government entities, NGOs, CBOs, PLWHA groups, the private sector, and other stakeholders, identify opportunities for incorporating additional resources whether, financial, technical, or programmatic, to carry out the Harm Reduction strategy and action plan;
- Act as the Focal person for all NACP Harm Reduction activities, serving as the Harm Reduction consultant for all Harm Reduction components in Program Operational Plan(POP), liaising with participating line Ministries and other government entities, NGO/CBOs, PLWHA groups, the private sector and other stakeholders involved in HIV/AIDS activities;
- Organize Harm Reduction co-ordination meetings with participating line ministries;
- Provide regular status reports and feedback to the NACP Director and HIV/AIDS Co-Ordination Committee of Afghanistan (HACCA) and prepare the presentation for the annual reviews;
- Outline approaches to facilitate Harm Reduction capacity development with other participants and stakeholders involved in HIV/AIDS activities;
- Continuously identify opportunities to build Harm Reduction capacity of the participating line Ministries other government entities, NGOs, CBOs, PLWHA groups the private sector and other stakeholders involved in HIV/AIDS activities.
- Write reports, proposals, and complete tasks as identified by the NACP Director, with special attention given to the behavioral change components of HIV/AIDS Communication Strategy and POP.
- Undertake any other function directly related to the efficient execution of the Harm Reduction strategy or action plan as directed by the NACP Director.

Responsibilities of the IEC/BCC Consultant

91. The IEC/BCC Consultant will be a member of the core technical staff of the NACP and report directly to the NACP Director. She/he will be responsible for directing the coordination of the IEC/BCC program in particular HIV/AIDS IEC/BCC Communication Strategy. She/he will be expected to build on

and work with the technical capacity of the participating line ministries and other government entities, NGOs, CBOs, the private sector, PLWHA groups and stakeholders.

- Lead the development of an action plan for overall HIV/AIDS IEC/BCC strategy, which takes into action the activities and action of other participants. On behalf of the NACP, coordinate the strategy and action plan, seeing to its implementation and monitoring;
- Under the direct supervision of NACP Director in collaboration with other donors, participating line ministries and other Government entities, NGOs, CBOs, PLWHA groups, the private sector, and other stakeholders, identify opportunities for incorporating additional resources whether, financial, technical, or programmatic, to carry out the HIV/AIDS IEC/BCC strategy and action plan;
- Act as the focal person for all NACP IEC/BCC activities, serving as the IEC/BCC consultant for all IEC/BCC components in Program Operational Plan(POP), liaising with participating line Ministries and other government entities, NGO/CBOs, PLWHA groups, the private sector and other stakeholders involved in HIV/AIDS activities;
- Organize IEC/BCC co-ordination meetings with participating line ministries;
- Provide regular status reports and feedback to the NACP Director and HIV/AIDS Co-Ordination Committee of Afghanistan (HACCA) and prepare the presentation for the annual reviews;
- Outline approaches to facilitate IEC/BCC capacity development with other participants and stakeholders involved in HIV/AIDS activities;
- Continuously identify opportunities to build IEC/BCC capacity of the participating line Ministries other government entities, NGOs, CBOs, PLWHA groups the private sector and other stakeholders involved in HIV/AIDS activities.
- Write reports, proposals, and complete tasks as identified by the NACP Director, with special attention given to the behavioral change components of HIV/AIDS Communication Strategy and POP.
- Undertake any other function directly related to the efficient execution of the NACP IEC/BCC strategy or action plan as directed by the NACP Director.

Responsibilities of the Procurement Consultant:

92. The Procurement Consultant will be a member of the core technical staff of the NACP and report directly to the NACP Director. She/he will be responsible for directing the coordination of the procurement activities. She/he will be expected to build on and work with the technical capacity of the participating line ministries and other government entities, NGOs, CBOs, the private sector, PLWHA groups and stakeholders. Specific responsibilities will also include the following tasks:

- Responsible for all the steps for procurement of goods and consultants services for shared activities;
- Assist procurement manager in his procurement activities and help him in developing reports in agreed format between the NACP/MoPH/GCMU and donors
- Obtain all necessary clearances within the MoPH/GCMU/donor requirements;
- Keep all procurement records in proper order, acceptable to the MoPH/GCMU/donor requirements ;
- Prepare/update an annual procurement plan and training/study tour plan in collaboration with NACP plans and submit to MoPH/GCMU/donors
- Coordinate review and approval of incremental operating costs for contacted NGOs, NACP and receive the payment from MoF
- Monitor procurement activities against the procurement plan and prepare agreed procurement reports as part of GCMU quarterly financial management reports
- Assist the donors staff during procurement post-review missions;

- Contribute to the preparation of project documents, studies and materials for the MoPH/GCMU/donors

Responsibilities of the Accountant Consultant:

93. The Account Consultant will be a member of the core technical staff of the NACP and report directly to the NACP Director. She/he will be responsible for directing the coordination of the procurement activities. She/he will be expected to build on and work with the technical capacity of the participating line ministries and other government entities, NGOs, CBOs, the private sector, PLWHA groups and stakeholders. Specific responsibilities will also include the following tasks:

RESPONSIBILITIES OF THE GCMU

93. All contracts will be executed and managed by the Grants and Contracts Management Unit (GCMU) of the MoPH, under the supervision of the NACP. GCMU will carry out daily financial management operations of the POP, preparation of payment forms, coordination with line ministries, donors, and selected NGOs. GCMU will (i) undertake the financial management of the POP; (ii) operate a management information system (MIS) to track POP processing; (iii) ensure the auditing of the POP accounts and other audits required by IDA, GMAT, the Government and other donors; and (iv) procure and manage independent firms (providers, consultants) to carry out POP activities.

RESPONSIBILITIES OF THE HACCA

94. HIV/AIDS Coordinating Committee of Afghanistan (HACCA) will provide assistance to the NACP by coordinating the effective implementation of the HIV/AIDS interventions within the framework of the POP.[21] HACCA has been formed in March 2007 as a multi-sectoral structure that aims to facilitate a consolidated response to HIV/AIDS via sound partnership between the GoA, local and international NGOs, civil society and development partners. Chaired by the Deputy Minister for Technical Affairs of the MoPH, and represented by a wide range of local and international stakeholders, HACCA is aimed to be a broad-based and effective mechanism of technical oversight to NACP. HACCA would ensure involvement of representatives of all provinces by facilitating information and knowledge sharing, coordination and partnership among all stakeholders. More specifically, HACCA will provide: (a) inputs to the NACP by reviewing the POP implementation on a routine basis (semi-annually and annually); (b) assistance for the formulation of a national HIV/AIDS policy, facilitate resource mobilization, foster HIV/AIDS advocacy within the government's structures, as well as among development partners and the donor community.

[21] Terms of Reference of the HACCA is presented in Annex 2

VII. PROGRAM IMPLEMENTATION PLAN

95. The POP will be implemented over a four-year period as a phased operation (Table 19: Road Map). Activities proposed in the POP will be launched in the order of priority, including:

- Phase 1 - first 6-months from the start-up of the POP cycle (April 2007)
- Phase 1 (cont.) - first year (April 2007- April 2008)
- Phase 2 - second year (May 2008-May 2009)
- Phase 3 - third year (May 2009- May 2010)
- Phase 4 - fourth year (June 2010 – April 2011)

96. The sophistication and coverage of the interventions is expected to start at a simple, most- feasible level (Phase 1) and expand as the national capacity and programmatic rapport with grows (Phase 2). An assessment of priority interventions will be used to establish baseline measures of the impact and outcome level indicators as summarised in the POP road map and presented in further detail in a Program Logical Framework (Table 20).

Table 19: Program Road Map

Component 1 – Developing National HIV/AIDS/STI Surveillance and M& E System
ROADMAP **March 2007- March 2008** • Develop an agreed set of national indicators for the NACP; document data sources and flow for the collection of national indicators • create standardized data collection/entry format for routine monitoring for each program area; analysis and dissemination of national indicators data; induction training of staff on data collection, entry and supervision of routine monitoring indicators • Establish Surveillance Working Group (SWG); develop strategy and implementation plan for surveillance surveys and KABP studies; • Launch first round of sero-prevalence surveys and KABP studies • Integration of HIV/AIDS/STI data into National System of Surveillance of Infectious Diseases and HMIS • Assessing quality and on-going strengthening of the HIV/AIDS/STI Surveys and KABP studies • Social Mapping and Size Estimation of High-Risk Groups • Establish system and schedule for annual implementing unit service quality assessments **April 2008- March 2009** • Assessing quality and on-going strengthening of the HIV/AIDS/STI data • Routine training of staff on data collection, entry and supervision of routine monitoring indicators • Document data sources and flow for the collection of national indicators • Poverty and Gender Assessment of Vulnerability to HIV/AIDS • Analysis and dissemination of national indicators data • Social Mapping and Size Estimation of High-Risk Groups **April 2009 – March 2010** • Launch second round of sero-prevalence surveys and KABP studies • Integration of HIV/AIDS/STI data into National System of Surveillance of Infectious Diseases and HMIS • Assessing quality and on-going strengthening of the HIV/AIDS/STI Surveys and KABP studies • Routine training of staff on data collection, entry and supervision of routine monitoring indicators • Document data sources and flow for the collection of national indicators • Analysis and dissemination of national indicators data • Social Mapping and Size Estimation of High-Risk Groups **April 2010 – March 2011** • Integration of HIV/AIDS/STI data into National System of Surveillance of Infectious Diseases and HMIS • Assessing quality and on-going strengthening of the HIV/AIDS/STI data • Document data sources and flow for the collection of national indicators • Analysis and dissemination of national indicators data • Social Mapping and Size Estimation of High-Risk Groups

Component 2 – Advocacy and Policy Development for HIV/AIDS Interventions
ROADMAP **March 2007- September 2007** • Establish HACCA • Develop National HIV/AIDS Policy • Develop National HIV/AIDS Communication and Advocacy Policy • Develop IEC Material for all target audiences **October 2007 – March 2008** • Lobbying the HIV/AIDS Agenda at the Office of the President and the National Parliament • Training for the Parliamentarians • Training for Mullahs • Training for Military Leadership • Training for Media, Journalists, Writers, Poets

Component 3 – Institutional Capacity Building for Program Management
ROADMAP **March 2007- March 2008** • Hiring of 7 national consultants to NACP • Hiring of an international HIV/AIDS consultant to NACP • Training Course for all NACP staff (central office and 8 regional-level offices, and provincial level HIV/AIDS officers) • Distance Learning for NACP staff; • Refurbishing and establishing NACP 8 regional-level offices • Hiring of staff for 8 regional-level NACP offices **April 2008- March 2009** • Training for NGOs/CBOs • Training for line ministries • Training for private sector • Training for universities • Training for vocational schools

- Training for urban schools
- Integration of HIV/AIDS into workplace policies
- Technical assistance for NGOs, CBOs to develop proposals for HIV/AIDS interventions

April 2009 – March 2010

- Training for universities
- Training for vocational schools
- Training for rural schools
- Integration of HIV/AIDS into workplace policies
- Technical assistance for NGOs, CBOs to develop proposals for HIV/AIDS interventions

April 2010 – March 2011

- Technical assistance for NGOs, CBOs to develop proposals for HIV/AIDS interventions

Component 4 – National Health Sector Capacity Building

ROADMAP

March 2007- March 2008

- Integration of HIV/AIDS into National Guidelines on Safe Blood Transfusion
- Integration of HIV/AIDS into National Guidelines on Infection Prevention (IP)
- Training of medical and lab personnel on blood safety and HIV/AIDS quality testing,
- Upgrading/Establishing of 8 regional-level branches of Central Blood Bank
- Expansion of medical equipment and consumables for 8 regional-level blood banks
- Screening of blood for HIV/AIDS/STIs
- Build national clinical expertise for HIV/AIDS/STI, diagnosis and treatment of opportunistic infections (150 persons) within the BPHS and EPHS

April 2008- March 2009

- Routine training of medical and lab personnel on blood safety and HIV/AIDS quality testing
- Routine training of medical and lab personnel on IP and Post-Exposure Prophylaxis (PEP)
- Upgrading/Establishing of 8 regional-level branches of Central Blood Bank
- Expansion of medical equipment and consumables for 8 regional-level blood banks
- Screening of blood for HIV/AIDS/STIs
- Build national clinical expertise for HIV/AIDS/STI, diagnosis and treatment of opportunistic infections (150 persons) within the existing BPHS and EPHS
- Develop national capacity for medical waste management
- Coordinate HIV/AIDS and TB joint interventions (screening of TB/HIV/AIDS patients)

April 2009 – March 2010

- Routine training of medical and lab personnel on blood safety and HIV/AIDS quality testing
- Routine training of medical and lab personnel on IP and Post-Exposure Prophylaxis (PEP)
- Upgrading/Establishing of 8 regional-level branches of Central Blood Bank
- Expansion of medical equipment and consumables for 8 regional-level blood banks
- Screening of blood for HIV/AIDS/STIs
- Build national clinical expertise for HIV/AIDS/STI, diagnosis and treatment of opportunistic infections (150 persons) within the existing BPHS and EPHS
- Develop national capacity for medical waste management
- Coordinate HIV/AIDS and TB joint interventions (screening of TB/HIV/AIDS patients)

April 2010 – March 2011

- Routine training of medical and lab personnel on blood safety and HIV/AIDS quality testing
- Routine training of medical and lab personnel on IP and Post-Exposure Prophylaxis (PEP)
- Upgrading/Establishing of 8 regional-level branches of Central Blood Bank
- Screening of blood for HIV/AIDS/STIs
- Build national clinical expertise for HIV/AIDS/STI, diagnosis and treatment of opportunistic infections (150 persons) within the existing BPHS and EPHS
- Develop national capacity for medical waste management
- Coordinate HIV/AIDS and TB joint interventions (screening of TB/HIV/AIDS patients)

Component 5 – Targeted Interventions for High-Risk Groups, Vulnerable Populations and PLWHA

ROADMAP

March 2007- March 2008

- Syringe/Needle Exchange Programs for IDUs, Prisoners
- Awareness Campaigns for high-risk groups and vulnerable populations, PLWHA
- Condom/Lubricant Distribution among high-risk groups and vulnerable populations, PLWHA
- Piloting of Substitution Therapy for IDUs
- Access to VCCT/STI services for high-risk groups and vulnerable populations, PLWHA
- Provision of ART for PLWHA
- Provision of supportive care for PLWHA and their families

April 2008- March 2009

- Syringe/Needle Exchange Programs
- Awareness Campaigns for high-risk groups and vulnerable populations, PLWHA

- Condom/Lubricant Distribution among high-risk groups and vulnerable populations, PLWHA
- Piloting of Substitution Therapy for IDUs
- Access to VCCT/STI services for high-risk groups and vulnerable populations, PLWHA
- Promotion of Alternative Livelihoods for FSW
- Provision of ART for PLWHA
- Provision of supportive care for PLWHA and their families

April 2009 – March 2010

- Syringe/Needle Exchange Programs
- Awareness Campaigns for high-risk groups and vulnerable populations, PLWHA
- Condom/Lubricant Distribution among high-risk groups and vulnerable populations, PLWHA
- Piloting of Substitution Therapy for IDUs
- Access to VCCT/STI services for high-risk groups and vulnerable populations, PLWHA
- Promotion of Alternative Livelihoods for FSW
- Provision of ART for PLWHA
- Provision of supportive care for PLWHA and their families

April 2010 – March 2011

- Syringe/Needle Exchange Programs
- Awareness Campaigns for high-risk groups and vulnerable populations, PLWHA
- Condom/Lubricant Distribution among high-risk groups and vulnerable populations, PLWHA
- Piloting of Substitution Therapy for IDUs
- Access to VCCT/STI services for high-risk groups and vulnerable populations, PLWHA
- Promotion of Alternative Livelihoods for FSW
- Provision of ART for PLWHA
- Provision of supportive care for PLWHA and their families

Component 6 – Targeted Interventions for General Population
ROADMAP **April 2008- March 2009** • Raising Awareness and Correct Knowledge about HIV/AIDS in urban communities • Raising Awareness of IP and incite to demand IP and safe blood transfusion • Raising Compassion, Tolerance and Acceptance of PLWHA and high-risk groups • Facilitate Access to STI services and VCCT centers • Condom/lubricant distribution **April 2009 – March 2010** • Raising Awareness and Correct Knowledge about HIV/AIDS in rural communities • Raising Awareness of IP and incite to demand IP and safe blood transfusion • Raising Compassion, Tolerance and Acceptance of PLWHA and high-risk groups • Facilitate Access to STI services and VCCT centers • Condom/lubricant distribution **April 2010 – March 2011** • Raising Awareness and Correct Knowledge about HIV/AIDS among women, youth and children • Raising Awareness of IP and incite to demand IP and safe blood transfusion • Raising Compassion, Tolerance and Acceptance of PLWHA and high-risk groups • Facilitate Access to STI services and VCCT centers • Condom/lubricant distribution

Table 20: Program Logical Framework

Narrative Summary	Key Performance (Measurable) Indicators	Data Source/ Means of verification	Frequency of review/reporting	Baseline (2007/2008)	Comments
GOAL Contain the spread of the HIV epidemic among the general population and vulnerable groups.	1. <0.5% overall in the country in 2010;	Modeling based on workbook method	Annual		Requires all available sero-prevalence data and behavioral survey data in high risk and especially vulnerable groups
	2. <5% among high risk and vulnerable groups in 2010 • IDU • FSW ----- (to be decided by SWG) • MSM (including MSW) • Truckers & transport industry • Prisoners?	Sero-prevalence surveys and data from selected sentinel surveillance sites	Community prevalence surveys twice during NACP; sentinel sites annually	(2006 HIV sero prevalence survey of HRG by UCSD; Note: may not be representative sampling)	Specific sampling design of surveys and selection of sites to be determined by the Surveillance Working Group
PROJECT DEVELOPMENT OBJECTIVE I. Develop capacity to offer comprehensive care, treatment and support services to persons w/ HIV/AIDS	1. % of contracted/ sanctioned implementation units w/ uninterrupted fund flow and service delivery (by line ministry) (UNGASS)	Financial management system	Annual		
	2. % of designated implementation units w/ full complement of proposed staff within 6 months of contracts (by line ministry)	Financial management system and NGO reports	Annual		Specific staff positions to be defined by each program area
II. Provide customized packages of prevention services for all persons engaged or vulnerable to engagement in high risk behaviour.	3. % of members of high risk and vulnerable groups who have correct knowledge of routes of HIV transmission (UNGASS) • IDU • FSW ---(to be decided by SWG) • MSM (including MSW) • Truckers and transport industry • Prisoners	Behavioral surveys of probability samples of selected groups	Annual*	2005 KAP by Action AID (convenience sampling): IDU – 49%	*Specific sampling design of surveys to be determined by the Surveillance Working Group. Feasibility of probability samples to be considered. KAP data are not for specific indicator, but for similar item on questionnaire.

Narrative Summary	Key Performance (Measurable) Indicators	Data Source/ Means of verification	Frequency of review/reporting	Baseline (2007/2008)	Comments
	4. % of members of selected groups who engage in key risk behaviors (UNGASS) • (for IDU) avoid sharing needles and/or syringes in the last 12 months • (for IDU) consistent condom use with any sex partner last 12 months • (for FSW, MSM, Truckers, prisoners) last time condom use during sex w/ commercial sex partner/ non-regular partner	Behavioral surveys of probability samples of selected groups	Annual*	2005 KAP by Action AID: Needle sharing: 8% ever shared Willing to use condoms: IDU – 83%; Truckers – 25% used at last time w/CSW	Specific sampling design of surveys to be determined by the Surveillance Working Group. KAP data are not for specific indicator or population, but for similar item
	5. % of general population who have correct knowledge of routes of HIV transmission (males and females separately)	Behavioral surveys of probability samples of the general population	Twice during NACP (baseline and endline) Twice during	2005 KAP by Action AID (convenience sampling): 95%	*Specific sampling design of surveys to be determined by the Surveillance Working Group. Potential source of baseline data: NVRA 2005 & 2007 KAP data are not for specific indicator, but for similar item on questionnaire
	6. % of general population who had medical injections or blood transfusions in the last month who requested/ received new needles/syringes.	Behavioral surveys of probability samples of general population or health facility survey			
	7. % of general population who express attitudes of stigma and discrimination against PLWHA and/or marginalized groups	Behavioral surveys of probability samples of general population		2005 KAP by Action AID: 35% not live in the same house.	
PROJECT COMPONENTS **COMPONENT 1:** Developing the national second generation HIV/AIDS surveillance system	1. Annual NACP progress reports and action plans based on analysis of surveillance & monitoring data	Availability of said report	Annual		
	2. % of provinces w/ annual mapping and size estimation of high risk groups and especially vulnerable populations	Availability of reports	Annual		Regional or central offices to be responsible for mapping of cross-province/border mobile populations); Geographic scope to be defined by the SWG.

Narrative Summary	Key Performance (Measurable) Indicators	Data Source/ Means of verification	Frequency of review/reporting	Baseline (2007/2008)	Comments
COMPONENT 2: Advocacy and policy development for HIV/AIDS	(see Project Development Objective Measures 1 & 2)				May also consider explicit measure of political commitment, or info & positive attitudes about HIV/AIDS to general public by political and community leaders.
	3. # of sectors for which expressions of commitment at national level have been signed and disseminated (presidential, parliamentarians, religious leaders, military officials, media/cultural leaders) by December 2007.	Public documents articulating support of HIV/AIDS programs or importance of addressing this issue	By December 2007		If December 2007 is not meant, indicator will track period of time until a particular sector lends its support to the NACP.
COMPONENT 3: Institutional Capacity Building for Program Management	(see Project Development Objective Measures 1 &2)				
COMPONENT 4: Strengthening to the National Health System Capacity to Implement HIV/AIDS Interventions	(see Project Development Objective Measures 1 & 2)				
	4. % of transfused blood units screened for HIV (syphilis, and hepatitis)	Facility-based routine monitoring data; Verify through annual facility survey	Monthly		Denominator should include all transfused blood units in the country. Proposed to be included in BPHS/EPHS reporting.
COMPONENT 4. (cont.)	5. % of BPHS/EPHS facilities w/ sufficient supply of infection prevention consumables.	Facility-based routine monitoring data	Quarterly		To be assessed based on patient volume vs. stock records of consumables.
	6. % of facilities w/ health care providers and support staff trained to implement infection prevention procedures	Training records	Annually		
	7. % of provinces with voluntary confidential HIV counseling and testing facilities	Facility-based routine monitoring data	Annually		
	8. # of persons who voluntarily seek confidential HIV counseling and testing (males and females separately)	Facility-based routine monitoring data	Monthly		

Narrative Summary	Key Performance (Measurable) Indicators	Data Source/ Means of verification	Frequency of review/reporting	Baseline (2007/2008)	Comments
	9. % of implementing units achieving satisfactory quality service standards. • VCCT • Blood Bank • TB/HIV • Infection Prevention	Service quality assessment reports from facility survey/site visit	Annually		Specific quality standards defined in each program area guideline. Assessment to be conducted by lead agency for that program area. Some quality issues to be assessed through BPHS/EPHS balanced score card system.
COMPONENT 5: Targeting High-risk Groups, Vulnerable Populations, and PLWHA	10. % of mapped high risk and especially vulnerable groups covered by outreach services of targeted intervention (UNGASS)	NGO routine monitoring reports	Monthly		Denominator will be limited to the geographic areas where programs are planned during any given reported period.
	11. % of implementation sites with 80% outreach coverage of high risk and especially vulnerable groups	NGO routine monitoring reports	Monthly		Unit of sites to be defined by implementation contract unit.
	(See Project Component 4. Indicator 9 on service quality assessments) • Targeted interventions for each risk group	Service quality assessment reports from facility survey/site visit	Annually		
COMPONENT 6: Targeting General Population	(see Project Development Objective Key Measures 5,6, & 7)				Output level indicators not required at national level.

VIII. PROGRAM FINANCING MANAGEMENT, DISBURSEMENT, AUDIT ING AND REPORTING

97. Financial management of government HIV/AIDS program activities will be coordinated by NACP through GCMU in the MOPH. As with all public expenditures, donor funds for the program will be routed through MoF. In keeping with current practices for other projects in Afghanistan, designated accounts (DAs) will be established for grants provided by different donors and these DAs will be operated by the Special Disbursement Unit (SDU) in the Treasury Department of MoF. Requests for payments from DA funds will be made to the SDU by the MoPH. In addition to payments from DA funds, the MoPH can also request the SDU to make direct payments to consultants or consulting firms, and special commitments for contracts covered by letters of credit. Such requests will follow previously established procedures agreed upon with the donor agencies. All withdrawal applications to the donor agencies, including replenishment, reimbursement, and direct payment applications, will be prepared and submitted by MoF.

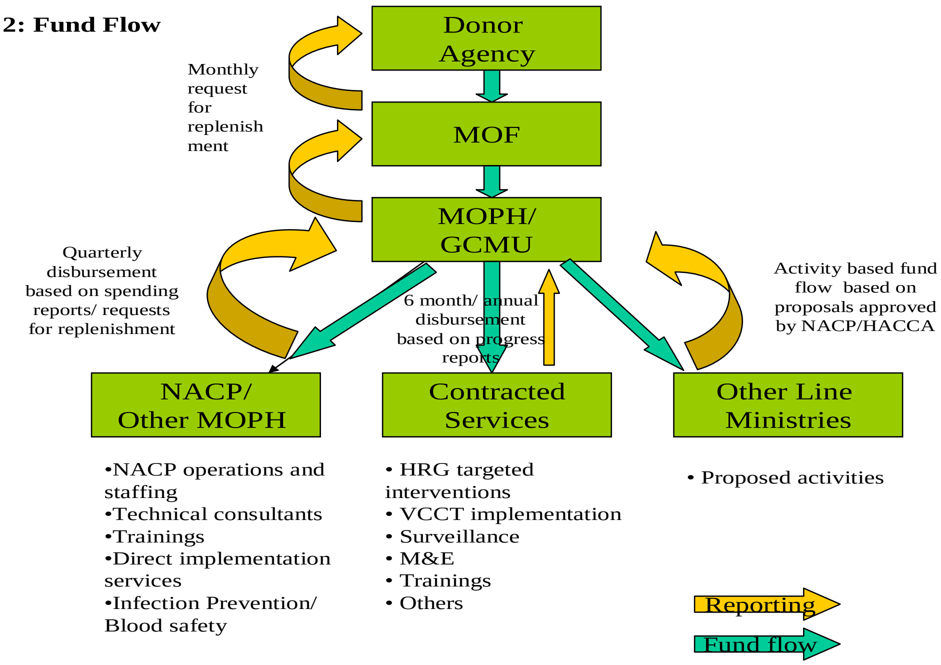
ACCOUNTING AND REPORTING

98. The financial management arrangements put in place for the current Afghanistan Health Sector Emergency Rehabilitation and Development Project will be applicable for this project with some amendments to reflect the cash flow through the MOPH to other involved ministries as well. This includes use of the Chart of Accounts developed to record project expenditure. Program accounts will be consolidated centrally in MOF, through the SDU. Consolidated Project Financial Statements will be prepared for all sources and uses of project expenditures. As a national indicator the flow of funds will be tracked on a quarterly basis, to ensure timely disbursement of funds and uninterrupted fund flow after contracts are awarded.

DISBURSEMENT METHOD

99. Disbursements from the program grants will be made in accordance with previously established guidelines agreed upon with donor agencies. The GCMU/MOF may request reimbursement, direct payment, and payments under Special Commitments including full documentation (submission of records) or against statements of expenditures, as appropriate (Figure 2)

Figure 2: Fund Flow



IX. PROCUREMENT

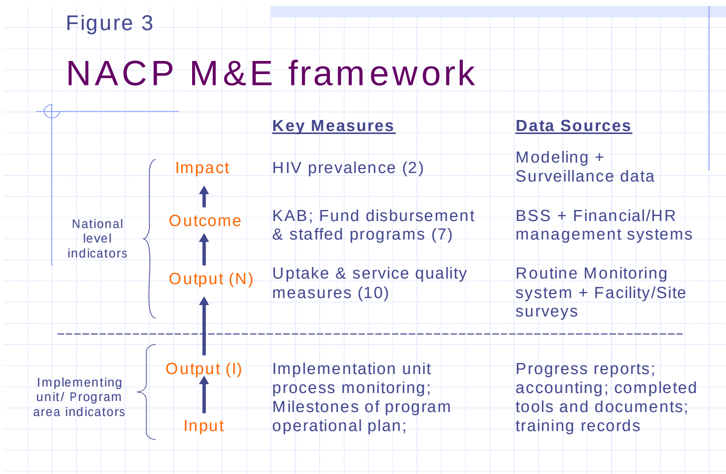
100. Procurement for NACP related activities will be carried out by the Ministry of Public Health (MoPH) through Grant Coordination Management Unit (GCMU).

101. A competent procurement specialist will be hired under Grant and Contract Management Unit (GCMU) of MoPH to procure small value of goods, works and consultancy contracts.The procurement specialist will be responsible for managing procurement for the project based on technical specifications provided by the NACP.

X. PROGRAM MONITORING & EVALUATION

GENERAL STRATEGY

102. The design of the M&E framework (Figure 3) for the POP was developed to reflect the priorities of the NACP and follow the principles of the "three ones." The NACP office serves as the country authority on HIV/AIDS related programming and coordinates the participation of donor agencies, implementing agencies, and technical partners to monitor the effectiveness and timeliness of the execution of the POP. The NACP system builds on existing infrastructure and technical expertise for monitoring and evaluation in the Ministry of Public Health, specifically the Departments of HMIS, M&E, and the GCMU.



103. A spare set of nineteen indicators comprise the national level M&E framework of the NACP. These indicators focus on the primary biological and behavioral outcomes among the general population and high risk/especially vulnerable groups; fund flow; human resource availability; service quality; and primary outputs of the highest priority program areas (targeted interventions, infection prevention, blood safety, VCCT, and surveillance), as presented in Table 20.

104. Use of the data from the M&E system will be phased by program area reflecting the phased nature of implementation. For example, in the early months NACP operations, the flow of funds and placement of minimum required staff at the implementation unit level form the key measure of program effectiveness, capacity, and political commitment for HIV/AIDS. Disaggregating the data by components and line ministries/implementing agencies will identify the systems level blocks in rolling out programs.

105. In addition to the national level indicators, program area specific monitoring plans also exist to improve management and operations of each area. Specific indicators for monitoring in each program area will be based on the guidelines and strategies developed for that area. These include tracking of essential outputs, inputs, and milestone achievement according to the timelines laid out in the POP. A minimum set of data elements will be collected through routine monitoring system (i.e. standardized data collection formats and procedures). Using a simple adaptation of the balanced scorecard for the BPHS/EPHS systems, NACP will commission an annual facility/site surveys to assess quality of services.

PROGRAM SUPERVISION

106. The head of the NACP is the overall program supervisor. The NACP head will review the status of the national level indicators on a quarterly basis with the HACCA through the use of standard reports based on the routine monitoring data. Annual progress reports and the justification of the annual action plan will rely on the cumulative year's data, incorporating routine monitoring info, service quality assessments, and available surveillance data. In turn, each program lead will review the more detailed routine monitoring data submitted by the implementation units for their area (e.g. VCCT, blood banks, targeted interventions, IEC) and provide appropriate feedback about intervention and data reporting quality.

107. The M&E lead from NACP will be the responsible officer for coordinating the annual service quality assessments and provide support to the other program leads in the areas of analysis and interpretation of the monitoring data. Adjustments to the monitoring system and databases will be managed by the M&E lead. This person is also responsible for regular scrutiny of the data quality of submitted reports from each area.

108. The NACP datasets will be made accessible to lower level reporting units, down to the implementing units, to allow local managers to analyze and act on the monitoring data. At the central level, routine monitoring data and quality assessments will be analyzed in the context o available surveillance data and form the basis of annual progress reports and action plans. Efforts will also be made to use the data from the NACP in conjunction with other sorts of data to develop advocacy materials to garner political support and resources for HIV/AIDS programming.

INFORMATION MEANS

109. A central NACP database will be constructed, using a similar platform and user interface to what has been developed for the MoPH HMIS. This database will consolidate information imported from multiple sources including existing data systems (see Figure 4):

- From the GCMU essential data on NACP fund flow and human resources from their existing databases.
- From the HMIS routine reporting of service uptake for NACP related services provided at the BPHS/EPHS
- From the National Health Performance Assessment (Balanced Score Card) – service quality indicators about NACP related services provided through the BPHS/EPHS system.
- Routine monitoring data reported by the non-BPHS/EPHS interventions (e.g. VCCT registers, Targeted interventions for HRG/especially vulnerable populations' outreach records, blood bank registers; etc.)
- Results of annual facility/site surveys of implementation units.
- Behavioral and biological surveillance data through population based or facility based surveys will provide the non-routine monitoring data.

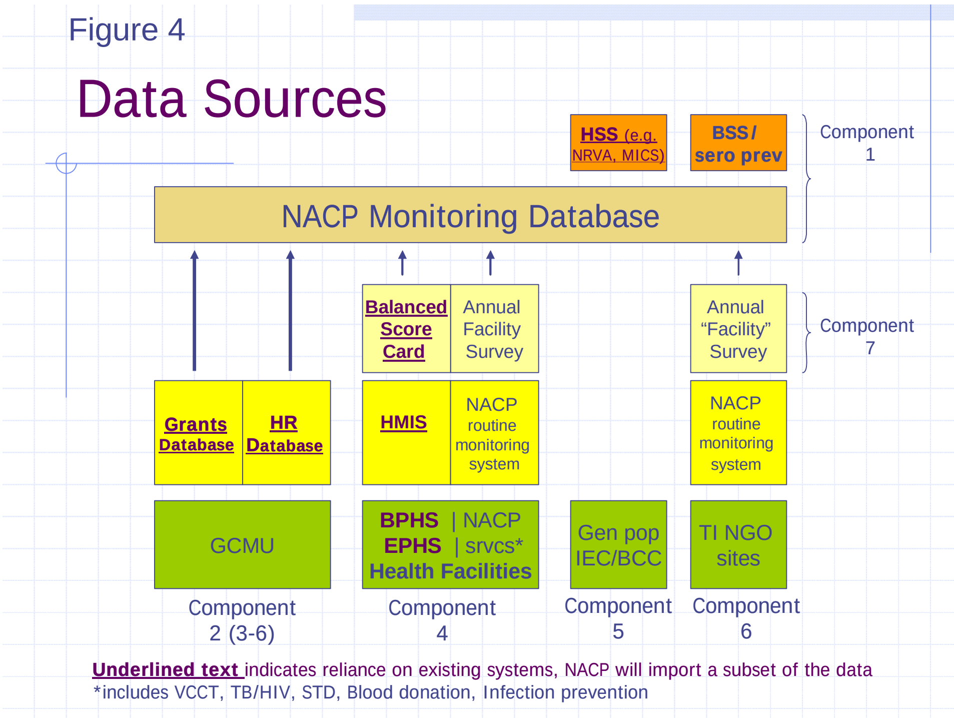


Figure 4
Data Sources
HSS (e.g. NRVA, MICS)
BSS / sero prev
Component 1
NACP Monitoring Database
Balanced Score Card
Annual Facility Survey
Annual "Facility" Survey
Component 7
Grants Database
HR Database
HMIS
NACP routine monitoring system
NACP routine monitoring system
GCMU
BPHS | NACP
EPHS | srvcs*
Health Facilities
Gen pop IEC/BCC
TI NGO sites
Component 2 (3-6)
Component 4
Component 5
Component 6
Underlined text indicates reliance on existing systems, NACP will import a subset of the data
*includes VCCT, TB/HIV, STD, Blood donation, Infection prevention

XI. PROGRAM OPERATIONAL PLAN – OVERALL COSTS

Table 21: Cost Summary of Sub- Components of the POP– 2007-2010 (4 years) in USD

Components/Sub-Components	Estimated Cost	Mobilized Funds	Source of Funding	Gap in Funding
COMPONENT 1 (TOTAL)	**3,570,000**	**1,600,000**	**WB**	**1,970,000**
Sub-Component 1.1:	**500,000**			
Sub-Component 1.2:	**3,070,000**			
COMPONENT 2 (TOTAL)	**1,510,000**	**300,000**	**WB**	**1,210,000**
Sub-Component 2.1:	**1,060,000**			
Sub-Component 2.2:	**250,000**			
Sub-Component 2.3	**220,000**			
COMPONENT 3 (TOTAL)	**2,489,250**	**2,100,000**	**WB**	**389,250**
Sub-Component 3.1:	**1,669,250**			
Sub-Component 3.2:	**820,000**			
COMPONENT 4 (TOTAL)	**14,585,200**	**6,840,000**	**FC**	**7,745,000**
Sub-Component 4.1:	**10,050,000**			
Sub-Component 4.2:	**20,000**			
Sub-Component 4.3:	**215,000**			
Sub-Component 4.4:	**880,200**			
Sub-Component 4.5:	**3,500,000**			
COMPONENT 5 (TOTAL)	**14,060,000**	**5,000,000**	**WB**	**9,060,000**
Sub-Component 5.1:	**4,560,000**			
Sub-Component 5.2:	**2,800,000**			
Sub-Component 5.3:	**3,000,000**			
Sub-Component 5.4:	**3,320,000**			
Sub-Component 5.5:	**1,200,000**			
COMPONENT 6 (TOTAL)	**1,000,000**	**1,000,000**	**WB**	**-------**
Sub-Component 6.1:	**200,000**			
Sub-Component 6.2:	**200,000**			
Sub-Component 6.3:	**200,000**			
Sub-Component 6.4:	**200,000**			
Sub-Component 6.5:	**200,000**			
TOTAL OF ALL COMPONENTS	**37,124,450**	**16,840,000**	**WB/FC**	**20,374,250**

XII. CRITICAL FACTORS OF PROGRAM SUCCESS

110. The are several factors that will determine the success of the Program. Those include issues related to the sustainability of (a) political commitment, (b)technical and managerial capacity, (c) participation of key staleholders, (d) financial mangement and fund flow. *Political commitment* must be sustained over time by the top national leadership, opinion/influential leaders (religious, community, civil-society, and military-based). The *technical capacity* must be sought and secured through extensive trainng of the local implementing agencies (GoA), NGOs, CBOs), faciltated by the key development partners (UN agencies). *Managerial capacity* will be build through institutional capacity building of the NACP and other multi-sectoral partners participating in the implementation of the Program at all levels – central and provincial. New skills and expertise of the NACP staff will be developed through collaboration with national and international experts on various aspects of the HIV/AIDS interventions, made available by developemnt partners throughout the Program cycle, including surveillance, M&E, procurement, accounting, finacial management and contract management.

XIII. DETAILED SUMMARY OF POP COMPONENTS – 2007-2010 (4 YEARS)[22]

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
COMPONENT 1: DEVELOPING THE NATIONAL SECOND GENERATION HIV/AIDS/STI SURVEILLANCE SYSTEM							
Sub-Component 1.1: Establishing of a National-Level Logical Framework & Strategic Information System							
1. Develop an agreed set of National Indicators for the NACP	TA	1 set of indicators		50,000			
2 Document data sources & flow for the collection of national indicators	TA			50,000			
3. Create standardized data collection/entry formats and data base for the routine monitoring system for each program area	TA	1 data set		100,000			
4. Training of Staff involved in data collection, entry, and Supervision of Routine Monitoring Indicators	TA	4 routine annual trainings	25,000	100,000			
5.Establishing of a system & schedule for annual implementing unit service quality assessments	TA	1 system		100,000			
6. Collection and analysis, and dissemination of national indicator data through reports and regularly scheduled review meetings of NACP stakeholders	TA	4 Dissemination workshops	25,000	100,000			
				500, 000			**500,000**
Sub-Component 1.1: Total Cost =500, 000 USD							
Sub-Component 1.2: Developing National Second Generation HIV/AIDS/STI Surveillance System							
1. Establishing a Multi-Disciplinary Technical HIV/AIDS/STI Surveillance Working Group (SWG)	SGW members mobilized (10 persons)	1 group	5,000 (mobilizations costs)	5,000			
2. Developing a Strategy & Implementation Plan for the National 2nd Generation HIV/AIDS/STI Surveillance System	TA from SWG	1 strategy					
3. Induction Training on 2nd Generation HIV/AIDS Surveillance System	TA	1 training for 100 persons	20,000	20,000			
4. Implementation HIV/AIDS/STI Surveillance Surveys & Behavioral Surveillance Studies, including:							

[22] The costing of the POP components will be refined further as the Program rolls, including gap analysis of the resources.

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
a. Sentinel HIV Sero-Prevalence Surveillance Surveys among high-risk groups conducted (IDUs, FSWs, Prisoners, MSM)	TA	2 round of surveys over 4 years	500,000 x 2	1,000,000			
b. KABP Studies among high-risk and vulnerable groups (IDUs, FSWs, Prisoners, MSM, migrant workers, mobile workers, refugees, returnees, IDPs)	TA	1 study per group= 1x3=3 studies (9 target groups divided in 3 groups)	250,000	750,000			
c. Poverty, Gender & Social Assessment of HIV/AIDS	TA	1 study	250,000	250,000			
d. Mapping and Size Estimation Studies (3 groups)	TA	1 study x 2 rounds	250,000	500,000			
5. Integration of the HIV/AIDS/STI data into the National System of IDS and HMIS, including:	TA						
a. Report on HIV/AIDS/STI data analysis	TA	1 report	25,000	25,000			
b. Report Dissemination Workshops	TA	4 workshops for 4 years	5,000	20,000			
Sub-Component 1.2: Total Cost				**3,070,000**			
Sub-Component 1.2: Total Cost=3,070,000 USD							
TOTAL COST OF COMPONENT 1, INCLUDING:				**3,570,000**	**1,600,000**	**The World Bank**	**1,970,000**
Sub-Component 1.1: Total Cost				**500,000**			
Sub-Component 1.2: Total Cost				**3,070,000**			
TOTAL COST OF COMPONENT 1=3,570,000 USD							
COMPONENT 2: ADVOCACY AND POLICY DEVELOPMENT FOR HIV/AIDS							
Sub-Component 2.1: Raising HIV/AIDS Awareness at the Top Political, Religious and Military Leadership							
1. Lobbying the HIV Agenda at the Office of the President							
2. Training for Parliamentarians	TA	2 training sessions	10,000	20,000			
3. Training for Imams and Mullahs	TA	34 provinces, including Kabul city	10,000 per training (at provincial level)	500,000			
4. Training Military Leadership (commanders, staff of the MoJ, MoD, MoI)	TA	34 provinces, including Kabul city	10,000 per at provincial level)	500,000			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
5. Training for Other Influential Individuals (Media Owners, Editors, Journalists, Writers/Poets)	TA	4 training sessions (100 persons)	10,000	20,000			
Sub-Component 2.1: Total Cost				**1,060,000**			
Sub-Component 2.1: Total Cost =1,060,000 USD							
Sub-Component 2.2: Assistance of the HACCA to NACP to Coordinate HIV/AIDS Interventions							
1. HACCA's Assistance to Implementation of HIV/AIDS Interventions, including:							
a. Review of POP	Annual Meeting	1 per year x 4 years =4	10,000	40,000			
b. Resource Mobilization Strategy for POP (RMS)	TA	1 RMS	10,000	10,000			
c. Regional Representatives Meeting on POP implementation	Meeting	4 times per year x 4 years=16	10,000	160,000			
d. Review of M&E Reports section on the utilization of resources for the POP	TA	4 Annual Reviews	10,000	40,000			
Sub-Component 2.2: Total Cost				**250,000**			
Sub-Component 2.2: Total Cost =250,000 USD							
Sub-Component 2.3: Developing Key Policy Documents for HIV/AIDS Interventions							
Developing Key Policy Documents							
1. Developing a National Policy on HIV/AIDS	TA						
a. Stakeholder workshop for the preparation of the National Policy	Workshop	3 workshops in Kabul with regional representatives	5,000	15,000			
2. Developing a National Communication and Advocacy Strategy on HIV/AIDS	TA						
a. Stakeholder workshop for the preparation of the Communication and Advocacy Strategy	Workshop	3 workshops in Kabul with regional representatives	5,000 U	15,000			
3. Dissemination of National Policy on HIV/AIDS and Communication & Advocacy Strategy , including:							
a. translation into Dari and Pashto	Translation costs	2 documents x 2 languages	3,000 per document	12,000			
b. printing	Printing costs	200 copies x 4 documents = 800 copies	100 per copy	8,000			

Components/Activity	**Inputs Required**	**Quantity Required** **(for the Entire Program Period)**	**Unit Cost in USD**	**Total Cost in USD**	**Amount Mobilized in USD**	**Source of Funds**	**Gap in Financing in USD**
c. shipping/transportation	Shipping/transportation costs	800 copies shipping/transportation to 34 provinces	300 per shipping/transportation cost per province	10, 200			
Developing IEC Material for Target Groups							
3. Developing and/or Expanding IEC material on HIV/AIDS in the context of high-risk behavior, including:	TA include document preparation and translation costs into Dari and Pashto						
IDU	TA	X number of documents	20,000				
SW	TA	X number of documents	20,000				
Prisons	TA	X number of documents X number of documents	20,000				
MSM	TA	X number of documents	20,000				
4. Developing and/or expanding IEC material on vulnerability associated with:							
Migrant work	TA	X number of documents (up to 4)	5,000	20,000			
Long-distance mobile work	TA	X number of documents (up to 4)	5,000	20,000			
5. Developing and/or expanding IEC material in the context of conflict and emergency, including:							
On Refugees	TA	X number of documents (up to 4)	5,000	20,000			
On Returnees	TA	X number of documents (up to 4)	5,000	20,000			
On IDPs	TA	X number of documents (up to 4)	5,000	20,000			
6. Developing and/or expanding IEC material on HIV/AIDS and women, including issues of:							
a. Reproductive health, STIs, MTCT	TA	X number of documents (up to 4)	5, 000	20, 000			
7. Developing and/or expanding IEC material on HIV/AIDS and youth, including:							
Sexual behavior, reproductive health of youth and adolescents	TA	X number of documents (up to 4)	5,000	20,000			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
Sub-Component 2.3=Total Cost				**220,000**			
TOTAL COST OF COMPONENT 2, INCLUDING:				**1,510,000**	**300,000**	**The World Bank**	**1,210,000**
Sub-Component 2.1=Total Cost				**1,060,000**			
Sub-Component 2.2=Total Cost				**250,000**			
Sub-Component 2.3=Total Cost				**220,000**			
TOTAL COST OF COMPONENT 2: 1,510,000 USD							
COMPONENT 3: STRENGTHENING OF THE NATIONAL CAPACITY TO IMPLEMENT A COORDINATED MULTI-SECTORAL RESPONSE TO HIV/AIDS							
Sub-Component 3.1:Institutional Capacity Building of the NACP to Coordinate the Multi-Sectoral Response to HIV/AIDS							
1. Distance-Learning for 4 NACP staff on HIV/AIDS (LSTMH)	Tuition	4 persons	10,000	40,000			
2.Training Course for the NACP coordinators/officers (34 persons)	Tuition	34 persons	5,000	170,000			
3. Hiring of National Consultants to NACP (7 positions)	Direct Investment	1 person (1,000 USD monthly salary x 12=12,000 x 4 years = 96,000)	7 persons x 48,000	336,000			
4. Refurbishing/Establishing NACP regional-level offices and Kabul Office (8 locations)	Equipment and main consumables, including:						
	Computers (4 per location)	8 major cities	2,000	64,000			
	Printers (2 printer per location)	8 major cities	800	6,400			
	Photocopiers (1 per location)	8 major cities	500	4,000			
	Generators (1 per location	8 major cities	2,000 per year x 4 years=	64,000			
	Rent (1 month per location)	8 major cities	2,000 x12=24,000	192, 000			
	Fuel (1 month per location)	8 major cities	1,000 x 12=12,000	96,000			
	Other consumables (1 month per location)	8 major cities	2,000 x 12= 24,00	192,000			
5. Salaries of staff of 8 Regional Offices, including:				316,000			
(a) 8 regional coordinators	Salary for 4 years	8 persons' annual salary for 4 years	300 monthly = 3,600 per year x 4 years	115,200			
(b) 16 regional officers	Salary for 4 years	16 persons' annual	200 monthly=2,400 per	153,600			

		salary for 4 years	year x 4 years				
(c) 8 administrative support	Salary for 4 years	8 persons' annual salary for 4 years	100 monthly=1, 200 per year x 4 years	38,400			
(d) 8 technicians	Salary for 4 years	8 persons' annual salary for 4 years	50 monthly=600 per year x 4 years	9, 6000			
Components/Activity	**Inputs Required**	**Quantity Required** **(for the Entire Program Period)**	**Unit Cost in USD**	**Total Cost in USD**	**Amount Mobilized in USD**	**Source of Funds**	**Gap in Financing in USD**
Sub-Component 3.1: Total Cost				**1,669,250**			
Sub-Component 3.1: Total Cost=1,669,250 USD							
Sub-Component 3.2: Developing and Strengthening the Institutional Capacity of Public, Private Sector, and Civil Society Stakeholders on HIV/AIDS							
1. Dissemination of the National Strategic Framework on HIV/AIDS/STI and Program Operational Plan (POP) to Key Stakeholders							
a. ANASF and POP translated into Pashto and Dari	Translation costs	2 documents x 2 languages	3,000 USD per document	12,000			
	Printing costs	200 copies x 4 documents = 800 copies	100 USD per copy	8,000			
	Shipping/transportation costs	800 copies shipping/transportation to 34 provinces	300 USD per shipping/transportation cost per province	10, 200			
b. ANASF and POP Dissemination Workshop	Workshop	4 workshops in Kabul with regional representatives	5,000 USD	20,000			
2. Training on HIV/AIDS for Key Stakeholders (Staff Training)							
a. Training for NGOs/CBOs (100 organizations)	TA	6 sessions over 4 years	1 session= 5,000 USD x 12 sessions x 4 years	120,000			
b. Training for line ministries (20 ministries)	TA	4 sessions over 4 years	1 session x 4= 5,000 USD x 4 =20,000 USD	80, 000			
c. Training for private business (20 companies)	TA	4 sessions over 4 years	1 session x 4= 5,000 USD x 4 =20,000 USD	80, 000			
d. Training for Universities	TA	4 sessions over 4 years	1 session x 4= 5,000 USD x 4 =20,000 USD	80, 000			
e. Training for Vocational Institutions	TA	4 sessions over 4 years	1 session x 4= 5,000 USD x 4 =20,000 USD	80, 000			
f. Training for Urban Schools	TA	6 sessions over 4 years	1 session= 5,000 USD x 12 sessions x 4 years	120,000			
g. Training for Rural Schools	TA	6 sessions over 4 years	1 session= 5,000 USD x 12 sessions x 4 years	120,000			
h. Training for Academia	TA	4 sessions over 4 years	1 session x 4= 5,000 USD x 4 =20,000 USD	80, 000			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
3. Integration of HIV/AIDS into Workplace Policies	TA will include preparation of documents, translation and dissemination costs						
a. Developing TA for private sector	TA	1 document	5,000 USD	5,000			
b. Developing TA for public sector	TA	1 document	5,000 USD	5,000			
c. Developing TA for NGOs, CBOs	TA	1 document	5,000	5,000			
4. Streamlining HIV/AIDS into Education, Research & Training Curriculum							
a. Curriculum Developed for Research Institutions	TA	1 document	5,000	5,000			
b. Curriculum Developed for Students of Vocational Institutions	TA	1 document	5,000	5,000			
c. Curriculum Developed for School Teachers	TA	1 document	5,000	5,000			
d. Curriculum Developed for Students (Primary Education)	TA	1 document	5,000	5,000			
e. Curriculum Developed for Students (Secondary Education)	TA	1 document	5,000	5,000			
5. Facilitation of Involvement of Staff and Students of Academic Institutions into Operational Research and Activities	Type of inputs and amount required will be determined within the overall budget of the contracts given out for the studies under various components						
a. Staff and students contracted for specific activities							
6. Expanding Participation of Public, Private and Civil Society Organizations in Implementing HIV/AIDS Interventions							
a. Organizations contracted for specific activities of the POP							
7. Technical Assistance to CBOs/NGOs to Develop Proposals and Access Funding for HIV/AIDS Interventions	TA						
a. Proposals, TORs developed	TA	X number of documents		20,000			
Sub-Component 3.2: Total Cost				**820,000**			
Sub-Component 3.2: Total Cost = 820,000 USD							

Components/Activity	**Inputs Required**	**Quantity Required** (for the Entire Program Period)	**Unit Cost in USD**	**Total Cost in USD**	**Amount Mobilized in USD**	**Source of Funds**	**Gap in Financing in USD**
COMPONENT 3: TOTAL COST, INCLUDING:				**2,489,250**	**2,100,000**	**The World Bank**	**389,250**
Sub-Component 3.1: Total Cost				**1,669,250**			
Sub-Component 3.2: Total Cost				**820,000**			
COMPONENT 3: TOTAL COST = 2,480,250 USD							
COMPONENT 4: STRENGTHENING OF THE HEALTH SYSTEM CAPACITY TO IMPLEMENT HIV/AIDS/STI INTERVENTIONS							
Sub-Component 4.1: Building a Safe Blood Bank System and Safe Blood Transfusion							
1. Finalizing National Guidelines on Safe Blood Transfusion	TA			5,000			**5,000**
2. Integration of HIV/AIDS in the National Infection Prevention (IP) Guidelines	TA			5,000			**5,000**
3. Training of Medical Personnel of Safe Blood Transfusion	TA	7 routine training sessions (14 days each) per year for 250 persons	210,000 USD per year x 4 years	840,000	1,140,000	French Cooperation	**300,000**
4. Training of medical personnel on the Infection Prevention (IP) Guidelines	TA	10 training sessions for all staff	5,000 USD per session	50,000 USD			**50,000**
5. Rehabilitation of the Central Blood Bank, the upgrading of four blood bank regional branches (Jalalabad, Kandahar, Mazar-e-Sharif, Herat), and the construction of a blood bank in Malalai Maternity Hospital in Kabul	Civil Works	Total of 8 blood banks across the country, including 2 in Kabul City (Central Blood Bank; and Malalai Maternity Hospital), one each in Jalalabad, Kandahar, Mazar-e-Sharif, Heart (4 blood banks)	800,000 USD per blood bank	6,400, 000 USD	4,000,000	French Cooperation	**2,400,000**
6. Procurement of medical equipment and consumables for blood safety and infection prevention	Equipment & consumables	8 blood banks	400,000 USD per blood bank (major cities)	2,800,000	2,000,000	French Cooperation	**800,000**
Sub-Component 4.1: Total Cost				**10,050,000**		French Cooperation	**7,140,000**
Sub-Component 4.1: Total Cost – 10,050,000 USD							
Sub-Component 4.2: Raising Public Awareness on Blood Safety, Infection Prevention and Safe Injection Practices							
1. Development of IEC Materials for General population on Blood Safety	TA will include the preparation and translation costs	X number of documents	20,000 USD	20,000 USD			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
				20,000			
Sub-Component 4.2: Total Cost – 20,000 USD							
Sub-Component 4.3: Building National Clinical Expertise on HIV/AIDS and STI							
1. Identification of trainees for training on HIV/AIDS and STI prevention and care within the existing BPHS staff and other candidates (160 persons)	TA will include mobilization costs			10,000 USD			
2. Identification and Hiring of HIV/AIDS/ STI Trainers	Lump-sum contracts (fees, one-time travel, per diem for international staff, including:						
	International Trainers	2 persons	10,000 per month x 4 months x 2 persons	80,000 USD			
	Local Trainers	2 persons	2,000 per month x 4 months x 2 persons	16,000 USD			
3. Developing Curriculums on: (a) HIV/AIDS Epidemiology; (b) Prevention; (c) Care and Treatment; (d) EIC; (e) Stigma and Discrimination	TA will include preparation of the curriculum included in consultants fees; TA will cover the translation and consultation costs	International and local consultants will be responsible for the preparation of materials					
	(a) Document Preparation	4 documents	3,000 per document for translation into Dari/Pashto	12,000 USD			
	(b)Consultation and building consensus with relevant stakeholders	4 workshops in Kabul with wide participation of out-of Kabul stakeholders	5,000 USD per workshop	20,000 USD			
4. Launching of HIV/AIDS Courses	Operational Costs	4 courses taught in Kabul for 160 persons throughout the duration of the courses					
	Office Rent	3 months	2,000 USD	6,000 USD			
	Accommodations and per diem for course out-of Kabul 100 participants	100 persons	50 USD per day x 3 months=4,500 USD x 100 persons	45,000 USD			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
	One-time travel in and out of Kabul	100 persons	100 USD per person	10,000			
	Teaching Materials	160 persons	100 USD per person	16,000			
	Out of Kabul (international trip) practical training costs (travel)	160 persons	500 USD per person per trip x 3 trips	240,000			
Sub-Component 4.3: Total Cost				**215,000**			
Sub-Component 4.3: Total Cost = 215,000 USD							
Sub-Component 4.4: Development and Expansion of the National Capacity for Quality HIV Testing							
1. Adoption of Standardized National VCCT and Diagnostic Testing Guidelines	TA			10,000			
2. Training of medical personnel of all HIV testing facilities on VCCT and diagnostic guidelines							
	(a) Training	12 routine training sessions per year for 10 persons (per facility) x 8 VCCTs	100, 000 USD per year x 4 years	400,000			
3. Developing and Dissemination of Promotional VCCT material	TA						
	(a) Translation costs	2 documents x 2 languages	3,000 USD per document	12,000			
	(b) Printing costs	200 copies x 4 documents = 800 copies	100 USD per document	8,000			
	(c)Shipping/transportation costs	800 copies shipping/transportation to 34 provinces	300 USD per shipping/transportation cost per province	10, 200			
4. Developing National Guidelines for Laboratory Diagnosis of Opportunistic Infections and Monitoring of HIV/AIDS Disease Progression	TA						
5. Training of lab personnel on Diagnosis and Monitoring of HIV/AIDS and Associated Opportunistic Infections	TA						
	(a) Training	12 routine training sessions per year for 10 persons (per facility) x X number of labs	100, 000 USD per year x 4 years	400,000			
6. Strengthening Capacity of Medical Waste Management, including training of the staff	TA						

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
	(a) Training	4 training sessions per year for 10 persons (per facility) x X number of labs	10, 000 per year x 4 years	40,000			
Sub-Component 4.4				**880,200**			
Sub-Component 4.4: Total Cost= 880,200 USD							
Sub-Component 4.5: Coordination of HIV/AIDS/STD and TB Joint Interventions							
1. Developing National Guidelines on Coordination in the Diagnosis, Prevention and Control of TB and HIV/AIDS	TA						
2. Screening for TB of the HIV Positive Patients	TA						
	(a) 12 routine training sessions per year for 250 persons	34 provincial level health facilities	100,000 USD per year x 4 years	400,000			
	(b) Procurement of testing kits	34 provinces for 4 years	1 USD per kit	500,000			
3. Screening for HIV among active TB Patients	TA		100,000 USD per year x 4 years	400,000			
	(a) 12 routine training sessions per year for 250 persons	34 provincial level health facilities	100,000 USD per year x 4 years	400,000			
	(b) Procurement of testing kits	34 provinces for 4 years for X number of persons	1 USD per kit	500,000			
4. Establishment of a Home & Community-based Training Program for the Care and Support of HIV/AIDS and TB clients	TA	12 routine training sessions per year for 250 persons	100,000 USD per year x 4 years	400,000			
	(a) 12 routine training sessions per year for 250 persons	34 provincial level health facilities	100,000 USD per year x 4 years	400,000			
	(b) Procurement of consumables (medecinses)	34 provinces for 4 years for X number of persons	1 USD per kit	500,000			
5. Developing an Electronic Health Information System (database) to Collect, Process and Communicate Disaggregated Clinical Data on HIV/AIDS and TB	TA (the cost is included in Component 1 – Surveillance Activities)						

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
Sub-Component 4.5: Total Cost				**3,500,000**			
Sub-Component 4.5: Total Cost = 3,500,000 USD							
COMPONENT 4: TOTAL COST, INCLUDING:				**14,585,200**	**6,840,000**		**7,745,000**
Sub-Component 4.1: Total Cost				**10,050,000**			
Sub-Component 4.2: Total Cost				**20,000**			
Sub-Component 4.3: Total Cost				**215,000**			
Sub-Component 4.4: Total Cost				**880,200**			
Sub-Component 4.5: Total Cost				**3,500,000**			
COMPONENT 4: TOTAL COST = 14,585,200 USD							
COMPONENT 5: PROVIDING CUSTOMIZED PACKAGES OF SERVICES FOR PREVENTION, TREATMENT AND CARE TO HIGH-RISK GROUPS, VULNERABLE POPULATIONS, AND PLWHA							
Sub-Component 5.1: Providing Packages of Services for IDUs							
1. Syringe/Needle Exchange Programs	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	8 cities	250,000 per year x 4 years per contract =1,000,000	2,000,000,000			
2. Facilitating Access to VCCT services							
3. Drop-in-Centers	Operational Costs for 4 years	16 drop-in centers (2 per city x 8 cities)	400,000 per year x 4 years	1,600,000			
4.Raising HIV/AIDS awareness and correct knowledge	IEC Material distribution and Cost of Campaigns	IEC Campaigns in 8 major cities					
5. Piloting of Substitution Treatment	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	2 cities only Kabul and Heart = 2,000 persons per year					
6. Training for Trainers (TOT) to Carry – Out Services for IDUs	Capacity building for outreach and health workers	100 persons per city per year x 8 cities=800 persons					

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
7. Peer-Education	Peer-education, including former IDUs	100 persons per year x per city x 8 cities =800 persons					
Sub-Component 5.1				**4,560,000**			
Sub-Component 5.1: Total Cost= 4,560,000 USD							
Sub-Component 5.2: Packages of Services for FSWs and Their Clients							
1. STI Services		8 major cities, including those along the main transport routes (200 persons per city)					
(a) Facilitating Access to STIs clinics, where possible							
	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	8 cities = 1,600 persons per year	Lumpsum contracts	800,000			
(b) Home-based STI services contracted to NGOs	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	8 cities = 1,600 persons per year	Lumpsum contracts	1,000,000			
2. Facilitating Access to VCCT services	2 Umbrella NGOs for 4 years	8 cities = 1,600 persons per year					
3.Raising HIV/AIDS awareness and correct knowledge	2 Umbrella NGOs for 4 years	8 cities = 1,600 persons per year					
4. Promotion of Alternative Livelihoods	2 Umbrella NGOs for 4 years	8 cities = 1,600 persons per year					
5. Condom and Lubricant Distribution							
	NGO Contracts (2 umbrella NGOs)	8 cities = 1,600 persons per year					
	Condoms/Lubricants	500,000 per year for all 8 cities	0.5 USD per condom x 500,000 per 4 years	1,000,000			
6. Training for Trainers (TOT) to Carry – Out Services for FSWs	Capacity building for outreach and health workers	100 persons per city per year x 8 cities=800 persons					
7. Peer-Education	Peer-education, including FSWs	100 persons per year x per city x 8 cities =800 persons					
Sub-Component 5.2: Total Cost				**2,800,000**			
Sub-Component 5.2: Total Cost=2,800,000 USD							

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
Sub-Component 5.3: Customized Packages of Services for Prisoners							
1. STI Services	Establishing STI Services in prisons in 8 major cities	8 STI Service Centers					
	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	8 cities, plus potentially provincial prisons (total of 34 locations)	100,000 USD per year x 4 years per contract =400,000 USD	400,000			
2. VCCT services	Establishing VCCTs in prisons in 7 major cities	7 VCCT centers					
	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	7 cities, plus potentially provincial prisons (total of 34 locations)	50,000 USD per year x 4 years per contract =400,000 USD	400,000			
3.Raising HIV/AIDS awareness and correct knowledge	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	2 cities, plus potentially provincial prisons (total of 34 locations)					
5. Condom and Lubricant Distribution	Contacts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	2 cities, plus potentially provincial prisons (total of 34 locations)					
Condoms/Lubricants		500,000 per year for all 8 cities	0.5 USD per condom x 500,000 per 4 years	1,000,000			
6. Needle/Syringe Exchange Programs	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	2 cities, plus potentially provincial prisons (total of 34 locations)	100,000 USD per year x 4 years per contract =400,000 USD	800,000			
7. Safe blood-exchange, safe hygiene practices information campaigns	Contracts for selected NGOs, including:						
	2 Umbrella NGOs for 4 years	2 cities, plus potentially provincial prisons (total of 34 locations)					
8. Training for Trainers (TOT) to Carry – Out Services for Prisoners	Capacity building for outreach and health workers	50 persons to cover 2 cities, plus potentially provincial prisons (total of 34 provinces)					
9. Peer-Education	Peer-education, including Prisoners	50 persons to cover 2 cities, plus 30 provinces					
Sub-Component 5.3: Total Cost				**3,000,000**			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
Sub-Component 5.3: Total Cost=3,000,000 USD							
Sub-Component 5.4: Customized Packages of Services for PLWHA							
1. Identification of all existing PLWHA	Contracts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 x 4 years per contract =200,000 USD	200,000			
2. ART	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	(a) provision of ART service		50,000 x 4 years per contract =200,000 USD	200,000			
	(b) ART costs	<1,000 persons x 4 years	350 x4 years=1,400	1,400,000			
3. Counseling	Contracts for selected NGOs, including:						
		X number of PLWHA	50,000 per year x 4 years per contract =200,000	200,000			
4. Provision of Supportive Care for PLWHA and their families	Contracts for selected NGOs, including:	X number of families of PLWHA					
			50,000 per year x 4 years per contract =200,000	200,000			
5. Condom and Lubricant Distribution	Contracts for selected NGOs, including:	X number of PLWHA					
			50,000 per year x 4 years per contract =200,000	200,000			
6. Training for Trainers (TOT) to Carry – Out Services for PLWHA	Capacity building for outreach and health workers	50 persons to cover 2 cities, plus potentially provinces (total of 34 provinces)	40, 000 per year x 4 years	160,000			
7. Peer-Education	Peer-education, including Prisoners	50 persons to cover 2 cities, plus provinces (34 persons)	40, 000 per year x 4 years	160,000			
Sub-Component 5.4: Total Cost				**3,320,000**			
Sub-Component 5.4: Total Cost= 3,320,000 USD							
Sub-Component 5.5: Customized Packages of Services for Vulnerable Populations							
A. Services Migrant Workers, Long-Distance Mobile Workers, Refugees, Returnees, IDPs							

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
1. STI Services, including:	Establishing STI Services	8 STI Service Centers					
	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. STI Services for migrant workers established							
b. STI Services for long-distance mobile workers (truck/ bus, taxi drivers) established on main transport routes							
c. STI Services in X number of refugees camps established							
d. STI Services for Returnees at check-points of return and host communities established							
e. STI Services for IDPs established in IDP camps/communities							
2. VCCT services	Referral to existing VCCTs						
	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. VCCT Referral System for migrant workers established							
b. VCCT Referral System for long-distance mobile workers (truck/ bus, taxi drivers) established on main transport routes							
c. VCCT Referral System in X number of refugees camps established							
d. VCCT Referral System for Returnees at check-points of return and host communities established							
e. VCCT Referral System for IDPs established in IDP camps/communities							
3.Raising HIV/AIDS awareness and correct knowledge	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
a. IEC campaigns among migrant workers							
b. IEC campaigns among long-distance mobile workers (truck/ bus, taxi drivers) at main transport routes							
c. IEC campaigns among X number of refugee camps							
d. IEC campaigns among X number of communities of returnees							
e. IEC campaigns among X number of communities of IDPs							
4. Condom and Lubricant Distribution among:							
	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. migrant workers							
b. long-distance mobile workers (truck/ bus, taxi drivers) at main transport routes							
c. X number of refugee camps							
d. X number of communities of returnees							
e. X number of communities of IDPs							
5. Training for Trainers (TOT) to Carry – Out Services for:	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. Migrant Workers							
b. Long-Distance Mobile Workers							
c. Refugees							
d. Returnees							
e. IDPs							
6. Peer-Education Among:	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. Migrant Workers							
b Long-Distance Mobile Workers							
c. Refugees							
d. Returnees							
e. IDPs							
B. Customized Package of Services for Uniformed Personnel (Police and Military)							
1. Encouraging Police and Military to use STI/VCCT Services among:							
	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. X number of police schools/academy							
b. X number of military bases							
c. X number of military schools							
2.Raising HIV/AIDS awareness and correct knowledge	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. IEC campaigns launched among X number policemen/women							
b. IEC campaigns launched among X number of military staff							
3. Condom and Lubricant Distribution among:	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 USD per year x 4 years per contract =200,000 USD	200,000 USD			
a. policemen/women							

Components/Activity	**Inputs Required**	**Quantity Required** **(for the Entire Program Period)**	**Unit Cost in USD**	**Total Cost in USD**	**Amount Mobilized in USD**	**Source of Funds**	**Gap in Financing in USD**
b. among military staff							
4. Training for Trainers (TOT) to Carry – Out Services for Police	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
4. Training for Trainers (TOT) to Carry – Out Services for Military	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
5. Peer-Education, including:	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
a. Peer-education conducted among policemen/women							
b. Peer-education conducted among military							
Sub-Component 5.5: Total Cost				**1,200,000**			
Sub-Component 5.5: Total Cost =1,200,000 USD							
COMPONENT 5: TOTAL COST, INCLUDING:				**14,060,000**	**5,000,000**	**The World Bank**	**9,060,000**
Sub-Component 5.1: Total Cost				**4,560,000**			
Sub-Component 5.2: Total Cost				**2,800,000**			
Sub-Component 5.3: Total Cost				**3,000,000**			
Sub-Component 5.4: Total Cost				**3,320,000**			
Sub-Component 5.5: Total Cost				**1,200,000**			
COMPONENT 5: TOTAL COST = 14,060,000 USD							

COMPONENT 6: TARGETING GENERAL POPULATION THROUGH RAISING AWARENESS AND KNOWLEDGE ABOUT HIV/AIDS							
Sub-Component 6.1: Raising HIV/AIDS Awareness and Correct Knowledge Among General Population							
Components/Activity	**Inputs Required**	**Quantity Required (for the Entire Program Period)**	**Unit Cost in USD**	**Total Cost in USD**	**Amount Mobilized in USD**	**Source of Funds**	**Gap in Financing in USD**
1.Raising HIV/AIDS awareness and correct knowledge among general population	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
(a) In urban communities							
(b) In rural communities							
Sub-Component 6.1: Total Cost				**200,000**			
Sub-Component 6.1: Total Cost =200,000 USD							
Sub-Component 6.2: Raising HIV/AIDS Awareness and Correct Knowledge Among Women, Youth, and Children							
1 .Raising HIV/AIDS awareness and correct knowledge among specific groups:	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
(c) women							
(d) youth							
(d) children							
Sub-Component 6.2: Total Cost				**200,000**			
Sub-Component 6.2: Total Cost =200,000 USD							
Sub-Component 6.3: Raising Awareness and Inciting the General Population to Demand Infection Prevention and Safe Injection Practices							
1. Raising awareness and inciting the general population to demand infection prevention and safe injection practices	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
a. IEC Materials for general population developed and distributed							
b. Workshops on IP and safe injection launched							
Sub-Component 6.3: Total Cost				**200,000**			

Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
Sub-Component 6.3: Total Cost =200,000 USD							
Sub-Component 6.4: Raising Awareness of the General Population on Reducing Discrimination of High-risk Groups, Vulnerable Populations and PLWHA							
1. Raising awareness of the general population on reducing discrimination of high-risk groups, vulnerable populations and PLWHA	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
a. IEC campaigns launched in 8 major cities							
b. IEC campaigns launched in X number of rural communities							
Sub-Component 6.4: Total Cost				**200,000**			
Sub-Component 6.4: Total Cost = 200,000 USD							
2. Raising awareness of private sector, civil society and religious organizations on reducing discrimination of high-risk groups, vulnerable populations and PLWHA	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
a. IEC campaigns launched private sector							
b. IEC campaigns launched for community-based organizations							
c. IEC campaigns launched for religious-based organizations							
3. Training for Trainers (TOT) to Carry – Out Services for women, youth and children	Contacts for selected NGOs, including:	8 major cities, plus provincial level (total of 34 locations)					
	2 Umbrella NGOs for 4 years		50,000 per year x 4 years per contract =200,000	200,000			
4. Peer-Education among women, youth and children							
Sub-Component 6.5				**200,000**			

Sub-Component 6.5=200,000 USD							
Components/Activity	Inputs Required	Quantity Required (for the Entire Program Period)	Unit Cost in USD	Total Cost in USD	Amount Mobilized in USD	Source of Funds	Gap in Financing in USD
COMPONENT 6: TOTAL COST, INCLUDING				1,000,000	1,000,000	The World Bank	------
Sub-Component 6.1: Total Cost				200,000			
Sub-Component 6.2: Total Cost				200,000			
Sub-Component 6.3: Total Cost				200,000			
Sub-Component 6.4: Total Cost				200,000			
Sub-Component 6.5: Total Cost				200,000			
COMPONENT 6: TOTAL COST = 1,000,000 USD							

ALL COMPONENTS: TOTAL COST

All Components	Estimated Cost	Mobilized Funds	Source of Funding	Gap in Funding			
COMPONENT 1:	3,570,000 USD	1,600,000 USD	WB	1,970,000 USD			
COMPONENT 2:	1,510,000 USD	300,000 USD	WB	1,210,000 USD			
COMPONENT 3:	2,489,250 USD	2,100,000 USD	WB	389,250 USD			
COMPONENT 4:	14,585,200 USD	6,840,000 USD	FC	7,745,000 USD			
COMPONENT 5:	14,060,000 USD	5,000,000 USD	WB	9,060,000 USD			
COMPONENT 6:	1,000,000 USD	1,000,000 USD	WB				
TOTAL	37,124,450 USD	16,840,000 USD	WB/FC	20,374,250 USD			