PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: AB2612

Project Name	Afghanistan HIV/AIDS Prevention Project
Region	SOUTH ASIA
Sector	Health (70%); General education sector (15%); Media (10%); General public administration sector (5%)
Project ID	P101502
Borrower(s)	GOVERNMENT OF AFGHANISTAN
Implementing Agency	
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Environment Category	[ ] A [X] B [] C [ ] FI [ ] TBD (to be determined)
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1. Key development issues and rationale for Bank involvement

1.1. Main issues

1.1.1. Afghanistan is in the early stage of the HIV epidemic, with high potential for rapid spread. Action is urgently needed to break transmission, especially among injecting drug users (IDUs) and their partners, and among other vulnerable groups at high risk such as sex workers (SW) and their clients, and men who have sex with men (MSM). The absence of a robust and reliable surveillance system and the resultant lack of seroprevalence data make it impossible to determine the size of the problem with any precision. But a recent survey found that already 3 percent of IDUs are HIV positive in Kabul. Moreover, behavioral surveys point to a high risk behavioral environment, in terms of low prevalence of condom use, socio-cultural factors that make open discussion of risky behaviors difficult and traditionally lower status of women that increase their vulnerability.

1.1.2. A critical contributor to the high risk and vulnerability for HIV and AIDS is the recent increase in opium production, Afghanistan being the world's largest producer (UNODC 2005). In addition, prolonged war and insecurity, poverty and cross border migration have inevitably led to increased drug use and vulnerability to HIV infection. Most of the drug use in Afghanistan is by ingestion or inhalation. But, injection is increasingly being resorted to, the leading population group for this being the refugees living in and returning from Iran and Pakistan. There are an estimated 920,000 drug users in

Afghanistan, of whom 19,000 are IDUs. Neighboring countries have significant concentrated HIV epidemics among IDUs as a result of sharing injecting equipment. Therefore, it is reasonable to expect a similar epidemic in Afghanistan, if timely and appropriate action is not taken right now. There is a rapidly closing window of opportunity to respond to such a threat. The experience in neighboring countries shows how quickly an IDU-driven epidemic spreads

1.2. National response

1.2.1. The 2006 national development strategy includes a five-year benchmark for HIV/AIDS: to maintain a low prevalence of HIV-positive cases (less than 0.5 percent) in the population and to reduce mortality and morbidity associated with HIV/AIDS. The Ministry of Public Health (MOPH) had developed a national strategic plan for Afghanistan for the period 2003 to 2007 (MOPH 2003). This has been revised into a draft Afghanistan National HIV/AIDS Strategic Framework 2006 – 2010 through a broad-based participatory process, which started off with thematic working groups addressing the issues of (i) capacity development and leadership (institutional development, multi sector approaches, surveillance, monitoring, and evaluation), (ii) high-risk and vulnerable groups, (iii) health sector issues (blood safety, VCT, links to tuberculosis and reproductive health, treatment, care and support) and (iv) IEC. These thematic groups, supported by a technical advisory group of coordinating agencies, developed the strategic framework. The translation of the strategic framework into a more detailed national operational plan has been initiated and is expected to be completed by the NACP by the end of December, 2006 with technical assistance being offered by UNAIDS as well as the World Bank.

1.2.2. A proposal for support to a multi sector response to HIV and AIDS has been submitted to the sixth round call for proposals by the Global Fund for AIDS, TB and Malaria (GFATM). A Country Coordinating Mechanism (CCM) is in place with involvement of most stakeholders (government, development partners, NGOs), and chaired by an International NGO. Some joint activities are undertaken between the demand reduction units of the Ministries of Counter Narcotics and of Public Health. These two Ministries have jointly developed a Harm Reduction Strategy for IDU and HIV/AIDS prevention. The Government of Afghanistan (GOA) adopted harm reduction as the nation's official drug policy already in 2004. A blood safety program based in blood banks is under development with financial support from the French Cooperation.

1.2.3. HIV prevention to date has been very weak, although a few NGOs are reaching out to high-risk populations on a small scale with harm reduction programs, including safe needle exchange programs. A scaled up comprehensive harm reduction program will be required to prevent HIV from further spread among high risk groups and into the general population, including: peer education, needle and syringe exchange, drug treatment including substitution treatment, health service referral and community development programs. Although these measures should be provided in community settings, attention to coverage of prison inmates is also required. Initial efforts are also under way to integrate HIV/AIDS services in the government's basic package of health services, aiming to cover 90 percent of the population. However, only 30 percent of transfused blood is tested for HIV. Anti retroviral therapy is not available for people living with HIV and AIDS in Afghanistan. Mapping and outreach to other groups at high risk from

unsafe sex is also urgently needed. If the epidemic continues to go unchecked, the country will face a serious HIV epidemic with significant cost to health, social, economic and national security, as seen in other countries.

1.2.4. A strategic multi-sector approach involving a few key ministries and sectors is required given the nature of the epidemic. With IDU as the main driver of the epidemic, it is paramount that drug law enforcement agencies adopt a balanced approach between supply reduction, demand reduction and harm reduction, as excessive drug law enforcement zeal tends to force the price of heroin up and the purity down, risking a shift to injecting drugs, in turn increasing the risk of HIV transmission. Non-health sectors are required to be involved while addressing other vulnerable groups such as sex workers, prison inmates, truck drivers and migrant labourers as well. AIDS is also a highly stigmatized problem – stigma, taboo and denial rooted in the deeply religious and traditional society. Programs will require active involvement and support from a number of ministries and sectors, including religious, women's and social affairs, education, counter narcotics, roads and transport.

1.3. Rationale for World Bank involvement

1.3.1. Lack of sufficient external financing support to HIV/AIDS programming – currently only GFATM and the French Cooperation seem likely to contribute with any significant funding; UN agencies have been involved, but only minimally and the GFATM financing is not yet approved; even if it does get approved, the proposal does not cover prevention among high risk groups. The French Cooperation resources for HIV prevention are limited to a blood bank system of one central and 4 regional blood banks, with no resources for further outreach of blood bank services. Additional resources are needed to scale up targeted interventions.

1.3.2. Existence of a successful model of contracting with NGOs under the Bank-financed Emergency Health operation provides hope for similar success of civil society involvement in the HIV/AIDS program under the same Ministry

1.3.3. Convening power – can help back up the MOPH/NACP as the leader of the inclusive coordination mechanism that is being set up and provide support to the eventual establishment of a broader-based institutional arrangement, while starting with the simpler approach of working through MOPH.

1.3.4. The Bank's long experience in other countries dealing with HIV both in Central and South Asia.

1.3.5. Multi-sector approach: The Bank is financing projects in Education and Infrastructure. (e.g., rural roads project under preparation in Herat which will have an AIDS component). This puts the Bank in a unique position of bringing multi-sectoral involvement in HIV prevention.

1.3.6. Economic advocacy. The Bank is probably best placed to undertake the necessary economic analyses and make the appropriate arguments to place HIV/AIDS on the national agenda as a priority intervention in the macro ministries such as Finance.

1.3.7. Volatile situation – WB offers more sustained and longer term financing than most other sources of funds for HIV/AIDS.

2. Proposed objective(s)

2.1. The Project's development objective is to support the Government of Afghanistan in maintaining a low prevalence of HIV-positive cases (less than 0.5 percent) among the general population, containing the spread of HIV transmission among vulnerable population groups, i.e., IDU, FSW, MSM, controlling HIV transmission, especially to the general population and thus averting a generalized epidemic.

2.2. To achieve the above objective, the project seeks to build the capacity of, and to contribute financially to an effective national response to HIV/AIDS, through a robust surveillance system, scaled up targeted interventions with sufficient coverage of vulnerable populations and appropriate communication activities to bring about changes in risky behaviors and stigma against HIV +ve persons.

2.3. Key Performance Indicators:

2.3.1. % of IDUs using safe injecting practices
2.3.2. % vulnerable population groups (IDUs, FSW, MSM) with correct knowledge about HIV causation and prevention
2.3.3. % condom use among vulnerable population groups
2.3.4. Availability of reliable surveillance data [Periodicity and geographical coverage of sero-prevalence and behavioral surveys]

2.4. Availability of baseline data for the key performance indicators would be ensured before the start-up of implementation. Existing sources of information

3. Preliminary description

3.1. While we are awaiting the finalization of a national Program Operational Plan, we can only provide some indicative ideas on what the project components might look like. A lot would depend on whether and to what extent, Afghanistan's request to GFATM for $35 million succeeds. Once the POP is ready and other donor inputs are identified, the Bank-financed project would seek to fill the gaps through a process of prioritization in consultation with the Government.

3.2. Tentatively, given the information so far available, the team is considering the following components. After the GFATM decision in November, and after the POP is finally made available, this would be reviewed and revised as necessary.

3.2.1. Strengthening surveillance system including Behavioral Surveillance
3.2.2. targeted interventions for high-risk and vulnerable groups, including support for innovative approaches and operations research to evaluate impact,
3.2.3. communications strengthening IEC/advocacy
3.2.4. Program management, capacity development and leadership (institutional development, multi sector approaches, monitoring and evaluation, coordination mechanism)

4. Safeguard policies that might apply

Environmental safeguards need to be adhered to, with regard to health care waste management, and the safe disposal of unclean needles and syringes that the project would collect in exchange for clean needles and syringes as part of the harm reduction activities targeted at injecting drug

users. The Ministry of Public Health already has a Health Care Waste Management Plan, prepared recently under the Bank-financed Emergency Health Project. That plan needs to be updated, especially to take account of the recently passed Environmental Safety Act. Once updated, the same plan would be applied to the interventions planned under this project as well.

Though no specific social safeguard policies would be triggered, the project would seek to address specific gender-based vulnerabilities as part of its design (empowerment of women to negotiate safer sex, gender-based violence and discrimination related to HIV +ve status, and workplace discrimination against women, based on HIV +ve status).

5. Tentative financing

Source:		($m.)
BORROWER/RECIPIENT		0
IDA Grant		10
	Total	10

6. Contact point

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