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Executive Summary

1. This submission was written in collaboration with the Afghan Family Guidance Association (AFGA),[1] in collaboration with the Sexual Rights Initiative[2] (SRI) and the International Planned Parenthood Federation South Asia Regional Office (IPPF SARO).[3]

2. Afghanistan is a heterogeneous nation, in which there are four major ethnic groups: Pashtoons, Tajiks, Hazaras, and Uzbeks. The majority of Afghans (99%) belong to the Islamic faith. The official languages of the country are Pashto and Dari. A country of 29 million people, Afghanistan fell to 181 out of 182 countries in the Human Development Index and is classified as one the poorest nations in the world.[4]. In 2010, the population under age 15 (as % of total) was 17.7[5]. In 2008, adult literacy rate (% age 15 and above)–was 28 and youth literacy rate (% age, 15-24) was 33.5.[6] Almost 70 percent of Afghanistan's population is below the age of 25, growing up in a challenging and complex environment, marked by poverty and increasing insecurity, lack of access to quality education, and violence.[7] The presence of a large number of street children (estimated at 50,000 persons), including drug users among them, is particularly alarming.[8]

3. In this current scenario with varied national priorities and limited availability and access of services, the needs and rights of the marginalized populations including people living with HIV (PLHIV), specifically people who Injects Drugs (PWID) are neglected. Afghanistan is the main producer of opium and after a long history of wars it is home to a large number of conflicts which affects individuals and children. High levels of unsafe drug injection place the youth population as extremely vulnerable to acquiring HIV. The number of PWID infected with HIV is 18% in Herat, 3% in Kabul and 1% in Mazar-e-Sharif. Zero point six percent (0.6 %) of prisoners in Kabul are infected with HIV and 1.6 % of prisoners in Herat are infected with HIV.[9] **The submission calls for the Government of Afghanistan to address the pressing need to deliver right-based and stigma-free health services for all Afghan citizens, particularly those living with HIV and those who inject drugs.**

[1] An Afghan non-governmental, not-for-profit and non-political organization established in 1968. However, AFGA activities were suspended due to war and conflict in the country for ten years (1992-2002) AFGA has been working in the field of Reproductive health and Rights since its inception and is an associate member of International Planned Parenthood Federation (IPPF) from 2002 onwards)

[2] The Sexual Rights Initiative is a coalition including: Action Canada for Population and Development (Canada); Coalition of African Lesbians (Africa), Creating Resources for Empowerment and Action (India), AKAHATA (Latin America), Egyptian Initiative for Personal Rights (Egypt), Federation for Women and Family Planning (Poland), and others **(**www.sexualrightsinitiative.com**)**

[3] The International Planned Parenthood Federation is a global service provider and a leading advocate on sexual and reproductive health in the world and now works throughout the world through a unique arrangement with family planning associations of each country who provide sexual and reproductive health services to communities. IPPF strives to reach out to the poor, marginalized, social excluded and underserved communities who are often, otherwise, deprived of the services which they need for their well-being. The New Delhi office at the IPPF South Asia Regional Office (IPPF SARO) works with member associations in Afghanistan (www.afga.org.af), Bangladesh (www.fpab.org), Bhutan (www.renewbhutan.org), India (www.fpaindia.org) Iran (www.fpairi.org), Maldives (www.she.org.mv), Nepal (www.fpan.org), Pakistan (www.fpapak.org) and Sri Lanka (www.fpasrilanka.org).

[4] Afghanistan at A Glance, World Bank, 2009; WHO, 2010; Human Development Report, 2009; Human Development Index (HDI) ranks countries based on income, life expectancy and literacy rates. In 2007, the Afghanistan National Human Development Report placed the country at 174 out of 178 countries.

[5] UNICEF Country Statistics, 2010.

[6] UNICEF Country Statistics, 2010.

[7] Youth literacy rates are low with 50 percent for boys and 18 percent for girls; secondary school enrolments are respectively 23 percent and 7 percent, and less than 1 percent of the Afghan population obtaining higher education.

[8] Best Estimates of Social Indicators for Children in Afghanistan, 2003.

[9] Integrated Bio-Behavioral Surveillance (IBBS), Johns Hopkins University, and National AIDS Control Program (NACP), 2010.

International human rights obligations

4. Afghanistan became a member of the United Nations on November 19, 1946. Afghanistan is a party to the following international Human Rights Treaties:
    - The International Covenant on Civil and Political Rights (ICCPR), ratified on 24th April 1983.
    - The International covenant on Economics, social and cultural Rights (CESCR), ratified on 24th April 1983.
    - The International Convention on the Elimination of all Forms of Racial Discrimination (CERD), ratified on 5th August 1983.
    - The Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (CAT), ratified on 26th June 1987.
    - The Convention on the Rights of the Child (CRC), ratified on 27th April 1994.
    - The Optional Protocol of the Convention of the Rights of the Child (CRC-OP-SC) on the sale of children, child prostitution and child pornography, ratified on 19th October 2002.
    - The convention on the Elimination of all Forms of Discrimination against Women (CEDAW), ratified on 5th March 2003.
    - The Optional Protocol to the Convention on the Rights of the Child (CRC-OP-AC) on the involvement of children in armed conflict, ratified on 24th Sept. 2003

Legal framework and national human rights institutions

5. The present Constitution of the Islamic Republic of Afghanistan was agreed upon by more than 500 delegates representing Afghan men and women from across the country at the Constitutional Loya Jirga (December 13, 2003 - January 4, 2004). The Constitution was formally ratified by President Hamid Karzai in 2004. According to the Constitution, Afghanistan is an Islamic republic with Islam as its "sacred religion"; followers of other religions are free to perform religious ceremonies in accordance with the provisions of the law; no law shall be contrary to the beliefs and practices of Islam and; men and women have equal rights and duties before the law. The Constitution protects the rights to equal protection under the law, freedom of movement, to choose one's residence, freedom of expression and freedom from cruel and inhuman treatment.

6. The Judiciary in Afghanistan is composed of the Supreme Court, Courts of Appeal and Primary Courts. Travelling courts may be established when needed, on recommendation by the Supreme Court and with approval from the President. The Judiciary is empowered to resolve disputes between and among individuals and legal entities, including the state.

7. Afghanistan Independent Human Rights Commission (AIHRC) was established pursuant to the Bonn Agreement (5 December 2001) and on the basis of the decree of the Chairman of the Interim Administration (June 6, 2002), Resolution 134/48 (United Nations General Assembly, 1993), the Paris Principles and Article 58 of the Constitution of the Islamic Republic of Afghanistan. Now the Commission is performing its activities in the areas of promotion, protection and monitoring of human rights.

8. The Afghan Government and the international community reaffirm their commitment to the protection and promotion of rights provided for in the Afghan constitution and under applicable international law, including the international human rights covenants and other instruments to which Afghanistan is party. With a view to rebuilding trust among those whose lives were shattered by war, reinforcing a shared sense of citizenship and a culture of tolerance, pluralism and observance of the rule of law, the Afghan Government with the support of the international community will implement the Action Plan on Peace, Justice and Reconciliation.

9. Increasing insecurity in Afghanistan especially in the Southwest and South provinces is the major concern for deterioration of human rights. The environment makes it difficult for the human right organizations to monitor and protect human rights of the people. Another source of concern is the lack of sufficient commitment and follow up by the Government in the promotion,

protection and monitoring of human rights. Increase in the number of civilian casualties by the international and NATO forces is another source of concern in terms of human right protections.

Situation of HIV and Drug use

1. The first HIV case was reported in Afghanistan in 1989. Since then, the Government of Afghanistan has taken steps in halting the epidemic that is now largely concentrated among key affected populations such as injecting drug users (IDUs), prisoners, female sex workers (FSWs), and men who have sex with men (MSM). In 2009, the number of PLHIV was reported at 636 persons,[10] while UNAIDS and WHO estimates between 2,000 to 3,000 PLHIV in the country. Available data shows Afghanistan is currently considered to have low HIV prevalence in the general population, but a concentrated epidemic among PWID. Although, Afghanistan is a country of low prevalence with under 0.5 percent among the general population, it exhibits a wide spectrum of risks and vulnerability factors of various segments of the population. These factors include certain economic, social, and demographic that, if not addressed, effectively may fuel the spread of HIV.

2. Another segment of the population with higher HIV prevalence rates are Internally Displaced Persons (IDPs). There are around 1 million IDPs, returnees and refugees in the country, of which 865,000 have been re-located to their original places and efforts are being made to re-locate the remaining 135,000 to the places of their origin[11]. In addition to the registered refugees, there are un-registered immigrants (migrant workers or economic immigrants) in Iran and Pakistan.[12] No data is presently available on HIV prevalence or behavioral data IDPs or refugees and returnees in Afghanistan. However, evidence from other countries in the region suggest that these groups are potentially vulnerable to HIV as majority had lived a long period of time in Iran and Pakistan and, partially, India; all countries with higher prevalence rates, easy availability of drugs (specifically injecting drugs), as well as commercial sex.[13] In addition, displacement, mobility, poverty and deprivation can seriously contribute to increasing odds of their HIV risks. Available information from the 2006 World Food Program (WFP) study of PLHIV in Afghanistan indicates that 40 percent of all HIV positive patients surveyed were either not currently living in their place of origin and or just returned from abroad.[14] Recently, UN Office on Drugs and Crime (UNODC) and Ministry of Public Health (MoPH) conducted a Drug and HIV Vulnerability Assessment and Mapping carried in 5 provinces (Kabul, Parwan, Herat, Nangrahar, Jawzjan and Baghlan)[15] estimated 28,000 recent heroin users among the refugee population and around 7,700 IDUs. Drug users in this sample were more likely to have engaged in risky behavior for HIV transmission, including regular reliance on commercial sex workers. Condom use was 30-40 percent amongst those who had had sexual contact with a non-regular partner, a proportion which was the same amongst drug users and non-users.

[10] Presentation by Ministry of Refugees and Returnees at HACCA meeting, Kabul, 20 April 2010.

[11] Presentation by Ministry of Refugees and Returnees at HACCA meeting, Kabul, 20 April 2010.

[12] According to figures provided by the Islamic Republic of Iran and Pakistan, more than one million Afghan economic immigrants who are un-registered live in Iran and more than 300,000 in Pakistan. The Ministry of Refugees and Returnees reported that since 2002 around 6 million people have returned to Afghanistan of which 4.4 have been re-located to their original places. However, there are still 3 million Afghans who live in Iran and Pakistan and elsewhere.

[13] Particular focus is needed on cross-border mobility with Pakistan and Iran, including refugees, those involved in economic activities and Afghan residents in neighboring countries. In the case of Pakistan, for example, a large population of Afghans resides in the main cities of this country, with the majority in the Province of Khyber Pakhtunkhwa (KPK) and the Federally Administered Tribal Areas (FATA). In the Province of KPK, and particularly in the provincial capital of Peshawar, Afghans account for a substantial proportion of those seeking health care, including those that cross over the border seeking health care from the bordering districts of Afghanistan. By October 2010, 65 Afghans living with HIV were being followed up by the ART center in Peshawar [source: National and Provincial AIDS Control Program, Pakistan, 2010].

[14] Survey to Determine the Impact of Food Assistance Programmes on PLWHA, World Food Program, MoPH, 2006.

[15] Drug and HIV Vulnerability Assessment and Mapping among Returnees and Deportees, UNODC, MoPH, 2011 (unpublished).

3. Injecting drug use in Afghanistan is associated with intravenous injection of: (a) heroin, (b) pharmaceutical drugs and (c) tranquilizers and painkillers that are often supplemented with other forms of substance abuse. The 2009 UNODC, MoCN and MoPH Drug Survey estimated the number of IDUs ranging from 19,000 to 25,000 persons, similar to the 2005 UNODC data that included 7,000 of those who inject heroin and 12,000 of those who inject pharmaceutical drugs.[16] The best available data point at distinct differences with regard to the patterns of injecting drug use by type of drugs, gender, age, and geographic location with three Western provinces of Herat, Farah and Nimrooz emerging as 'hotspots', in addition to Kabul City that is thought to the a home to the largest number of opium users, heroin users and IDUs. According to UNODC, while the majority of IDUs are males, women IDUs are more likely to be widowed or divorced, with less education and more than twice as likely not to have a job.[17] Available information suggest a profile of a drug user having the following social and demographic characteristics as being from any ethnic group, a poor male under 30 years of age, unemployed, with little or no education, married and living with the extended family; if employed, usually as a farmer or unskilled worker and supplementing his income to meet the costs of his drug use via selling family assets, borrowing money, stealing, begging, or committing other petty crimes.[18] While systematic information is presently unavailable, data suggest a considerable number of adolescents and children among IDUs and drug users at large.[19]

Legal and Social context

4. Afghanistan National HIV Code of Ethics aims to serve as foundation for ethical practice of all HIV prevention, treatment, care, and support services in the country. The National HIV and AIDS Policy of May 2011 is a key policy document that reiterates ensuring that every person in the country has equitable access to HIV prevention, treatment, care and support services and the right to live with dignity. According to the Policy, all HIV testing should be voluntary; no mandatory testing should be practiced. The Policy also emphasizes that PLHIV will have the same rights as all other citizens, and will not be discriminated against or stigmatized on the basis of their HIV status, gender, socioeconomic status, or HIV-risk behaviors.

5. There are no policies or legislation that criminalizes the transmission of HIV in Afghanistan.

6. The Public Health law of Afghanistan declares that the provision of health care services to all must be done without any form of discrimination or stigma. However, implementation and follow to this requirement remains a challenge. Prevailing levels of stigma and discrimination associated with HIV is one of the main challenges for the HIV response as whole. Most of the stigma appears as marginalization and avoidance in the involvement of social gathering and ceremonies. Stigma and discrimination against drug user is also prevalent, however, there is no exact data available on the frequency, degree and primary causes. Prevailing insecurity,[20] low socio-economic conditions leading to poverty, unemployment and existing levels of stigma and discrimination experienced by drug users are common challenges associated with successful HIV prevention programs for PWID.

7. The 2010 Afghanistan drug law mentions that drug use is illegal and punishable by law. The issue of drug use is primarily treated as a criminal issue and taking drugs and carrying it is illegal and punishable by law. Sex work is also considered a crime and punishable by law.

[16] Data provided by the MoCN, 2006.

[17] UNODC, MoCN, 2009, Todd C.S, Addul Nasir, Katja Fiekrt, et al, Results of the Intervention and Community Phases of Integration of Needle Exchange & VCT in Kabul, Afghanistan, 2010, IBBS 2009.

[18] UNODC, MoCN 2009, *Ibid.*

[19] Sabawoon A, Samarrudin and G. Sayed, A Rapid HIV Situational Assessment of Herat Province, NACP, The World Bank, 2010 .

[20] Refers to continuous conflicts and war in the country which affect the effective implementation of the rule of law.

8. During the World AIDS Day (WAD) 2011 ceremony organized in Ministry of Public Health, the government, for the first time, heard the voices of PLHIV from an HIV support group. The group requested that their access to HIV prevention car and support services be improved. Despite this, the involvement of PLHIV in the national AIDS response is presently non-existent, and interventions to strengthen this area have been limited, thus violating PLHIV right to participate.

Availability and Accessibility of Services

9. With the support of key international donor and development agencies, the country has taken a multi-sectoral approach to the HIV response in order to arrest the potential spill over of the HIV from concentrated epidemic to generalized epidemic. The HIV/AIDS Co-ordination Committee of Afghanistan (HACCA) is an inter-sectoral structure at the national level and reflects the full commitment and priorities of Islamic Republic of Afghanistan in response to HIV and AIDS. The organizations represented in the HACCA, with programs for PWID include: MDM (Medicine Du Monde), SDO (Sanayee Development Organization), OTCD (Organization of Technical cooperation for Community Development), Nejat Center, KOR (Kathez Organization for Rehabilitation), AFGA (Afghan Family Guidance Association), Zendagi Nawin and World Vision.

10. Currently, HIV services are integrated within the BPHS (Basic Package of Health Services) and EPHS (Essential Package of Hospital Services) which are the two main health services delivery mechanisms in the country. The BPHS is implemented in districts where 85 percent of the country's population resides. ART treatment has expanded from a modest beginning where now ART is being provided to 110 persons as of December 2011[21].There are only two ART centers – Kabul and Herat cities which HIV+ cases have been referred to for treatment, care and support. This presents significant challenges to those requiring services outside these cities, which has a direct impact on their right to the highest attainable standard of physical and mental health.

11. Male condoms are available in all health centers. However, female condoms and lubricant are not available in the country. This constitutes violations of women's rights, specifically their right to equality.

12. Out of 18,000 to 23,000 existed PWID, only 5,500 (25%) are covered by the implementation of the MoPH contracted-out programs in 8 provinces. The remaining 75% of PWID do not have access services. Harm reduction activities for PWID are available in 8 provinces which only cover 25% of PWID in the country. Opiate substitution treatment (OST) is now available on a pilot basis in a centre run by MDM in Kabul, where by November 2010, 71 people were receiving methadone maintenance therapy (MMT). There is a strong need to reach a much larger number of PWID. Geographic coverage of harm reduction programmes, in particular of Needle Syringe exchange program (NSP), remains low. There are day-care centers run by NGOs such as Nejat center, Zendagi Nawin which PWID can meet each other and have access to harm reduction services including, outreach services, peer education and recreational activities. Harm and risk reduction activities for prisoners target primarily IDU prisoners, including in 8 cities: Herat, Ghazni, Kabul, Kandahar, Balkh, Kunduz, Jalalabad, and Badakshan under the World Bank and Global Fund to Fights AIDS, Tuberculosis and Malaria supported nationally implemented projects. The harm reduction response in prisons remains limited and condoms, MMT (Methadone Maintenance Therapy) and NSP are not yet permitted in prison settings despite ongoing policy dialogue.

13. Nutritional and socio-economic support programs for PLHIV and their families such as children affected by the HIV/AIDS are not available and nor are psycho-social and continuum of care interventions in place.

[21] Country progress report 2012.

14. There are mobile health teams for IDP; however, there is a lack of quality health services in most rural areas where many IDP live. IDPs are more vulnerable compared to the rest of the population. The literacy rate for both IDP men and women is below national averages. IDPs live in larger households (9.5 people) compared to other Afghans (7.3), requiring greater support and resources, but have lower household incomes. The unemployment rate for IDPs is well above national averages and contributes to increases in the length of their displacement. Due to post-displacement difficulties in securing employment, IDP households surveyed have seen their monthly incomes decrease by 21%.

Recommendations

a. Legal and Policy context:

15. **Educate and sensitize all public officers, particularly those in the health and law-enforcement sectors on their obligations in terms of non-discriminatory treatment towards women, and persons living with HIV and AIDS and PWID.** Specifically, **provide rights-based training to health system service providers**, in order to ensure they respect patients' confidentiality, provide non-judgmental care and work to prevent stigma and discrimination, while working specifically with PWID.

16. **Create a legal framework to safeguard the rights of PLHIV**, including their access to testing and confidentiality.

17. **Eliminate stigma and discrimination experienced by PWID and PLHIV by launching communication campaigns** using print and audio-visual media to increase awareness of society on rights of drug users and HIV prevention, treatment and care.

18. **Financially support the collection of triangulated data** to ensure correct and more accurate information related to PWID and PLHIV.

b. Accessibility and Availability of services:

19. **Expand harm reduction packages to other provinces** which have high number of PWID in a planned and phased manner. This involves working with the Ministry of Justice for the implementation of full harm reduction package in prisons settings, including NSP.

20. **Approve and provide OST as a national program throughout the country and training of relevant staff on its implementation,** including capacity building and technical support to relevant stakeholders on scale up of OST, and mechanisms to evaluate its effectiveness.

21. **Increase the number of ARV centers especially in major cities** such as Kandahar, Mazar and to adopt an effective supply management system to ensure timely and continuous supply of ARV drugs.

c. Participation and rights:

22. **Increase awareness of PWID and PLHIV on their rights and encourage their meaningful participation in national forum and policy dialogue** for programs affecting them; specifically, provide spaces for participation of ex (rehabilitated) addicts in shaping policy framework through active dialogue and interface to create more responsive laws and policies.

23. **Establish mechanisms to empower PWID and PLHIV to report violations of their human rights to relevant authorities,** such as Human Rights Commission.

24. **Provide funding for national level Civil Society Organizations to create models of interventions** which may later be scaled up by the government with support from donors and multilateral organizations.