



# HIV/AIDS SAARC REGION

UPDATE 2012



SAARC Tuberculosis and HIV/AIDS Centre (STAC)





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## Foreword

HIV epidemic continues to pose as a major challenge in the realm of human development. The current estimated number of persons living with HIV globally in 2011 was 34.2 million [31.8 million –35.9 million]. The global incidence of HIV infection has stabilized and begun to decrease in many countries with generalized epidemics. In 2011, more than 8 million people living with HIV in low- and middle-income countries were receiving antiretroviral therapy, up from 6.6 million people in 2010 – for an increase of more than 20%. It is encouraging to note that more people than ever are getting treatment, care and support.

SAARC Region has an estimated 2.54 million People Living with HIV/AIDS and India alone bears an estimated 2.39 million of that. HIV epidemic in the SAARC Region is a collection of different epidemics in the Member States with their own characteristics and dynamics. The diversity existing in the region needs to be fully addressed and defined, in order to achieve the success in prevention and control activities.

The SAARC TB & HIV/AIDS Centre has been coordinating the efforts of Member States in combating HIV/AIDS epidemic. Along with the other regular activities, STAC brings out reports and publications regularly in order to disseminate information related to TB and HIV/AIDS. The STAC also strives hard in assisting the member states in achieving the strategy of zero new HIV infections, zero discrimination, and zero AIDS-related deaths.

SAARC HIV/AIDS Update – 2012 incorporates updated information on HIV/AIDS as of December 2011. This is the 10th annual report on HIV/AIDS situation in the SAARC Region. It includes general information on HIV/AIDS and describes global, regional and SAARC Member States HIV/AIDS situation. I hope that the information contained in this report will help the SAARC Member States and the stakeholders who are engaged in the field of HIV/AIDS prevention and control in the region.

STAC is grateful to SAARC Member States for their cooperation and support extended in providing timely relevant information to compile this report in time. STAC also acknowledges with thanks the efforts rendered by the Professional staff and the support given by the General Services Staff of the centre in the preparation of this report.



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# Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CPT	Cotrimoxazole Prophylaxis Therapy
CSW	Commercial Sex Worker
CVM	Condom Vending Machines
DNA	Deoxyribonucleic Acid
DOTS	Directly Observed treatment Short course
ICRC	International Committee of Red Cross
FSW	Female Sex Worker
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counseling Treatment center
IDU	Injecting Drug User
IPT	Isoniazid Preventive Therapy
MSM	Man having Sex with Man
MSW	Male Sex Worker
MTCT	Mother to Child Transmission
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NASP	National AIDS STD Programme
NCASC	National Center for AIDS and STD control
NSACP	National STD and AIDS Control Programme
NGO	Non Governmental Organization
NTP	National TB Control Programme
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child transmission



PWID	People Who Inject Drug
RNTCP	Revised National Tuberculosis Control Programme
SAARC	South Asian Association for Regional Cooperation
STAC	SAARC TB and HIV/AIDS Centre
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nation's Programme for AIDS
VCT	Voluntary counseling and Testing
WB	World Bank
WHO	World Health Organization

# 1. SITUATION OF HIV/AIDS

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## 1.1 INTRODUCTION

The South Asian Association for Regional Cooperation (SAARC) comprises of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. SAARC is a manifestation of the determination of the people of South Asia to work together towards finding solutions to their common problems in a spirit of friendship, trust and understanding and to create an order based on mutual respect, equity and shared benefits.

SAARC Tuberculosis and HIV/AIDS Centre (STAC) is one of the Regional Centres of SAARC, located in Kathmandu, Nepal. The Heads of State or Government of Member Countries of SAARC at their Fifth Summit held in Male from 22 to 23 November 1990 decided that SAARC Tuberculosis Centre would be set up in Nepal. It was established in 1992 and became fully functional in 1994. The initial mandate of the centre was to work for prevention and control of TB & HIV/AIDS related TB in the Region. But later on its mandate has been extended to work for prevention & control of HIV/AIDS and TB/HIV co infection in the Region. The Centre has been renamed as **SAARC TB & HIV/AIDS centre** in November 2005. Since then the centre has been working for prevention and control of TB and HIV/AIDS in the Region by coordinating the efforts of the National Tuberculosis Control Programs (NTPs) and National AIDS Control Programs (NACPs) of the Member States.

One of the main functions of this centre is to collect, analyze and disseminate latest relevant information in the field of TB and HIV/AIDS control in the region and elsewhere. In this regard the Centre has been publishing annual SAARC Regional Epidemiological Reports on HIV/AIDS since 2003. This update is on the HIV/AIDS and TB/HIV Co-Infection situation in the SAARC Region and is the tenth in the series.



The global HIV epidemic has emerged as a formidable challenge to public health, development and human rights. Sub-Saharan Africa still continues to bear the major brunt of the global epidemic.

The SAARC Member States have varied epidemiological patterns of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS). In spite of different predominant HIV risk behaviors in the region, it has extremely diverse capabilities to develop and support public health prevention and control programmes. In reviewing the current epidemiology of HIV and AIDS within the SAARC region, this diversity needs to be fully addressed and defined. Despite these diversities, Member States are committed to take necessary actions and contain HIV and AIDS epidemic.

The HIV epidemic has had a variable impact in countries of the region. HIV epidemic is in different stages in each country. Through implementation of surveillance system for HIV prevalence, as well as sexual and injecting risk behaviours by some of the Member States, understanding of the many diverse HIV determinants of the epidemic in the region has improved substantially. Overall HIV prevalence rate in the SAARC Member States remains low, but there are major public health concerns regarding the future growth potential of HIV epidemic within the region.

The HIV epidemic is heterogeneously distributed within the region and within countries. Some countries are more affected than others and at country level there are variations in infection levels between different provinces, states or districts and between urban and rural areas. Actually the national picture is made up of a series of epidemics with their own characteristics and dynamics.

This report presents an overview of the HIV pandemic and a more detailed description of its epidemiology within the SAARC region. In addition, this report also contains progress in HIV/AIDS control in the region, impact of HIV/AIDS and contribution of STAC towards control of HIV/AIDS in the region.

## 2. GLOBAL SITUATION OF HIV/AIDS

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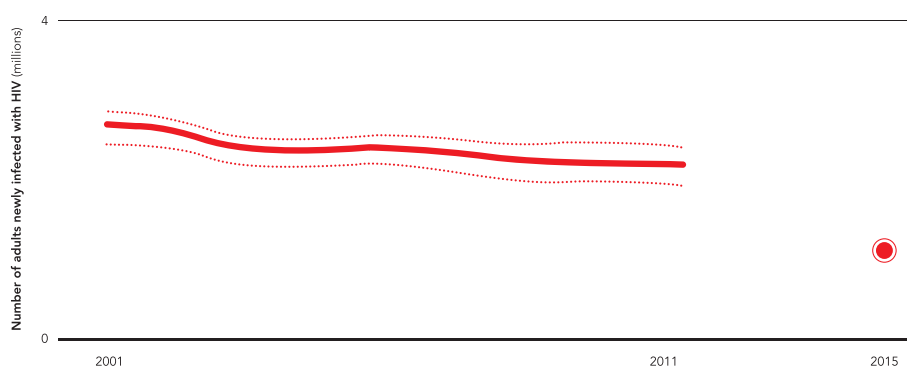
### 2.1 Global HIV Epidemic

Globally, there were 34.2 million [31.8 million–35.9 million] people living with HIV in 2011, and the women comprised half (49% [46–51%]) of the adults living with HIV, a proportion that has varied little in the past 15 years. The estimated number of adults acquiring HIV infection in 2011 was 2.2 million [2.0 million–2.4 million], 500 000 fewer than in 2001. This declining trend stems from a combination of factors, including the natural course of HIV epidemics, behavioural changes and increasing access to antiretroviral therapy. The number of adolescents and adults newly infected with HIV keeps on to declining globally as prevention efforts acquire momentum. Nevertheless, the rate of decline is not sufficient to reach the goals of reducing the number of people acquiring HIV infection by 50% by 2015.

Most of the adults newly infected are still living in sub-Saharan Africa, but the number getting HIV infection is declining. The number of adults acquiring HIV infection in 2011 in that region fell by more than 35% to 1.5 million [1.3 million–1.6 million] from the estimated 2.2 million [2.1 million–2.4 million] at the height of the epidemic in 1997. HIV services are not yet reaching all key populations at higher risk of infection, such as sex workers, people who inject drugs and men who have sex with men. The number of people newly infected is therefore, not declining sufficiently in areas where the epidemic is concentrated among key populations at higher risk. This is particularly evident in Eastern Europe, Central Asia, the Middle East and North Africa. After slowing in the early 2000s, the number of people newly infected in Eastern Europe and Central Asia has been rising again since 2008. The annual number of people newly infected has also risen in the Middle East and North Africa for the past decade.



**Figure 01: Number of adults newly infected with HIV (2001-2011) and the target for 2015**



Source: *Together we will end AIDS UNAIDS, 2012*

The number of people dying annually from AIDS-related causes worldwide decreased from a peak of 2.3 million [2.1 million–2.5 million] in 2005 to an estimated 1.7 million [1.6 million–2.0 million] in 2011.

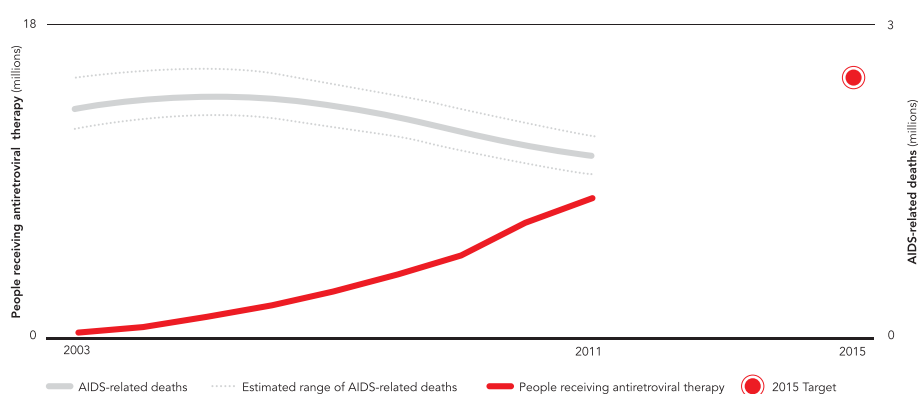
Globally, an estimated 1.2 million [1.1 million–2.8 million] women and girls newly acquired HIV infection in 2011. Globally, women represent 49% of all adults living with HIV. Young women have a much higher risk of acquiring HIV than young men. HIV strategies therefore need to account for the specific needs of women and girls, and they need budgets to get implemented. In low- and middle-income countries, an estimated 1.5 million [1.3 million–1.6 million] women living with HIV were pregnant in 2011. Reaching the target of halving the number of mothers dying among these women requires that all the estimated 620 000 [600 000–700 000] pregnant women living with HIV who are eligible for treatment receive it. This is especially crucial in sub-Saharan Africa, where AIDS is the leading cause of mothers dying.

About 330 000 [280 000–380 000] children were newly infected with HIV in 2011, almost half the number in 2003, when the number of children acquiring HIV infection peaked at 570 000 [520 000–650 000], and 24% lower than the number of children newly infected in 2009 (the baseline year for the Global Plan). Among the 21 Global Plan priority countries in sub-Saharan Africa, the number of children newly infected decreased from 360 000 [320 000–420 000] in 2009 to 270 000 [230 000–320 000] in 2011, a 25% decrease. With accelerated efforts, the number of children acquiring HIV infection can probably be reduced by 90% by 2015 from the baseline year of 2009.



An estimated 1.4 million more people were receiving antiretroviral therapy in low- and middle-income countries in 2011 than in 2010, similar to the progress made between 2009 and 2010. The most dramatic progress has been in sub-Saharan Africa, where treatment coverage increased by 19% between 2010 and 2011. In addition, at least 745 000 people were receiving antiretroviral therapy in high-income countries. More lives are being saved. Antiretroviral therapy has added 14 million life-years in low- and middle-income countries globally since 1995, with more than 9 million of these in sub-Saharan Africa.

**Figure 02: Number of people receiving ART versus the 2015 target and the number of AIDS related deaths in low and middle income countries (2003-2011)**



Source: *Together we will end AIDS UNAIDS, 2012*

The number of people dying annually from AIDS-related causes worldwide decreased from a peak of 2.3 million [2.1 million–2.5 million] in 2005 to an estimated 1.7 million [1.6 million–2.0 million] in 2011. The impact of HIV treatment is most evident in sub-Saharan Africa, where an estimated 550 000 (or 31%) fewer people died from AIDS-related causes in 2011 than in 2005, when the number of AIDS-related deaths peaked.

## 2.2 Regional Variations

In sub-Saharan Africa in 2011, an estimated 1.5 million [1.3 million–1.6 million] adults were newly infected with HIV in 2011, about 22% fewer than in 2001 and 3% fewer than in 2010. Modifications in risky behaviour, including a reduced number of sexual partners, increased condom use and delayed sexual debut provided the momentum for this downward trend, as did increasing coverage of biomedical interventions, such as male circumcision and antiretroviral therapy. The vast majority of adults newly infected with HIV in sub-Saharan Africa acquire



the virus during unprotected sexual intercourse, including paid sex and sex between men. Especially in countries with high prevalence, many of the people acquiring HIV infection have multiple and concurrent partners. Another important share of the people newly infected are HIV-discordant couples.

The burden of HIV on women, however, is considerably greater in sub-Saharan Africa, where 6 in 10 adults living with HIV in 2011 were women. Progress is especially impressive in sub-Saharan Africa, where nearly 6.2 million people were receiving antiretroviral therapy in 2011, up from just 100 000 in 2003. In sub-Saharan Africa, increased access to HIV treatment has reduced the number of people dying from AIDS-related causes from an annual peak of 1.8 million [1.6 million–1.9 million] in 2005 to 1.2 million [1.1 million–1.3 million] in 2011. Almost half these deaths occurred in southern Africa. Most of the children who averted infections live in sub-Saharan Africa, where the number of children who acquired HIV infection in 2011 (300 000 [250 000–350 000]) was 26% lower than in 2009.

The annual number of adults newly infected with HIV in Oceania has declined in recent years, including in Papua New Guinea, which has the largest HIV epidemic in this region.

In the Caribbean, the estimated 12 000 [8700– 14 000] adults newly infected with HIV in 2011 were 38% fewer than in 2001. Although most countries in the region have acknowledged that heterosexual transmission is a main route of HIV infection. There is no sign yet that the epidemics in Eastern Europe and Central Asia are slowing down. An estimated 160 000 [110 000– 220 000] adults were newly infected with HIV in 2011, 22% more than in 2005. In the Russian Federation, the number of people reported newly diagnosed increased from 39 207 in 2005 to 62 581 in 2010. Since 2005, newly reported HIV cases have also been increasing in the smaller epidemics in Central Asia (Kyrgyzstan, Tajikistan and Uzbekistan). The use of contaminated injecting equipment remains the main route of transmission in this region.

### **2.3 HIV/AIDS in Asia**

The rate of HIV transmission is slowing in Asia. An estimated 360 000 [240 000– 480 000] adults were newly infected with HIV in the region in 2011, considerably fewer than the 440 000 [290 000–510 000] estimated for 2001. This reflects slowing HIV incidence in the larger epidemics, with seven countries accounting for more than 90% of people living with HIV: China, India, Indonesia, Malaysia, Myanmar, Thailand and Viet Nam. Although India has done



particularly well, halving the number of adults newly infected between 2000 and 2009, some smaller countries in Asia, such as Afghanistan and the Philippines, are experiencing increases in the number of people acquiring HIV infection. Injecting drug use, unprotected sex between men and unprotected paid sex fuel the epidemics in this region. The prevalence of HIV among these key populations at higher risk is high in many Asian countries. Overall, an estimated 16% of the people who inject drugs in Asia are living with HIV, but the prevalence of HIV infection is much higher in some places. Between 8% and 32% of men who have sex with men are living with HIV in cities in China, India, Indonesia, Myanmar and Thailand. Treatment coverage is low in Asia (44% [36– 49%]), the HIV epidemic are mostly concentrated among key populations at higher risk of HIV infection (such as people who inject drugs, sex workers and their clients and men who have sex with men), who often face special difficulties in accessing treatment and care services.

Although the numbers of AIDS-related deaths are declining globally and in most regions, this trend is not universal. The number of people dying from AIDS-related causes has remained stable in Asia, where the number of people dying from AIDS-related causes in 2011 totaled an estimated 330 000 [260 000–420 000].

## **2.4 Decline in TB/ HIV co-infection**

HIV-related tuberculosis (TB) remains a serious challenge. In 2010, 8.8 million people acquired active TB worldwide, of which 1.1 million were living with HIV. TB remains the leading cause of death among people living with HIV. More than 80% of the people living with HIV and TB are in sub-Saharan Africa; in some countries in this region, up to 82% of people with TB are also living with HIV. Action to tackle HIV and TB jointly is increasing, but it needs to accelerate further. Reducing mortality figures will require increasing TB cure rates from 70% to 85%, detecting at least 80% of TB cases among people living with HIV and ensuring that at least 30% of people with HIV who do not have active TB receive isoniazid preventive therapy, an inexpensive and highly effective regimen.

Without treatment and prophylaxis, people living with HIV have a 20–30 times higher lifetime risk of developing active tuberculosis, compared with people without HIV. The number of tuberculosis deaths among people living with HIV has been declining since 2004. Close collaboration between HIV and tuberculosis programmes can accelerate this decline further to meet the global goal of halving the number of HIV-related tuberculosis deaths by 2015.



## 2.5 Key Findings of Global HIV Epidemic:

- Globally, there were 2.5 million new HIV infections occurred in 2011.
- In 2011, more than 8 million people living with HIV were receiving antiretroviral therapy in low- and middle-income countries.
- The number of people dying annually from AIDS-related causes worldwide decreased from a peak of 2.3 million [2.1 million–2.5 million] in 2005 to an estimated 1.7 million [1.6 million–2.0 million] in 2011.
- About 330 000 [280 000–380 000] children were newly infected with HIV in 2011, almost half the number in 2003, when the number of children acquiring HIV infection peaked at 570 000 [520 000–650 000].
- The estimated number of women living with HIV dying from pregnancy-related causes has declined worldwide by 20% since 2005.
- In low- and middle-income countries, an estimated 1.5 million [1.3 million–1.6 million] women living with HIV were pregnant in 2011.
- If a woman becomes infected with HIV during pregnancy or when breastfeeding, the probability of transmission to the child is higher than among women who are already living with HIV. It is therefore vital that pregnant women and women who are breastfeeding take extra precautions to avoid HIV infection.
- In 2011, an estimated 620 000 [600 000– 700 000] pregnant women were eligible for antiretroviral therapy for their own health, but only 190 000 pregnant women living with HIV with a CD4 count less than or equal to 350 cells per ml received it.
- Almost 600 000 new HIV infections among children have been averted since 1995 because of antiretroviral prophylaxis being provided to pregnant women living with HIV and their infants. Most of the children who averted infections live in sub-Saharan Africa.



## 3. HIV/AIDS SITUATION IN THE SAARC REGION

HIV epidemic in SAARC region is also a collection of diverse epidemics in countries, provinces & districts. HIV/AIDS continues to be a major public health problem in the SAARC Region. All eight Member States of the SAARC region are designated as low prevalence countries. On the basis of latest available information this region is home for an estimated number of 2.54 million HIV infected people in 2011. Table 01 shows the estimated number of People Living with HIV/AIDS (PLHA) in eight Member States of the SAARC Region in the year 2011. Three countries, namely India, Nepal and Pakistan account for majority of the regional burden.

**Table 01: Adult HIV Prevalence Rates and Estimated Number of PLHA in SAARC Region, 2010/11**

Country	HIV Prevalence Rate (%)	Estimated No. of PLHA
Afghanistan	<0.1	1,250
Bangladesh	<0.1	7,500
Bhutan	<0.1	< 500
India	0.31	2.39 million
Maldives	<0.1	< 100
Nepal	0.3	50288
Pakistan	0.1	97,400
Sri- Lanka	<0.1	3000
<b>Regional</b>		<b>2.54 million</b>

The overall adult HIV prevalence in SAARC region remains below 1%. However, there are important variations existing between countries. Bangladesh, India, Nepal and Pakistan have reported concentrated epidemics among most at risk populations (MARPs). Of the estimated number of PLHA in SAARC region, 2.39 million were living in India in 2011.



The first HIV/AIDS infected persons were diagnosed in 1986 in India and Pakistan. By 1993, all SAARC Member States had reported the existence of HIV infection in their countries. The cumulative numbers of reported HIV/AIDS infected persons by Member States of the SAARC Region at the end of the year 2011 are given in Table 02.

**Table 02: Cumulative No. of Reported HIV & AIDS Cases by SAARC Member States, 2010/11**

Country	Cumulative Number of Reported HIV Positives	Cumulative Number of Reported AIDS Patients	Cumulative Number of Reported AIDS Death	Year of 1st HIV Positive Detected
Afghanistan	1,250	122	10	1989
Bangladesh	2,533	1,101	325	1989
Bhutan	291	-	52	1993
India*	1,169,050	-	-	1986
Maldives	16	-	11	1991
Nepal	19,118	-	-	1988
Pakistan	5,256	5,256	-	1986
Sri Lanka	1,408	374	253	1987

\*till Dec.2010

Sexual Transmission drives the HIV epidemic throughout most parts of India, accounting for nearly 90% of prevalence nationwide. The brothel based sex workers are more likely than home based sex workers to be infected with HIV and the risk is also more for currently unmarried sex workers in India. HIV transmission during injecting drug use is the primary mode of transmission in north-eastern parts of the country

HIV epidemic in India is highly heterogeneous and appears to be stable or diminishing in some parts of the country while growing in others. HIV epidemic of Nepal is concentrated among most at risk populations and diverse in various regions/zones and districts.

HIV epidemic in Pakistan is a concentrated epidemic among IDUs and Hijra sex workers. IDU group is the core group which drives HIV epidemic in Pakistan and having the highest prevalence of 27.2%. The HIV prevalence among commercial sex workers in Pakistan is 0.6%. However, there is evidence of sexual networking between female sex workers and IDUs. The

geographic trend of the epidemic is expanding from major urban cities and provincial capitals to smaller cities and towns.

Migration itself is not a high risk factor for HIV transmission. However, the circumstances in which migration occurs may increase vulnerability to infection. Cross-border migration of the sexual and drug-using networks along the India-Nepal border appears to be contributing to a two-way flow of HIV. Migrants are considerably more likely than non-migrants to delay seeking medical treatment for infectious diseases due to various factors which are held responsible for exclusion of them from basic health services in the settings to which they have migrated.

Women account for a significant proportion of people living with HIV in SAARC region. A large proportion of women appear to have acquired the virus from regular partners who acquired HIV infection during paid sex. In the region as a whole, HIV prevalence is low among general population, however, significantly higher among Most at Risk Populations [MARPs]. The low prevalence of HIV among the general population poses a significant threat as it undermines the gravity of the situation. When the infection gets established in the bridging groups such as clients of sex workers through them, HIV may spread to the low risk groups in the general population such as housewives at an exponential pace. As a result, generalized epidemics may arise in many parts of the region unless the responsible authorities take the timely decisions for implementation of appropriate timely prevention approaches to contain the HIV in the region.

All the Member States have high levels of high risk factors to fuel the HIV epidemic further and faster. The identified prevailing high risk factors in the SAARC region are:

- Low level of literacy/illiteracy
- Poverty
- Rapid and unplanned urbanization
- Low status of women
- Discrimination and stigmatization
- High prevalence of Sexually Transmitted Infections
- High rates of internal and international migration
- Trafficking of women and children
- Low level of health care seeking behavior
- Social marginalization of population groups
- Low levels of condom use
- Unsafe injection practices in formal and informal health care settings
- Porous borders between some countries



- Growing numbers of Most at Risk Populations
- Civil war situations creating a huge group of internally displaced people (IDP)

These identified risk factors create favorable conditions for the spread of virus across the SAARC region. In order to implement an effective prevention package for the region of SAARC, the diversity is to be considered. The factors responsible for diversity should be identified and addressed during designing as well as implementation phase.

The wide disparity between the estimated numbers of people living with HIV/AIDS and reported numbers of people living with HIV/AIDS is to be considered by both regional authorities responsible for the HIV prevention and care as well as by the National AIDS Control Programmes in prioritizing, designing and implementation of activities in HIV prevention and care continuum.

**Figure 03: Prevalence Rate of HIV in SAARC Member States, 2011**

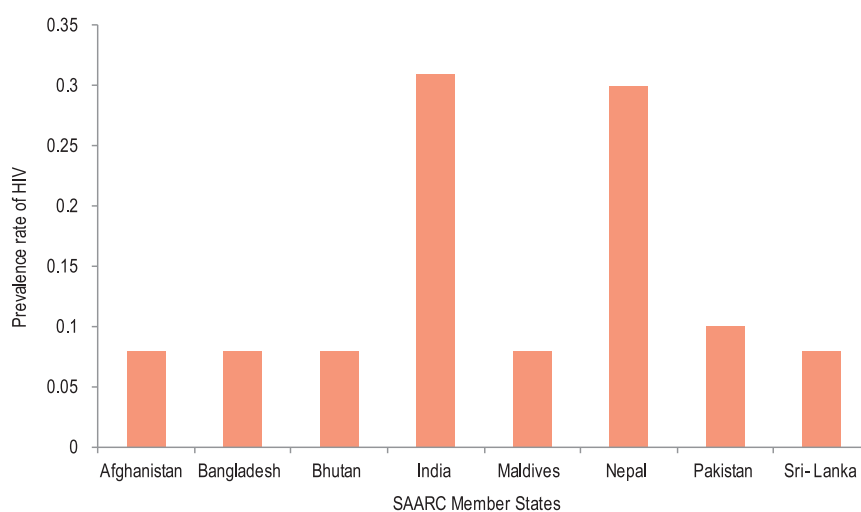


Figure 03 shows the prevalence rate of SAARC Member States it is evident that as per prevalence rate India has highest prevalence rate among adults, followed by Nepal.



## 4. COUNTRY PROFILES

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 **Afghanistan**

 **Bangladesh**

 **Bhutan**

 **India**

 **Maldives**

 **Nepal**

 **Pakistan**

 **Sri Lanka**



# Afghanistan

Islamic Republic of Afghanistan is one of the eight member countries of the SAARC Region. It is a land-locked country, it is bordered by Pakistan in the south and the east, Iran in the west, Turkmenistan, Uzbekistan and Tajikistan in the north, and China in the far northeast. The land area is 647,500 square kilometers. The primary administrative unit in Afghanistan is a Province which is governed by a Governor. Afghanistan consists of 34 provinces and 398 districts. Afghans comprise the second largest number of refugees and internally displaced people in the world.

## HIV/AIDS Situation

Afghanistan has a low and concentrated HIV. With a health information system not yet fully functional, the HIV and other STI surveillance system is basic. Available data shows Afghanistan is currently considered to have low HIV prevalence in the general population, but a concentrated epidemic among people who inject drugs. According to the Afghanistan Drug Use Survey in 2009 carried out by UNODC, Ministry of Counter Narcotics (MoCN) and Ministry of Public Health (MoPH), there are an estimated 20,000 (18,000 - 23,000) PWID. HIV prevalence among PWID is estimated at a national average of 7% (18% of PWID in Herat, 3% in Kabul and 1% in Mazar were infected with HIV according to the IBBS, 2009).

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



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

### **Important Aspects of National Program Response**

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

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



## Activities carried out

### Afghanistan HIV/AIDS prevention project (AHAPP):

- Targeted Intervention: Harm Reduction with 9 components in 4 provinces, Sex worker in one province, OST in one province and Harm Reduction in Kabul prison).
- Surveillance project.
- Capacity building.
- Advocacy and communication.

### Strengthening Provincial HIV Program (SPHP):

- DIC in 4 provinces (Harm Reduction with 9 components).
- Prisons VCT in 7 provinces.
- VCT in 8 provinces.
- Street children and community sensitization

### UNODC:

- Harm reduction for female IDUs in country.

## Challenges

- Stigma and discrimination against HIV and AIDS patients.
- Low awareness.
- Low coverage of program (8 provinces out of 34 provinces).
- Less staff at national level, management team of NACP.
- Less trained staff for implementation of HIV projects.
- Staffs turn over.
- Increasing IDUs and IDUs numbers in country.
- Low budget for program to cover the priorities.

## Major planned activities

- KAP among policy makers.
- IBBS in MARPs in 11 cities of country to have strategic information for future plan.
- To strength the surveillance of HIV in country.
- To strength the TB/HIV collaborative activities.

- To strengthen the multi-sectorial response to HIV epidemic in country.
- To scale up the structure of NACP.
- Awareness of the community and religious leaders on HIV.
- Integration of some HIV key activities in BPHS and EPHS.
- Full involvement of civil society in prevention of HIV in country.
- To find mechanism to increase the access of PLWH to ART (Urban and rural population who are HIV positive).
- To strengthen the five PPTCT centers activities.
- Increase the number of VCTs in vulnerable and border provinces of country.
- To establish coordination mechanism for HIV control with border countries for prevention of HIV among returnees and migrant workers.
- Printing of enough HIV IEC materials and media campaign.

### **New initiatives/ Best practices**

- Speech of PLWH in World AIDS Day in 2011 in front of government high ranking officials.
- Gathering of HIV positive people, self support group and their training.
- Establishment of VCT in Kunar province.
- Establishment of 5 PPTCT centers and task force committee.
- Development of new required reporting format for data collection.
- Strong coordination and referral system between VCT and TB centers

### **Research Studies Published/carried out**

- OST evaluation is completed at end of May 2012.

**Table No. 03: Reported HIV/AIDS Situation at the end year 2011 (Cumulative)**

Cumulative number of	Male	Female	Total
Cumulative HIV infected < 15 years	22	4	26
Cumulative HIV infected 15 - 44 years	1,040	184	1,224
Reported AIDS cases	83	39	122
Reported Adult Deaths due to AIDS	9	1	10



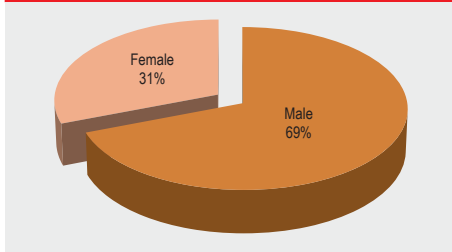
**Table No. 04: Most at Risk Populations [MARPs]**

MARPs	Estimated size of the MARP	If available, HIV prevalence among MARP
Commercial Sex Workers	1160	
IDUs	18000 - 23000	7.10%
Prisoners	26,000	2.20%
Truckers	60,000	

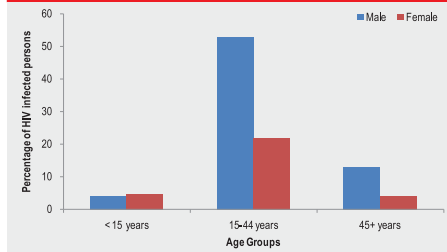
**Table No. 05: Service available for HIV infected and affected persons, 2011**

Type of service	Number of Health facilities providing services till December, 2011	Public sector
Health care facilities with Voluntary Counseling and Testing (VCT)/ICTC	19	19
Detoxification Centres	66	66
Health care facilities with Laboratory facilities for CD <sub>4</sub> Testing	2	2
Health care facilities with ARV treatment - First line regimen	2	2
Health care facilities with ARV treatment - Second line regimen	2	2
Health care facilities with PMTCT services	5	5
Health care facilities with Post Exposure Prophylaxis for health care workers	3	3
Centers with social welfare facilities for HIV infected	3	3
Screening of HIV in Blood Banks	12	12
treatment Link Centres	2	2
Targeted intervention sites and their types (e.g., CSW, IDU and truckers etc.)	31	31
Health care facilities with TB screening activity	9	9

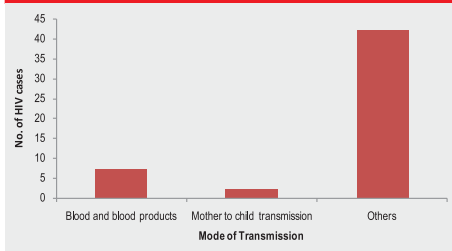
**Figure 04: Percentage of Sex distribution of Cumulative HIV positive cases (2011)**



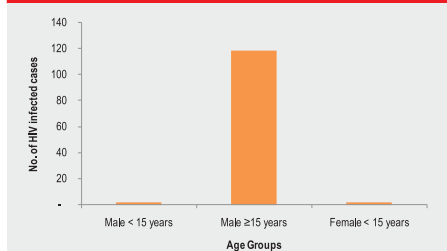
**Figure 05: Percentage of HIV infected persons by age-group and sex (2011)**



**Figure 06: Mode of transmission for HIV transmission in the year (2011)**



**Figure 07: Cumulative Number of HIV infected people on Anti-Retroviral Treatment (2011)**



### Epidemiology, 2011

Population(mid-year)	24.48 million
Children under 15 yrs	11.28 million
Male ≥ 15 years	6.84 million
Female ≥ 15 years	6.35 million
<b>Estimated Number of people living with HIV/AIDS at the end of 2011</b>	<b>1250</b>
Estimated number of deaths due to AIDS during the year 2011	2
Cumulative Number of HIV pregnant mothers who received ARV for PMTCT	4
Cumulative Number of HIV pregnant mothers who received ARV for PMTCT	1



# Bangladesh

Bangladesh is a relatively small coastal country in south central Asia. It is bordered by India on all sides, Burma (Myanmar) on the southeast and the Bay of Bengal to its south. With a population of around 149.77 million, it is one of the most densely populated countries in the world, with the highest densities occurring in and around the capital city of Dhaka.

Although Bangladesh is still a low prevalence country for overall HIV rates (less than 1%), there are risk factors that could fuel the spread of HIV among high-risk groups and general population.

## Status of HIV/AIDS

The prevalence of HIV in Bangladesh is less than 0.1% in the general population and has remained so over the years, whether the total population is considered or when segregated for the most at risk and bridge populations (groups of men who are on the move and are likely to be clients of sex workers, such as truckers and rickshaw pullers).

According to the latest Serological Surveillance (Round 9, 2011) of Bangladesh, the HIV prevalence among PWID, Female Sex Workers, MSW, MSM and Hijras was 0.7%. Although HIV prevalence was below 1% in most groups of female sex workers, in casual sex workers (those who were selling had either one or more other main sources of income) from Hilli (a small border town in the northwest part of Bangladesh), prevalence was 1.6. Active syphilis rates among street based sex workers significantly declined in three of the four sites sampled. Among hotel, residence based and casual sex workers no change was observed in syphilis rates except for hotels in Dhaka. The estimated number of HIV/AIDS remains at 7,500. In 2011 the NASP informed that there were 445 newly reported cases of HIV and 251 new AIDS cases, while 84 people had died. Thus the cumulative number of reported HIV cases till date in Bangladesh stands at 2,533, AIDS cases at 1,101 and deaths at 325.



**Table 06: Cumulative reported number of HIV/AIDS Cases & Mortality, 2011**

Cumulative number of HIV/AIDS Cases & Mortality	Total
HIV positive cases	2,533
Reported AIDS cases	1,101
New HIV cases	445
New AIDS cases	251
Deaths due to AIDS cases	325

Source: NASP Bangladesh, 2011

### **Activities carried out for the prevention of HIV infection**

The prevention programs continue to be focused on the MARPs such as PWID, FSW, MSM, MSW, Transgender (Hijras) and their intimate partners. The three key funders in the country are USAID, World Bank and GFATM. The funding mechanism is usually through management agencies. A new National size estimation exercise of MARPs, under the leadership of NASP and with support from UNAIDS, was conducted in 2009.

Currently there are five key prevention intervention programs being implemented in the country, which are, as discussed earlier: The HIV/AIDS Intervention Services (HAIS), Global Fund to Fight AIDS, Tuberculosis and Malaria supported national programs, Modhumita, and two Global Fund supported regional programs.

Another key programme is the Modhumita being implemented with support of USAID. Some of the key activities/components supported through Modhumita are: tuberculosis and family planning integration into services for PLHIV and KAP-activities include TB awareness raising, sputum collection for screening and testing for TB, follow-up for DOTS, developing BCC materials etc.; integration of VCT in Public Health Sector (2 Upazila Health Complexes) in collaboration with DGHS; quality assurance and quality improvement (QAQI) approaches to ensure for example provider compliance with clinical guidelines and standards; satellite VCT to reach more people who inject drugs; and Medical Waste Management which is supported by a standard operating procedure and required training to guide Modhumita centers for using safe and environment friendly procedures that comply with local regulations. This project is currently reaching about 2000-2500 PWID with demand reduction services and 7,000 FSW in 17 districts.



The National Strategic Plan for HIV/AIDS (2011 -2015) has included international migrant workers, transport workers, especially vulnerable adolescents and prisoners within its framework and has set relevant indicators to track progress.

For International Migrant Workers focus will be on HIV LSE, message reinforcement, and VCT for returning workers. Transport workers include among others, truck drivers, rickshaw pullers and dock workers. Pilot interventions based on findings from international and Bangladesh interventions previously conducted will be implemented and evaluated and then scaled up if justified by evidence. Experiences from the pilot intervention among prisoners is planned to be scaled up.

In addition to the above, strategies have been outlined to minimize HIV and STI transmission among the young people and general population through BCC, VCT and PITC, STI service provision, condom access, LSE, YFHS and work-place based interventions.

The existing programs among the garments factory workers and youth implemented via Save the Children with the Global Fund support have been the main focus of interventions for the general population. Activities include: HIV prevention information through radio and television shows that have attracted very large audiences, open air concerts and print media (billboards, advertisements, posters, leaflets, stickers, calendars, T-shirts and caps); life skills education through youth organizations and clubs; integration of HIV prevention information into the secondary school curriculum; youth friendly services for sexually transmitted infections and outreach activities and peer education to promote safe sex and encourage more treatment seeking; and conducting research to guide evidence based programs.

## Challenges

The required human resources to fill out the major roles are yet to be available in a sustained manner. Despite its best efforts and endeavors, the NASP has not been able to play its expected roles due to:

- ad hoc status of NASP within DGHS organogram;
- frequent turnover of staff led to inconsistent leadership and lack of adequate knowledge retention and related oversight activities;
- the inconsistent staffing arrangements which involve the use of MoHFW out-posted staff, contract staff and consultants with differing levels of reward make it difficult to create a cohesive unit and a fully functioning skill-mix;



- inadequate use of program management tools and techniques;
- shortage of skilled specialists, especially in the fields of procurement, finance, M&E and research.
- sustained funding sources, especially for mainstreaming of activities
- Integrated data collection and update

The process of setting up an automated MIS linking to the national health MIS has been ongoing for the last two years, however progress has been very slow due to several reasons, including a lack of standard definitions and lack of infrastructure at implementation site level.

### **Planned activities**

Different health packages under the Global Fund resources for specific target groups of population were contracted out to competitive bidders and being implemented. Specific health Packages under the national health sectoral programme (HPNSDP) are underway for selection of competitive bidders. Besides these, different partner UN agencies and donor activities in health programme are being implemented by different stakeholders i.e. Government and NGOs in HIV/AIDS programme under annual or biennium work plan.

### **New initiatives/ Best practices**

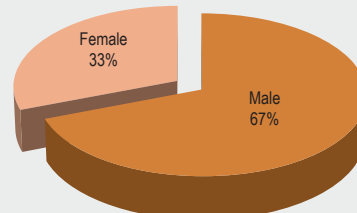
Piloting Opioid Substitution Therapy with Methadone in Dhaka, Bangladesh  
Enhancing and assessing interventions among key affected populations.



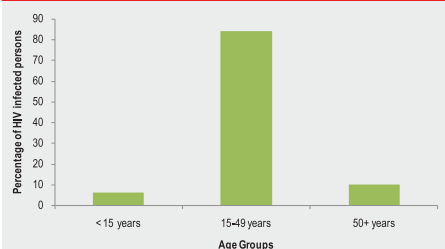
**Figure 08: Cumulative reported No. of people living with HIV (2003 – 2011)**



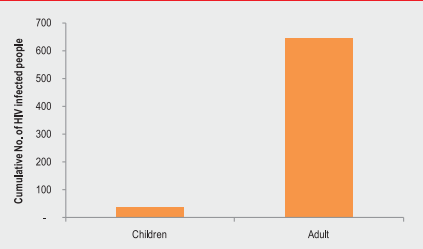
**Figure 09: Percentage of Sex distribution of reported HIV positive cases, 2011**



**Figure 10: Percentage of HIV infected persons by age –group, 2011**



**Figure 11: Cumulative No. of HIV positive cases on ART, 2011**



### Epidemiology, 2011

Population(mid-year)	149.77 million
Estimated HIV/AIDS cases	7500
Cumulative HIV/AIDS cases	2533
<b>Total Cumulative Deaths</b>	< 500
New HIV identified cases in 2011	445



# Bhutan

Bhutan is a land locked country situated in the Himalayas, it has border with China and India. Bhutan has an area of 38,394 sq km and the altitude varying from 180 m to 7,550 m above sea level. The total population of Bhutan is 7, 08,265 with a population density of 16.36 person/km. The country is divided into 20 districts for administrative purposes.

The Himalayan Kingdom of Bhutan, though isolated geographically, is not impervious to HIV/AIDS. Increasing cross-border migration and international travel, combined with behavioral risk factors of the population, Bhutan could face rapid growth of HIV. As the epidemic is at a very early stage, there is still time for vigorous action to stop its spread.

## Status of HIV/AIDS

Bhutan is a low HIV prevalence county with different existing and emerging risk factors and vulnerabilities. The first case of HIV was detected in 1993 through a routine medical screening. Ever since, the cumulative number of HIV cases detected as of July 2012 stands at 291. Of these, 52 people are reportedly dead and 225 people are known to be living with HIV (PLHIV). Current evidence shows that the most predominant route of HIV transmission is heterosexual intercourse (90%), followed by mother-to-child transmission (MCTC) (8.1%) and less than 2 per cent of the transmission is through blood transfusion and injecting drug use.

Bhutan also has seen sharp increase in the HIV detection rate since 2004 with highest annual incidence of 75 per 10,000 populations in 2011.

As of 1st July, 2012, a total of 291 HIV + cases has been detected with a total increase of 21 new cases as compared to the previous report updates of December, 2011. Out of 21 detected cases, 42% (n=9) are male and 58% (n=12) are female with almost equal representation from almost every occupational background including 3 minors below age of 14 years. Now, Bhutan has the total of 291 HIV+ confirmed cases with 225 people currently living with virus and 52 reported deaths due to AIDS related complications and other factors. Almost 30% (n=86)



People Living with HIV/AIDS were put on life-long Antiretroviral Therapy (ART), out of which 15 died on ART and currently 31% (n=71) are living on ART. Almost 90% of the total reported cases are reported within the age range of 15-49 years (49% male and 51% female). The total prevalence of HIV as of today is 3.2 per 10,000 population (n=225). Out of the total reported cases (N=291), maximum number of the cases are concentrated in the western region, followed by the Eastern region. The cases are reported from almost all the occupational groups with Majority 24% (n=69) of the total reported cases are from the unemployed section of the population followed by the farmer, private business group, drivers, government official and armed forces. The laboratory examination (Baseline CD4 count) determined that most of the reported cases were old infections and were diagnosed late, approximately after 2-3 years of actual infection.

The HIV prevalence in Bhutan still remains to be below 0.1% and the UNAIDS estimated that the total number of HIV + cases in Bhutan will be at least 500 by the end of 2009. Hence, the National Program is embarking on to detecting maximum number of cases to reduce to mortality and morbidity associated with AIDS complications and enrolls the positive living HIV clients for comprehensive HIV treatment, care and support.

### **Risk and vulnerability**

In light of recent evidence, HIV in Bhutan must be primarily considered to be a Sexually Transmitted Infection (STI). STIs are important biomarkers of high-risk behaviour for HIV transmission. In countries with low HIV prevalence, like Bhutan, focus on controlling STIs can be an effective strategy for reinforcing prevention and ensuring that conditions remain unfavourable for HIV. There is growing evidence of high-risk behaviours among specific population groups, which threatens to jeopardize the current response to control the transmission of STI and HIV. PLHIV have been detected in 19 of the 20 districts and in most occupational groups. Notably, more than half of the PLHIV have been detected in Thimphu and Phuentsholing. Risk behaviours for the transmission of STIs and HIV in Bhutan include prevalence of STIs, high levels of casual sexual encounters, consistently low condom use, increasing transactional sex, risk of drug use, and high mobility.

### **Activities carried out for the prevention of HIV infection**

The health system was strengthened through the development of national guidelines (including guidelines for voluntary testing, ART, opportunistic infection (OI) and STI management, and PMTCT) for service delivery. Both at central and district levels, capacities have been built through

trainings and training of trainers (ToT) in blood safety, laboratories, waste management and infection control. HIV has been mainstreamed in the education system through life-skill based STI/HIV prevention education for in-school and out-of school youth and vocational trainees. Multi-sectoral Task Forces (MSTF) have been established in all 20 districts, functioning under the chairpersonship of the district governors, and have worked to raise awareness among the general population and support the implementation of HIV activities.

STI/HIV services were strengthened through training of health care providers and district teams in STI diagnosis and treatment and in HIV/AIDS management and care. In all the 20 districts, VCTs have been established and integrated into the hospital settings to provide countrywide HIV counseling and testing, especially to pregnant women. On an average, more than 1,000 people access VCTs per month and the HIV positivity is 0.13% (Data from Q4 2009 and Q1 2010 from 20 VCTs), higher than the estimated adult prevalence. Of the 20 VCTs, two free-standing VCT cum Health Information Service Centers (HISC) have also been set up in Thimphu and Phuentsholing to address the needs of young people and MARPs. Data shows that the average HIV positivity at these centres is 0.5% (12-month data from the year 2009–10). Approximately 1.4 million condoms were distributed in 2009 through various outlets. Currently, ART is provided free of cost.

## Challenges

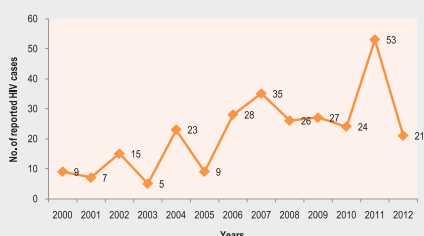
- HIV services in Bhutan are mostly facility based. The system has limited outreach or linkages to vulnerable population and MARP groups. Even the MSTFs, which were established to support the HIV program at the district level, are often not effective and lack community participation and resource mobilization.
- The health system has limited capacities to address the specific treatment and care needs of MARPs. The NBA among drug users conducted in the year 2009 found that drug users are not accessing voluntary testing facilities and STI/HIV services. The World Bank Aide Memoire, 2010 indicates that the program needs to reach hot spots and increase its focus on MARPs on an urgent basis.
- The health system is not currently geared to deliver the (WHO recommended) “comprehensive package” of services essential for the prevention of HIV among MARPs.
- The quality of health services needs to be improved. The 2009 Health Facility Survey recommends that the VCT/STI services need to be improved. The same survey also



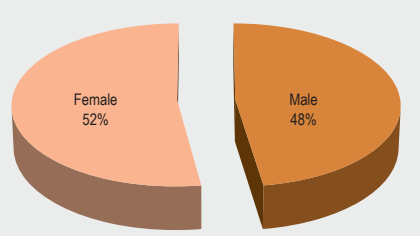
found that 60 per cent of the facilities (BHU I and above) did not have adequate STI/HIV Information, Education and Communication (IEC) materials and recommends that these should be made available in all health facilities.

- Services for TB patients need to be improved, including counseling and routine HIV testing, through establishment of better collaborations. This was validated by an external national TB program review conducted in 2010.
- The monitoring system is not integrated with the Health Management Information System (HMIS) and is unable to capture access of MARPs to services adequately
- Assessing the true incidence of STIs in Bhutan remains a challenge, due to the limitations of sentinel surveillance, assumed gross under reporting, as well as non-disclosure of infections and self-treatment by many persons. Additionally, some people also seek treatment from border towns in India, and from Indian Military Training Team hospitals in Bhutan, thereby making the assessment of STI incidence difficult.

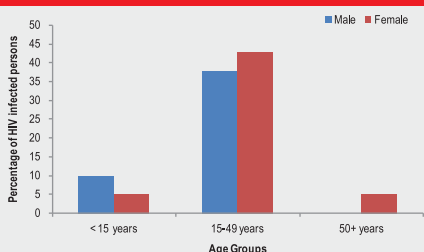
**Figure 12: Trend of Reported HIV Positive Cases, (2000-2012)**



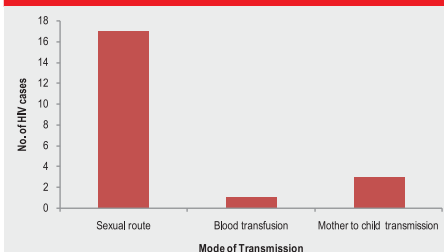
**Figure 13: Percentage of Sex distribution of reported HIV positive cases, July 2012**



**Figure 14: Reported No. of HIV positive cases by age group and sex distribution, July 2012**



**Figure 15: Mode of Transmission of HIV in Bhutan July, 2012**



### Epidemiology, 2011

Population(mid-year)	7, 08,265
Total HIV positive cases	291
PLHIV on Anti Retroviral Treatment (ART)	71
Deaths due to AIDS	52



## India

India is one of the largest countries in South Asia. Geographically it is the seventh largest and second most populous country in the world. Its estimated total population was 1,210,190,000 (RNTCP report, 2012). Bounded by the Indian Ocean on the south, the Arabian Sea on the south-west, and the Bay of Bengal on the south-east, it shares land borders with Pakistan to the west; China, Nepal, and Bhutan to the north-east; and Burma and Bangladesh to the east.

### Status of HIV/AIDS

HIV epidemic in India is concentrated in nature. The HIV prevalence among the High Risk Groups, i.e., Female Sex Workers, Injecting Drug Users, Men who have Sex with Men and Transgender is higher than the general population. Based on HIV Sentinel Surveillance 2008-09, it is estimated that 23.9 lakh people are infected with HIV in India, of whom 39% are female and 4.4% are children. The estimates highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. Adult HIV prevalence at national level has declined from 0.41% in 2000 to 0.31% in 2009. The estimated number of new annual HIV infections has declined by 56% over the past decade from 2.7 lakh new infections in 2000 to 1.2 lakh in 2009.

One of the significant characteristics of this round of estimations is that it allowed for generating estimates of the HIV incidence (number of new HIV infections per year). Analysis of epidemic projections revealed that the number of new annual HIV infections has dropped by around 56% during the last decade (2000-2009). This is one of the most important evidence on the impact of the various interventions under National AIDS Control Programme and scaled up prevention strategies. It is estimated that India had approximately 1.2 lakh new HIV infections in 2009, as against 2.7 lakh in 2000. This is one of the most important evidence on the impact of the various interventions under NACP and scaled-up prevention strategies.



## Adult HIV Prevalence and Declining Trends of Adult HIV Prevalence

The estimated adult HIV prevalence in India was 0.32 percent (0.26% – 0.41%) in 2008 and 0.31 percent (0.25% – 0.39%) in 2009. The adult prevalence was 0.26 percent among women and 0.38 percent among men in 2008, and 0.25 percent among women and 0.36 percent among men in 2009.

The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41 percent in 2000 through 0.36 percent in 2006 to 0.31 percent in 2009. All the high prevalence states show a clear declining trend in adult HIV prevalence. HIV has declined notably in Tamil Nadu to reach 0.33 percent in 2009. A clear decline is also evident in HIV prevalence among the young population (15-24 yrs) at national level, both among men and women. Stable to declining trends in HIV prevalence among the young population (15-24 yrs) are also noted in most of the states. However, rising trends are noted in some states including Odisha, Assam, Chandigarh, Kerala, Jharkhand and Meghalaya.

## People Living with HIV/AIDS (PLHA)

The total number of people living with HIV/AIDS (PLHA) in India is estimated at 24 lakh (19.3 – 30.4 lakh) in 2009. Children under 15 yrs account for 4.4 percent of all infections, while 83 percent are in the age group 15-49 years. Of all HIV infections, 39 percent (9.3 lakhs) are among women. The four high prevalence states of South India (Andhra Pradesh–5 lakhs, Maharashtra–4.2 lakhs, Karnataka–2.5 lakhs, Tamil Nadu–1.5 lakhs) account for 55 percent of all estimated PLHIV in the country. West Bengal, Gujarat, Bihar and Uttar Pradesh are estimated to have more than one lakh PLHA each and together account for another 22 percent of estimated PLHIV in India.

## AIDS Related Deaths

It is estimated that about 1.72 lakh people died of AIDS related causes in 2009 in India. Wider access to ART has resulted in a decline of the number of people dying due to AIDS related causes. The trend of annual AIDS deaths is showing a steady decline since the roll out of free ART programme in India in 2004.



## Routes of Transmission

Heterosexual mode of HIV transmission accounts for 88.2% of HIV positive cases detected, mother to child transmission accounts for 5.0%, Infected Syringe and Needle 1.7%, Homosexual 1.5% and contaminated blood and blood products account for 1.0% of HIV infections detected during 2011-12.

## Integrated Counseling and Testing Centre

Integrated Counseling and Testing Centre (ICTC) is a place where a person is counseled and tested for HIV on his/her own volition (Client Initiated) or as advised by a health service provider (Provider Initiated). People who are found HIV-negative are supported with information and counseling to reduce risks and remain HIV-negative. People, who are found HIV-positive, are provided psychosocial support and linked to treatment and care.

The ICTC programme offering Counseling and Testing services for HIV includes three main components – (i) Integrated Counseling and Testing Centres (ICTC), (ii) Prevention of Parent to Child Transmission (PPTCT) and (iii) HIV-TB collaborative activities. During 2011-12, 161.39 lakh clients including 70.87 lakh pregnant women were counseled and tested till January 2012.

## Mobile ICTCs

The high-risk or vulnerable populations are less likely to access fixed-facility ICTC due to several impediments most important being distance and timing. Mobile ICTCs are a way of taking the package of health services to the community. A mobile ICTC consists of a van with a room to conduct a general examination and counseling, and a space for the collection and processing of blood samples.

In addition to 4,486 stand alone ICTCs, 4,071 Facility Integrated ICTCs, 902 Public Private Partnership model ICTCs and 105 Mobile ICTCs are currently functional.

## HIV-TB Collaborative Activities

Tuberculosis is commonest opportunistic infection among people living with HIV. The existence of HIV and TB together greatly amplifies harmful effects of each other at individual level and contribute substantially to mortality among PLHIV. TB is estimated to cause one in four deaths among PLHIV in India. Overall, the HIV/TB collaborative activities consist of: Measures for



prevention of TB infection and disease among HIV infected individuals and Measures for early detection of HIV in TB patients and linkage to care and support services.

The referrals between NACP and RNTCP consistently show an increasing trend, with more than 12 lakhs cross-referrals and detection of about 45,000 HIV/TB cases in 2011. A total of 73,073 HIV infected TB cases were detected in 2011 through the HIV/TB cross referrals at ICTC and ART centres. This includes TB cases detected through ICF at ART centres. Overall ICF activities at ICTC and ART centres contributed about 8% of TB case notification in the country. At the national level, the proportion of TB cases tested for HIV has increased to 62% in the fourth quarter of 2011.

### **Key Initiatives**

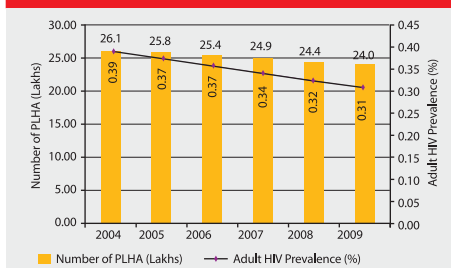
1. User-specific Operational Manuals and Site-specific Wall Charts developed & distributed
2. Supervision of all state level trainings of sentinel site personnel by officers from Regional Institutes (RIs)
3. Mop-up trainings & on-site training for sentinel site personnel who missed the trainings
4. Introduction of Bi-lingual data forms with instructions for the first time; Data forms translated into Hindi & 7 regional languages
5. Unique site codes and lab codes developed for error-free compilation of data ; Elimination of errors in coding of site information through pre-printed stamps/ stickers provided to sentinel sites
6. Composite site mechanisms specified with pre-allotted sub-site number and sample size
7. Development of SIMS Application for HSS with separate modules for Data entry, Data monitoring, Lab monitoring & Field monitoring
8. Specialized data entry module with in-built validation reports, matching reports & reports to monitor data entry status & positivity rates
9. Double data entry at RIs under close supervision and quality checks
10. Enhanced quality of specimen processing by limiting testing to SRLs & NRLs; 17 best labs designated for testing of DBS specimens
11. Streamlined External Quality Assurance mechanisms through online reporting
12. Special focus on strengthening Field Supervision –100% sites covered through supervisory visits in most of the states



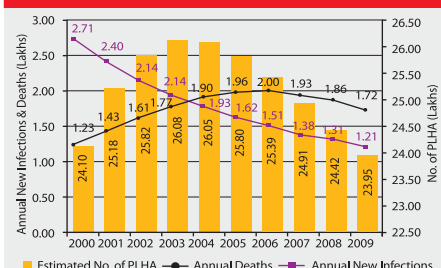
## Key Activities undertaken

1. Completed sample collection at 484 High Risk Groups sentinel sites (including 163 new sites).
2. Completed testing of dried blood spot specimens at 17 designated testing laboratories.
3. Completed double entry of data from all risk groups completed at six Regional Institutes using Strategic Information Management System (SIMS) Application for HIV Sentinel Surveillance (HSS).
4. Undertaken data cleaning and validation of data; Provisional findings were generated and reviewed.
5. Conducted a workshop of data management teams from Regional Institutes for finalization of HIV Sentinel Surveillance data at National Institute of Health and Family Welfare (NIHFW), New Delhi.
6. Conducted regional and national post-surveillance review meetings at the six regional institutes and National Institute of Health and Family Welfare, New Delhi to review the issues during implementation of HSS and identify corrective measures.
7. Organized meetings for dissemination of HIV Estimations to State AIDS Control Society (SACS) officers and state epidemiologists in phased manner.
8. The national dissemination of HIV estimations to national stakeholders as well as North and North eastern states was conducted on 2nd March 2012 at PGIMER, Dr. RML Hospital, New Delhi. The technical report on HIV estimations was formally released during the meeting by the Secretary & DG, NACO, Secretary, Ministry of Statistics & Programme Implementation and Chief Statistician of India and Country Coordinator, UNAIDS India.

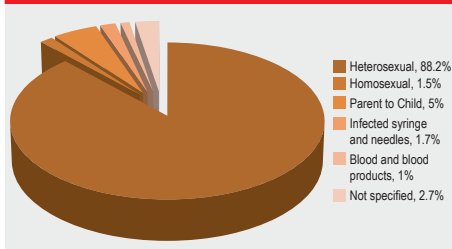
**Figure 16: Estimated Adult HIV Prevalence & Number of PLHA, India, 2004-09**



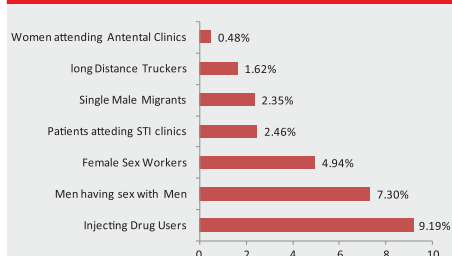
**Figure 17: Decline in No. of PLHA as a result of Greater Decline in New Infections, Despite Increased Survival of PLHA due to ART**



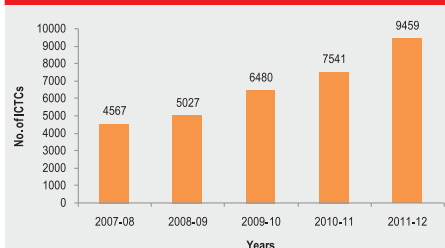
**Figure 18: Routes of Transmission of HIV, India, 2011-12 (till Jan. 12)**



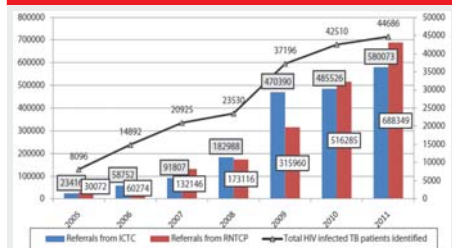
**Figure 19: HIV Prevalence: India, 2008-09**



**Figure 20: Scale up of ICTCs in Last Five Years**



**Figure 21: Scale of HIV-TB Collaborative Activities India (2005 - 2011)**



### Epidemiology, 2011

Population(mid-year)	1210 million
Children under 15 yrs	380 million
Male ≥ 15 years	427 million
Female ≥ 15 years	403 million

#### Estimated Number/Prevalence of people living with HIV/AIDS, at the end of 2011

Children (less than 15 years):	105,160
Adults Male( ≥15 years):	13,52,740
Adults Female(≥ 15 years):	9,32,100
Estimated number of deaths due to AIDS during 2010	172,000



# Maldives

Republic of Maldives is a country formed by a number of natural atolls plus a few islands and isolated reefs which form a pattern from North to South. The islands are located southwest of the Indian subcontinent stretching 860 km north to south and 80 – 129 km east to west. For administrative purposes, the Country has been organized into seven provinces. The Republic of the Maldives is situated in the Indian Ocean, close to India and Sri Lanka. It consists of nearly 1,200 islands and atolls, of which around 200 are inhabited. In addition, there are around 90 inhabited islands that have been developed as tourist resorts.

The population of Maldives was over 330,652 as at the end of year 2011. Of which approximately one third of the population is living in the island of Male', the capital. The remaining two-thirds of the population are spread out over 198 islands.

## HIV/AIDS Situation

The first HIV positive person in Maldives was reported in 1991. There were 257 cumulative number of HIV positives among expatriate workers reported to the National AIDS Control Programme in Maldives as of December 2009. Only 16 cumulative cases of Maldivians with HIV infection was reported to the centre as of December 2011. Of the 16 HIV positive nationals, 11 have died. Among the 16 HIV positive cases 14 were males. As of December 2011, four HIV positive cases were on antiretroviral treatment.

All infections were reportedly acquired through sexual transmission. Despite the high level of drug use and the increasing popularity of injecting drug use, no needle or syringe related transmission has been reported yet. So far in Maldives, no mother to child transmission was reported.

Maldives being a low prevalence country, major efforts have been put on prevention and maintaining the low level of HIV infection in the Maldives. Through established national surveillance mechanisms and required screening performed under medical care, a total of 16



cases of HIV had been identified among Maldivians between 1991 and 2011. Out of which 11 have passed away.

All pregnant women are still screened for HIV along with Venereal Disease Research Laboratory test and hepatitis B, but pre-test and post-test counseling is not available. 1,368 women were tested in 2008 and 2,024 in 2009, accounting for around 14% of all HIV tests conducted in those years. Pre-employment screening was the most important source of HIV test results (49% of the total of nearly 30,000 tests in 2008 and 34% of the total in 2009). patients

The first Biological Behavioral Survey [BBS] on HIV/AIDS was carried out in 2008 among vulnerable populations. The vulnerable populations surveyed were female sex workers, MSMs, IDUs, sea farers, resort workers, construction workers and youth. However, HIV infection was found among male resort workers. In 2010, a Risk Behavior Mapping was conducted at selected islands and atolls. The researchers, using both geographical mapping and network analysis, developed size estimations for those at highest risk.

The Risk Behavior Mapping estimated the number of female sex workers at the 12 islands that were selected for inclusion to be between 545 and 625, i.e. around 585 persons. Based on the mapping results it was estimated that there are a total of 1,139 female sex workers [range: 1030 - 1247] in the whole country. The risk behavior mapping report estimated that there were 685 MSM in the 12 selected islands [range: 577 to 792]. Based on these findings, it was extrapolated that there are a total of 1,199 MSM [range: 975 to 1,408] in the Maldives. The estimated range of injecting drug users (IDU) was (382 - 437 persons).

## **Important Aspects of National Response**

Maldives established the National AIDS Control Programme in 1987, four years before the first domestic HIV positive patient was reported. National AIDS council, NAC, a multi-sectoral representative body was formed to provide direction to National AIDS Control Program (NAP). The Center for Community Health and Disease Control is responsible for implementing the National Strategic Plans, under guidance of the National AIDS Council, which consists of Government, NGO and private sector stakeholders. The National AIDS Program has successfully advocated for HIV related issues, including the drafting of a new Drugs Bill.



## **National Strategic Plan on HIV/AIDS (2007-2011)**

The current National Strategic Plan was developed in 2007 with support from the UN joint team on AIDS. The NSP 2007-11 aims to limit HIV transmission, provide care for infected people, and mitigate the impact of the epidemic through seven strategic directions:

1. Provide age and gender appropriate prevention and support services to key populations at higher risk: drug users, sex workers and men who have sex with men.
2. Reduce and prevent vulnerability to HIV infection in adolescents and young people.
3. Provide HIV prevention services in the workplace for highly vulnerable workers.
4. Provide treatment, care and support services to people living with HIV.
5. Ensure safe practices in the healthcare system.
6. Build and strengthen capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic.
7. Strengthen the strategic information system to respond to the epidemic.

## **Activities carried out by NACP**

- Testing and counseling: Continued supporting the VCT services offered by civil society organizations/NGOs targeting KAPs and migrant workers. Including capacity building; by training of VCT counselors and monitoring of services.
- Treatment and care for people living with HIV: New treatment guidelines (revised as per new WHO guidelines) developed and endorsed.
- Sexually transmitted infections: New treatment guideline developed, and new case reporting and referral formats piloted in one region.
- Promotion of a safe blood supply: Capacity building of health care providers on rational use of blood and blood products.
- Prevention of HIV among drug users and injecting drug users: Established drop in centers in the premises of two NGOs working with drug users.
- Prevention migrants: Migrant peer outreach programme run by the NGO SHE, with support from Global fund continued, clubbed with VCT services and referral to other SRH services.





## Challenges

- Decentralization of Health Services had an impact on reporting of activities, as well as completeness and timely reporting of national STI/HIV surveillance data.
- Limited human resources/staff working in the national programme

## Major planned activities

- Development of national guidelines and protocols for establishing Youth Friendly Health Services and link/integrate HIV testing, sexual reproductive and sexual health services
- Development of Guidelines and protocols for establishing regional level behavior change communication teams

## New initiatives/ Best practices

- Initiated HIV testing on all TB Patient (as part of the national TB treatment protocols)
- Initiated the provision of ART for the expatriates who get HIV positive while working in the Maldives, and patients were enrolled.

## Research Studies published/carried out

- Mapping Most-At-Risk Populations for HIV prevention in the Maldives 2011. (draft). to be published
- Biological and behavioral survey in the Prisons 2011, Maldives – Final draft, to be published.



**Table No. 07: Most at Risk Populations [MARPs], 2011**

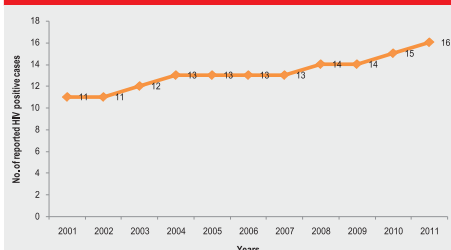
Most at Risk Populations (MARPs)	Estimated size of the MARPs
Commercial Sex Workers	545 - 625
MSM	577 - 792
IDUs	382 - 437
New AIDS cases	251

**Table No. 08: Service available for HIV infected and affected persons, 2011**

Type of service	Number of Health facilities providing services till December, 2011
Health care facilities with Voluntary Counseling and Testing (VCT)/ ICTC	9
Detoxification Centres	1
Health care facilities with Laboratory facilities for CD4 Testing	1
Health care facilities with ARV treatment - First line regimen	1
Health care facilities with ARV treatment - Second line regimen	1
Health care facilities with PMTCT services	1
Health care facilities with Post Exposure Prophylaxis for health care workers	1
Screening of HIV in Blood Banks	1
Treatment Link Centre	1
Targeted intervention sites and their types (e.g., CSW, IDU and truckers etc.)	3
Health care facilities with TB screening activity	116
Number of Health care facilities with referral services	1

There are 09 Health care facilities with Voluntary Counseling and testing (VCT) facilities providing. And there are 116 Health care facilities providing TB screening activities for the affected persons.

**Figure 22: Estimated Adult HIV Prevalence & Number of PLHA, India, 2004-09**



### Epidemiology, 2011

Population(mid-year)	330,652
Children under 15 yrs	87,896
Male $\geq$ 15 years	122,218
Female $\geq$ 15 years	120,538

#### Reported Number of people living with HIV/AIDS, at the end of 2011

Adults Male( $\geq$ 15 years):	14
Adults Female( $\geq$ 15 years):	02
Number of deaths due to AIDS during the year 2011	11

Source: NACP, Maldives, 2011



## NEPAL

Nepal is a landlocked country and is located in the Himalayas and bordered to the north by the China and to the south, east, and west by the India. It is comprised of 75 districts divided into five regions (Far- Western, Mid-Western, Western, Central and Eastern). It has an area of 147,181 square kilometers and a population of approximately 26.93 million. The urban population is largely concentrated in the Kathmandu valley. Nepal has a market economy mainly based on farming and tourism.

### Status of HIV/AIDS

HIV in Nepal is characterized as a concentrated epidemic with a prevalence of 0.30 per cent among adult aged 15–49 years in 2011. There are approximately 50,200 people estimated to be living with HIV, where four out of every five infections are transmitted through sexual transmission. People who inject drugs (PWIDs), men who have sex with men (MSM) and female sex workers (FSWs) are the key populations who are at a higher risk of acquiring HIV. Male labor migrants (who particularly migrate to high HIV prevalence areas in India, where they often visit FSWs) and clients of sex workers in Nepal are playing the role of bridging populations that are transmitting infections to low-risk general populations.

The rate of occurring new HIV infections throughout Nepal has reduced significantly during the last five years essentially owing to the targeted prevention interventions among key population groups. However, it is critical to improve the effective coverage of proven prevention interventions, especially among new entrants engaging in high-risk behaviors, and to sustain these interventions for achieving the national target of halving new HIV infections by 2015.

Over 80 per cent of the HIV infections are transmitted through heterosexual transmission. As the epidemic is maturing—approximately 24 years have elapsed since the first HIV case was reported in 1988—increasing number of infections are being recorded among the low-risk general population.



**Table 09: Cumulative number of HIV/AIDS Situation, 2011**

Cumulative number of	Male	Female	Total
Cumulative HIV infected < 15 years	769	496	1,265
Cumulative HIV infected 15 - 49 years	11,049	6,102	17,151
Cumulative HIV infected 50+ years	484	218	702

Source: NCASC Nepal, 2011

The first HIV infected persons in Nepal was detected in 1988. Since, then the HIV epidemic in the country has evolved from low to concentrated epidemic. As of end of 2011, a total 19,118 HIV positive cases were reported to the National Centre for AIDS and STD Control. Among them 64% were males and 36% were females.

**Table 10: Most at Risk Populations (MARPs), 2011**

MARP	Estimated size of the MARP	If available, HIV prevalence among MARP
Commercial Sex Workers	26,878	2.41%
MSM/TG	256,600	3.78%
Patients with STDs	261,661	N.A.
IDUs	31,308	3.00%
Prisoners	13,380	N.A.
Migrant workers	1,322,612	0.88%
Truckers	741,824	0.26%

Source: NCASC Nepal, 2011

In Nepal seven Most at Risk Populations (MARPs) were available in which 1,322,612 were migrant workers and 26,878 were Commercial Sex Workers.



**Table 11: Services available for HIV infected and affected persons, 2011**

Type of service	Number of Health facilities providing services till December, 2011	Public sector	Private sector
Health care facilities with Voluntary Counseling and Testing (VCT)/ICTC	200	75	125
Detoxification Centres	3	3	0
Health care facilities with Laboratory facilities for CD4 Testing	14	14	0
Health care facilities with ARV treatment - First line regimen	36	34	2
Health care facilities with ARV treatment - Second line regimen	36	34	2
Health care facilities with PMTCT services	22	22	22
Health care facilities with Post Exposure Prophylaxis for health care workers	36	34	2
Screening of HIV in Blood Banks	65	0	65
HIV Care and support Centres (Community)	1	0	0
Neonatal Screening (PMTCT)	5	5	0
<b>Targeted intervention sites and their types:</b>			
FSW	26	0	26
PWIDs	33	10	23
MSM/TG	29	10	19
Truckers	26	0	26
Migrants	59	20	39
Health care facilities with TB screening activity	36	34	2
Number of Health care facilities with referral services	250	200	50

Source: NCASC Nepal, 2011

There are 200 Health care facilities providing Voluntary Counseling and testing (VCT) facilities and 14 Health care facilities with Laboratory facilities for CD<sub>4</sub> Testing.

**Table 12: Number of HIV infected people on Anti-Retroviral Treatment, 2011**

HIV Infected People	Number
<i>Children:</i>	
Male < 15 years of age:	91
Female < 15 years of age:	53
<i>Adult:</i>	
Male ≥ 15 years of age:	713
Female ≥ 15 years of age:	759

Source: NCASC Nepal, 2011

Table 12 explains the number of HIV infected people who are on Anti-Retroviral Treatment among those receiving the ART 144 was children and 1472 were adults.

### Activities carried out for the prevention of HIV infection

- BCC/BCI, condom programming among key populations at higher risk to HIV (FSWs, clients, MSM/TG, PWIDs, migrants and their spouses, prison inmates, and general population)
- HIV testing and counseling among
- STI diagnosis and treatment and referral
- Harm reduction activities among PWIDs that include Opioid substitution therapy by methadone maintenance from three sites; and needle and syringe exchange programme
- Blood safety programme through Nepal Red Cross Society for 100% screening of HIV in quality assured manner
- PMTCT (Options B), including early infant diagnosis (EID)
- Prevention of HIV in health care settings, including universal precaution, post-exposure prophylaxis
- Positive prevention among PLHIV



- Prevention related awareness programmes– National Condom Day, World AIDS Day
- Prevention related enabling environment support activities – advocacy, human rights and social protection, capacity building efforts
- Health and community system strengthening for HIV prevention efforts

## Challenges

- Increasing the effectiveness of HIV and STI prevention and control interventions at local level (districts and below) with universal coverage, improved quality and better effectiveness
- Expansion of comprehensive PMTCT services to reach more women, girls, men and children
- Scaling up of care and support service for PLHIV and affected populations
- Managing quality of care of interventions, including community and home base care, community care services among PLHIV
- Predictability of funds and exploring the resources, and increase the implementation of activities (burn rates)
- Correcting unevenly distribution of care and support programmes between the districts
- Reducing the duplication of prevention and care activities by implementing partners and so the reporting
- Retaining the trained and qualified staffs
- Strengthening of HIV and STI surveillance and monitoring & evaluation systems and research activities

## Planned activities

- There are targeted interventions (TI) among key populations at higher risk to HIV such as people who inject drug, men who have sex with men, labour migrants and their spouses, and prison inmates through contracted non-government organizations in selected districts. The TI includes HIV testing and counseling, BCC, STI diagnosis & treatment and referral services. PWIDs are provided opioid substitution therapy by methadone maintenance from six sites; and needle and syringe exchange programme for PWIDs are available.
- STI diagnosis, treatment and referral are provided from HIV testing and counseling sites, hospitals and few NGO run sites to key populations as well as general population.





- Scaling up of PMTCT services up to PHCCs and districts hospitals in selected districts are planned to reach 100 sites (47 institution-based and 53 community-based sties). WHO recommended Option B will be provided to all HIV infected pregnant women and girls.
- Blood safety programme will be implemented through Nepal Red Cross Society for 100% screening of HIV in quality assured manner.
- Scaling up of antiretroviral treatment (ART) services will be made to 8,335 PLHIV with improved coverage and quality. Opportunistic infections will be managed among PLHIV. PLHV will be provided nutritional support while taking ARV for the first time. TB-HIV co-infected PLHIV will be provided treatment for TB and HIV. PLHIV will be provided community and home based care and community care services.
- 600 Children affected by AIDS (CABA) will be provided monthly cash payment from selected districts.
- Health system strengthening activities are planned in the coming year such as training to public and private health care providers; strengthening of strategic information (HIV surveillance, M&E and research); procurement of HIV related commodities, including ARVs, test kits, and STI drugs, and its regular supply; strengthening of national and local response to HIV (NCASC and DACC).
- Community system strengthening activities are planned through NGOs to create the demand of services, reduce stigma and discrimination and ensure their rights to quality services.

### **New initiatives**

- Providing HIV and STI prevention services among female drug users by creating enabling environment
- Early Infant Diagnosis
- Adoption of new WHO guidelines of 350 CD4 cut off for enrollment in ART
- Option B in PMTCT
- Community Care Centres (CCC) for chronically ill PLHIV
- Monthly direct cash transfer to about 600 CABA in selected districts
- Community- based PMTCT in selected districts
- Nutritional support for PLHV while on ART for the first time
- Starting of comprehensive Targeted Prevention Interventions among key populations



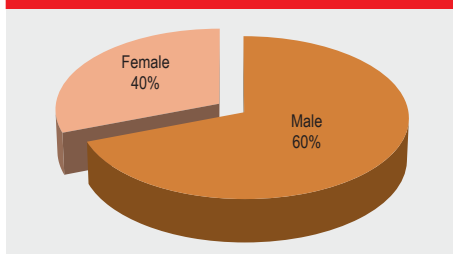
(FSWs/Clients, MSM/TG, PWIDs, prison inmates, migrants/spouses) with nationally recognized comprehensive standard operational procedures (SOPs). Earlier there were fragmented prevention programme services by various organizations and donors

- HSS and CSS activities in more intensified approach
- Provision of dedicated regional HIV/AIDS officers at the regional level (RHDs) and Coordinators at District AIDS Co-ordination Committees in 50 districts.

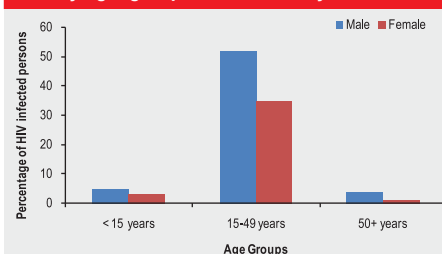
### Best practices

- Legal and constitutional campaign among MSM/TG communities - to empower the communities for their rights and identities
- Community-based PMTCT in selected districts – to improve the coverage
- Effective co-ordination by strategic information technical working groups to harmonize different studies on stigma and discrimination by various donors and agencies
- Supporting programme through quality data – data quality assessment in selected programme districts (FSWs and clients) – in USAID funded ASHA project

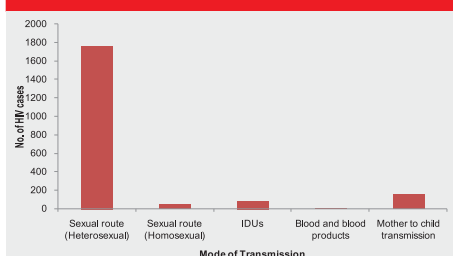
**Figure 23: Percentage of Sex distribution of reported HIV positive, 2011**



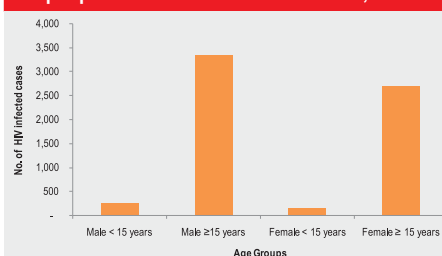
**Figure 24: Percentage of HIV infected persons by age -group and sex in the year 2011**



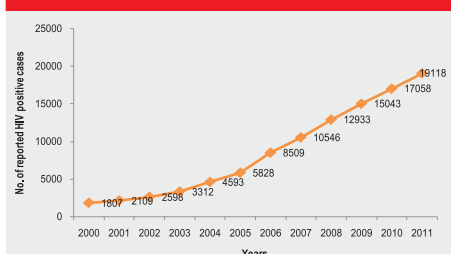
**Figure 25: Reported mode of HIV transmission, 2011**



**Figure 26: Cumulative Number of HIV infected people on Anti-Retroviral Treatment, 2011**



**Figure 27: Trend of Cumulative Reported HIV positive cases in Nepal (2000 – 2011)**



### Epidemiology, 2011

Population(mid-year)	330,652
Children under 15 yrs	87,896
Male ≥ 15 years	122,218
Female ≥ 15 years	120,538

#### Estimated Number/Prevalence of people living with HIV/AIDS, at the end of 2011

Estimated cases	Number	Prevalence rate (%)
People living with HIV/AIDS (total)	50288	0.3
Adults Male ≥ 15 years	33447	0.36
Adults Female ≥ 15 years	16841	0.16
Estimated number of deaths due to AIDS during the year 2011		4,722
Cumulative Number of HIV pregnant mothers who received ARV for PMTCT		400
Cumulative Number of babies born to HIV pregnant mothers who received ARV for PMTCT		459

Source: NCASC Nepal, 2011



# Pakistan

Pakistan is located in South Asia. It has the Arabian Sea in the south and is bordered by India to the east, Afghanistan to the west and north, Iran to the southwest and China in the far northeast. It has a total area of 796,095 km<sup>2</sup>. The estimated population is 187 million in 2011 and is the sixth most populous country in the world. Pakistan comprises of four provinces and 129 districts.

## Status of HIV/AIDS

Pakistan had an estimated 97,400 people living with HIV by the end of 2009, with 5,256 PLHIV registered in 17 ART centers by end of 2011, including 189 children, 1,018 and 4,049 adult females and males, respectively. Out of these, 2,491 PLHIV are on ART of which 105 are children, 646 adult females and 1,740 adult males. Looking at recent trends there has been a gradual increase in the number of PLHIV registered at ART centers and on ART.

The trend of a concentrated HIV epidemic among Key Affected Populations in Pakistan continues to be driven by PWID exhibiting the highest HIV prevalence at 27.2% in 2011. This is followed by 'Hijra' (HSWs) or transgender and male sex workers (MSWs) at 5.2% and 1.6%, respectively. Among the Key Affected Populations identified in the country, female sex workers (FSWs) exhibit the lowest prevalence of 0.6%. Other than the Key Affected Populations, evidence also exists of either HIV-related risk factors or infection among certain vulnerable populations, such as the spouses of at-risk persons, imprisoned populations, most at-risk adolescents and in certain occupational settings, including in some cases through nosocomial infection.



**Table 13: Cumulative reported HIV/AIDS Situation Pakistan, 2011**

Cumulative number of	Total
Cumulative HIV infected < 15 years	189
Cumulative HIV infected 15-44 years	1,018
Cumulative HIV infected 45+ years	4,049
Reported AIDS cases	5,256

Source: NACP Pakistan, 2011

As of end of 2011, a total 5,256 AIDS cases were reported to the National AIDS Control Programme.

**Table 14: Most at Risk Populations (MARP) in Pakistan, 2011**

MARP	Estimated Size of the MARPs	If available, HIV prevalence among MARP
Commercial Sex Workers	89,178	0.6%
MSM	19,119	1.6%
IDUs	46,351	27.2%
Hijra Sex Workers	23,317	5.2%

Source: NACP Pakistan, 2011

In Pakistan there are four Most at Risk Populations (MARP) available in which 89,178 Commercial Sex Workers, 19,119 MSM, 46,351 IDUs and 23,317 Hijra Sex Workers were estimated size of the MARPs.

**Table 15: Services available for infected and affected persons in Pakistan, 2011**

Type of services	Public sector
Health care facilities with Voluntary Counseling and testing (VCT)	17 Adult treatment centres and 7 PPTCT centres
Health care facilities with Laboratories facilities for CD4 Count	2
Health care facilities with Laboratories facilities for viral load testing	1
Neonatal Screening (PMTCT)	4

Source: NACP Pakistan, 2011

There are 17 Health care facilities with Voluntary Counseling and testing (VCT) facilities providing and 02 Health care facilities with Laboratories facilities for CD4 Count.

**Table 16: Cumulative Number of HIV infected population on Anti-Retroviral Treatment 2011**

HIV Infected People	Cumulative Number
Children	105
Adult:	2,386
Male ≥ 15 years of age	1,740
Female ≥ 15 years of age	646

Source: NACP Pakistan, 2011

Table 16 explains Cumulative Number of HIV infected people on Anti-Retroviral Treatment overall 2,386 HIV Infected adults were on ART.

### Activities carried out for the prevention of HIV infection

- Training workshop was held for the benefit of Journalists, journalism teachers and representatives of NGOs on strengthening media professionalism and NGO media interface in Pakistan for HIV/AIDS epidemic coverage.
- NACP Treatment and Care team visit Adiala Jail, Rawalpindi.
- United Nations Joint Programme Component-5 Task Force Meeting for joint implementation and promoting synergies at JPC level among all UN participating organizations and participating government counterparts on HIV/AIDS held in Islamabad.
- Advocacy session with Health reporters' National strategic framework on HIV (NSF-II) review meeting
- Closing ceremony of the second International E-health conference
- Technical Workshop group meeting on HIV treatment and care
- Six days National training workshop for counselors on voluntary testing & counseling for female sex workers (FSWs)
- Four day Consultative workshop "Understanding & Application of self help groups for female sex workers (FSWs)
- Participates in programme of sensitization seminar at AFIP Rawalpindi Armed forces titled "Scaling up HIV prevention in the Pakistan Uniformed personnel."
- NACP Participates in SBM sports Fiesta, 2011

- Advocacy session with religious leaders and Advocacy session with Health reporters
- Seminar for Anti Narcotics Force (ANF) training staff, officials & families
- Two days workshop was organized by NACP in collaboration with support of WHO.
- Advocacy session with school teachers
- Two days Technical workshop on Monitoring & Evaluation system strengthening
- Assessment Consultative meeting to plan for the Global Fund Round-11 proposal
- Drug demand reduction and HIV/AIDS technical workshop group (TWG) meeting
- Training of master trainers on mapping techniques for MARPS
- Follow-up meeting to plan for the Global Fund Round-11 Concept paper Development
- Training of master trainers on IBBS for MARPs
- NACP participates in Consultative Meeting for National Educational Festival
- A consultation meeting of stakeholders to plan “National Education Festival knowledge city”
- World AIDS Day Celebrated
- Training workshop on “Development & Implementation of effective IPC & SBC approaches for Female Sex Workers

## **Planned Activities**

### ***HIV Prevention and Treatment services***

Provision of:

- Anti Retroviral medicines
- Opportunistic Infection Medicines
- STIs Medicines
- HIV screening kits
- Pneumococcal vaccines
- Infection control supplies (bio hazard bags, sharp bins, autoclaves, gloves, etc)

Conduction of:

- CD4-T-Lymphocytes tests
- HIV Viral Load tests
- Confirmatory testing (western blot)
- Screening testing (rapid & Elisa)

Provision of consumables item (HIV treatment unit, (FANA & FATA)

Provision of Condoms for NACP/FATA

Training for PPTCT, HIV Care (adult & Pediatric), Lab staff on blood screening



Training on Laboratory Staff on HIV/AIDS Screening  
Systems analysis to assess the STI reporting mechanism  
Development and Operationalization of STI monitoring system  
Operations of the national STI monitoring system  
Gonococcal resistance Monitoring  
Development of tools for STI monitoring system  
Training of Master Trainers in STI management and STI information system

***Advocacy & Communication***

Formative and impact assessment research to direct advocacy  
Advocacy for politicians, public and private sector leaders  
Formative and impact research for communication campaign  
Communication campaign will be based on a “need” research based communication

***Governance and Institutional Framework of the HIV response***

Meeting of National Steering Committee  
Impact Assessment Committee meeting  
National Technical Advisory Committee (TACA) on AIDS  
Meetings TACA sub-committees  
Management Training for public sector and SDP managers  
Participation in national conferences NACP/FANA  
Participation in international conferences NACP/FANA  
Training for Master Trainers and others  
Quality Assurance visits  
Research under National Referral Laboratory  
Lab. Equipment maintenance

***Programme Management***

Annual Meeting of Stakeholders  
Printing Monitoring tools and reports  
3rd Party Evaluation (Communication campaign, Treatment and Care. STI, PPTCT and VCT)

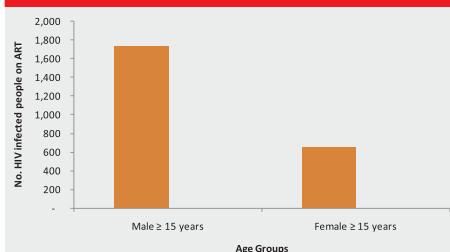
***Global Fund Project for 2012***

Roll out Care and support Manual  
M & E Training & Management  
Capacity Building of Sub- Recipients  
Meeting with Stake Holders to ratify Charter  
Establishment of community health based centers at Lahore, Multan, Rawalpindi, Karachi, DG Khan, Gujrat, Larkana, Sukkur, Sargodha, Peshawar, Kohat, Abbottabad, Quetta, Turbat





**Figure 28: Cumulative Number of HIV infected people on Anti-Retroviral Treatment, 2011**



**Figure 29: Cumulative Number of reported HIV cases, (2000- 2011)**



Source: NACP Pakistan, 2011

### Epidemiology, 2011

Population(mid-year)	187 million
Children under 15 yrs	64.13 million
Male ≥ 15 years	57.15 million
Female ≥ 15 years	53.29 million
Estimated Number of people living with HIV/AIDS, at the end of 2011	97400
Estimated Prevalence of people living with HIV/AIDS, at the end of 2011	0.1%
Cumulative Number of HIV pregnant mothers who received ARV for PMTCT	55
Cumulative Number of babies born to HIV pregnant mothers who received ARV for PMTCT	38

Source: NACP Pakistan, 2011



## Sri-Lanka

Sri-Lanka is an island country in the Indian Ocean, separated from the south- eastern coast of peninsular India. Its estimated population is 20.27 million in 2011. The Sinhalese are the predominant ethnic group, constituting about three quarters of the population. Other ethnic groups include Tamils and Muslims.

### Status of HIV/AIDS

Sri Lanka is experiencing a low level HIV epidemic. The estimated number of people living with HIV as at end 2009 was 3000 and the estimated HIV prevalence among adults (15-49 years) is less than 0.1%. Survey data observes that even among individuals considered at higher risk of infection on the basis of their occupation, behaviors and practices, the HIV prevalence is below 1%. As at end December 2011, a cumulative total of 1463 HIV persons were reported to the NSACP. The main mode of transmission is due to unprotected sex between men and women (82.8%). Men who have sex with men have accounted for 12.3% of the transmission while mother to child transmission was 4.4%. Transmission through blood and blood products was 0.4%. Injecting drug use in Sri Lanka is not a common phenomenon (0.5%).

In 2010, a mapping exercise was conducted to map the female sex workers and men who have sex with men. Four districts were covered in this process and population sizes were extrapolated to the whole country. The estimated FSW and MSM were 41,000 (35,000 - 47,000) and 31,000 (24,000-37,000) respectively.



**Table 17: Cumulative HIV/AIDS Situation Sri Lanka, 2011**

Cumulative number of	Male	Female	Total
Cumulative HIV infected < 15 years	33	19	52
Cumulative HIV infected 15 - 44 years	626	449	1,075
Cumulative HIV infected 45+ years	173	108	281
Reported AIDS cases	255	119	374
Reported Deaths due to AIDS	-	-	253

Source: NSACP Sri Lanka, 2011

The cumulative number of HIV positive cases reported to the National STD/AIDS control Programme (NSACP) was 1408 of which 59% males and 41% females. Among them, 374 persons were reported as having AIDS. Reported number of AIDS deaths was 253.

**Table 18: Most at Risk Population of Sri Lanka, 2011**

MARP	Estimated size of the MARP	If available, HIV prevalence among MARP
Commercial Sex Workers	35,000-47,000	0.20%
MSM	24,000-37,000	0.90%
Patients with STDs	200,000	0.20%
IDUs	900	N.A
Prisoners	30,000	0
Migrant workers	350,000	N.A
Drug users	45,000	0.20%

Source: NSACP Sri Lanka, 2011

In Sri Lanka seven Most at Risk Populations (MARP) were available in which 0.35 million were Migrants workers, 37,000 were MSM, 47,000 were Commercial Sex Workers, 900 were IDUs and 30,000 were prisoners.



**Table 19: Service available for HIV infected and affected persons, 2011**

Type of service	Number of Health facilities providing services till December, 2011	Public sector	Private sector
Health care facilities with Voluntary Counseling and Testing (VCT)/ICTC	96	57	13
Detoxification Centres	9	5	4
Health care facilities with Laboratory facilities for CD4 Testing	2	2	0
Health care facilities with Laboratory facilities for Viral load Testing	1	1	0
Health care facilities with ARV treatment - First line regimen	5	5	0
Health care facilities with ARV treatment - Second line regimen	5	5	0
Health care facilities with PMTCT services	5	5	0
Health care facilities with Post Exposure Prophylaxis for health care workers	28	28	0
Centers with social welfare facilities for HIV infected	12	0	12
Screening of HIV in Blood Banks	92	87	5
<b>HIV Care and support Centres (Community)</b>	3	N.A	3
Targeted intervention sites and their types (CSW)	4	N.A	4
Health care facilities with TB screening activity	205	203	2

Source: NSACP Sri Lanka, 2011

There are 96 Health care facilities with Voluntary Counseling and testing (VCT) facilities providing. Health care facilities with post exposure Prophylaxis for health care workers are 28. There are 12 Centres with social welfare facilities.

**Table 20: Number of HIV infected people on Anti-Retroviral Treatment, 2011**

HIV Infected People	Cumulative Number
<i>Children</i>	
Male < 15 years of age	02
Female < 15 years of age	02
<i>Adult</i>	
Male ≥ 15 years of age	41
Female ≥ 15 years of age	36

Source: NSACP Sri Lanka, 2011

Table 20 explains the number of HIV infected people on Anti-Retroviral Treatment in which 04 children and 77 adult were HIV Infected.

### Activities carried out for the prevention of HIV infection

- Targeted HIV interventions for FSW, MSM and beach boys commenced with Global fund round 9.
- Advocacy programmes initiated for drug users.
- Police officers and armed forces sensitized for HIV prevention.
- HIV prevention activities initiated in prison.

### Challenges

Low priority given to HIV by authorities due to low HIV prevalence and other health issues

### Planned activities

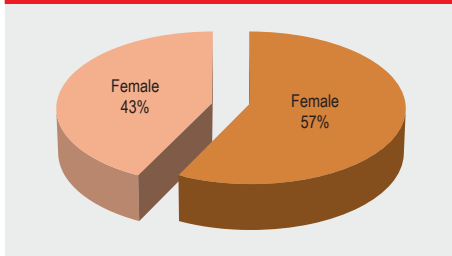
Scaling up of HIV prevention activities for FSW and MSM  
Creating a policy for drug user interventions  
Conducting national size estimation and IBBS with GF money

### New initiatives/ Best practices

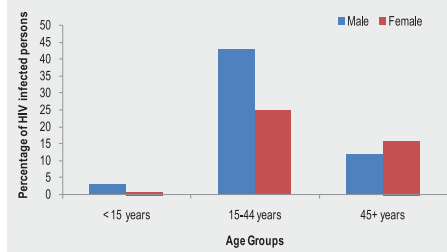
Involvement of NGOs for reaching various communities such as FSW, MSM and beach boys.  
Strengthening NGOs of PLHIV  
Addressing stigma and discrimination by health care workers.



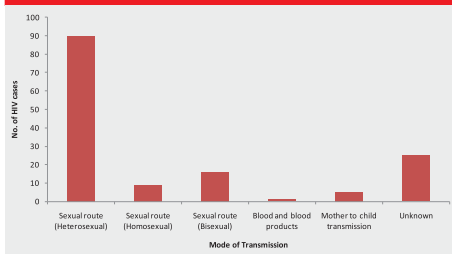
**Figure 30: Percentage of Sex distribution of reported HIV positive in Sri Lanka, 2011**



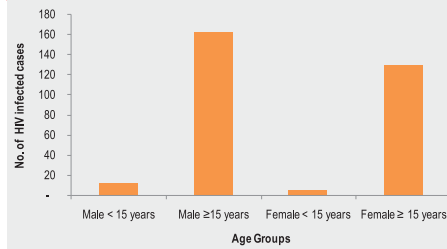
**Figure 31: Percentage of HIV infected persons by age group and sex, 2011**



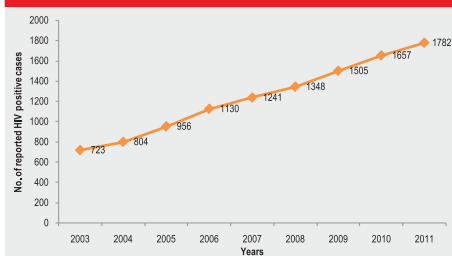
**Figure 32: Reported No. of HIV infected persons by mode of transmission, 2011**



**Figure 33: Cumulative Number of HIV infected people on Anti-Retroviral Treatment, 2011**



**Figure 34: Trend of Cumulative reported HIV Positive Cases, (2000-2011)**



### Epidemiology, 2011

Population(mid-year)	20.27 million
Children under 15 yrs	5.4 million
Male ≥ 15 years	7.7 million
Female ≥ 15 years	7.7 million

#### Estimated Number/Prevalence of people living with HIV/AIDS, at the end of 2011

Estimated cases	Number	Prevalence rate (%)
People living with HIV/AIDS (total)	3000	< 0.1 %
Adults Male ≥ 15 years	1801	< 0.1 %
Adults Female ≥ 15 years	1196	< 0.1 %
Estimated number of deaths due to AIDS during the year 2011		175
Cumulative Number of HIV pregnant mothers who received ARV for PMTCT		16
Cumulative Number of babies born to HIV pregnant mothers who received ARV for PMTCT		17

Source: NCASC Nepal, 2011

## 5. TB HIV CO-INFECTION

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TB HIV Co-infection poses a critical challenge for the health-sector and for people living with HIV and TB. HIV is the strongest risk factor for developing active TB disease. An HIV positive person is more likely to develop TB disease as compared to an HIV negative person.

In 2011, 1.1 million (13%) of the 8.7 million people who developed TB worldwide were HIV-positive; 79% of these HIV-positive TB cases were in the African Region. Globally, there were an estimated 0.4 million HIV-associated TB deaths in 2011, with approximately equal numbers among men and women. Seventy-nine percent TB patients known to be HIV-positive were provided with CPT, and 48% were started on ART, similar to levels achieved in 2010. More work remains to be done to ensure that all HIV-positive TB patients are rapidly started on ART, in line with WHO recommendations. And in 2011, 3.2 million people enrolled in HIV care were reported to have been screened for TB, up 39% from 2.3 million in 2010. Of those without active TB disease, 0.45 million were provided with IPT. The scale-up of collaborative TB/HIV activities saved a total of 1.3 million lives between 2005 and the end of 2011.

WHO recommends, the three I's for HIV and TB – intensified TB case-finding, isoniazid preventive treatment and TB infection control – to decrease the burden of TB among people with HIV. The SAARC TB & HIV/AIDS Center also includes a fourth 'I' in its Regional strategy on TB/HIV Co-infection (Revised), it states about the integrated case management including ART & DOTS.

Worldwide, the number of HIV-positive TB patients on ART has grown from a very low level in 2004 to reach 258 000 in 2011. Among TB patients notified in 2011 and who had a documented





HIV-positive test result, 48% were on ART globally in 2011. And globally, the number of TB patients living with HIV who were enrolled on CPT increased to 0.41 million in 2011. The coverage of CPT among TB patients with a documented HIV-positive test result was 79% in 2011.

The World Health Organization recommended interventions are collectively known as collaborative TB/ HIV activities. They include HIV testing of TB patients, provision of antiretroviral therapy (ART) and co-trimoxazole preventive therapy (CPT) to TB patients living with HIV, HIV prevention services for TB patients, intensified TB case-finding among people living with HIV, isoniazid preventive therapy (IPT) for people living with HIV who do not have active TB, and infection control in health-care and congregate settings. Globally in 2011, there were an estimated 0.43 million (range, 0.40 million–0.46 million) deaths from TB among people who were HIV-positive.

Antiretroviral therapy considerably reduces the risk of morbidity and mortality from TB. A meta-analysis published in 2012 found that ART decreases the individual risk of TB disease by 65%, irrespective of CD4 cell-count. IPT and ART given together can have an additive effect and substantially reduce the risk of developing active TB disease among people living with HIV. This evidence is the reason why updated WHO policy guidance on collaborative TB/HIV activities (issued in 2012) includes earlier initiation of ART along with the Three Is for HIV/TB as key interventions to prevent TB among people living with HIV. ART is recommended for all TB patients living with HIV, irrespective of their CD4 cell-count. The number of TB patients who knew their HIV status reached 2.5 million in 2011; equivalent to 40% of notified cases of TB.

Joint activities between national TB and HIV/AIDS programmes are crucial to prevent, diagnose and treat TB among people living with HIV and HIV among people with TB. These include establishing mechanisms for collaboration, such as coordinating bodies, joint planning, surveillance and monitoring and evaluation; decreasing the burden of HIV among people with TB (with HIV testing and counseling for individuals and couples, co-trimoxazole preventive therapy, antiretroviral therapy and HIV prevention, care and support); and decreasing the burden of TB among people living with HIV (with the three I's for HIV and TB: intensified case-finding; TB prevention with isoniazid preventive therapy and early access to antiretroviral therapy; and infection control for TB). Integrating HIV and TB services, when feasible, may be an important approach to improve access to services for people living with HIV, their families and the community.



**Table 21: HIV testing and provision of CPT, ART and IPT in the SAARC Region, 2011**

Country	TB patients with known HIV status		HIV-positive TB patients		HIV-positive TB patients started on		HIV-positive people screened for TB	HIV-positive people provided with IPT
	No.	%	No.	%	CPT	ART		
<b>Afghanistan</b>	6,445	23	05	< 1	04	04	-	-
<b>Bangladesh</b>	1,900	01	81	04	81	81	69	-
<b>Bhutan</b>	-	-	-	-	-	-	-	-
<b>India</b>	688,530	45	44,702	06	40,583	26,165	386,081	-
<b>Maldives</b>	-	-	-	-	-	-	-	-
<b>Nepal</b>	-	-	-	-	-	-	-	-
<b>Pakistan</b>	8,322	3	33	<1	11	28	-	-
<b>Sri Lanka</b>	1,832	18	21	-	-	-	-	7

Source: Global TB Report WHO, 2012

In Afghanistan 6,445 TB patients have known their HIV status in 2011. In Bangladesh 1,900 TB patients have known their HIV status among them 81 were HIV positives. And 69 HIV positive patients were screened for TB. In India, 688,530 TB patients have known their HIV status. In Pakistan 8,322 TB patients have known their HIV status among them 33 were HIV positives while in Sri Lanka 1,832 TB patients have known their HIV status in 2011.

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