HIV & AIDS SAARC REGION

UPDATE 2013

SAARC Tuberculosis and HIV/AIDS Centre (STAC)

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Foreword

HIV epidemic continues to pose a major challenge in the realm of human development. The current estimated number of persons living with HIV globally was 35.3 million [32.2 million –38.8 million] in 2012. 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 2.24 million People Living with HIV and India alone bears an estimated 2.09 million of that number. 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 and HIV&AIDS Centre has been coordinating the efforts of Member States in combating HIV and 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 – 2013 incorporates updated information on HIV&AIDS as of December 2012. This is the 11th HIV&AIDS SAARC Region Update. It includes statistical information and brief analysis on HIV&AIDS and describes global, regional and SAARC Member States HIV&AIDS situation. 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.

Dr. Kashi Kant Jha
Director
SAARC TB and HIV/AIDS Centre

Contents

Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
BBS	Biological Behavioral Survey
CPT	Co-trimoxazole Preventive Therapy
DNA	Deoxyribonucleic Acid
FICTs	Facility Integrated Counseling & Testing Centre
FSW	Female Sex Worker
GoA	Government of Afghanistan
HIV	Human Immunodeficiency Virus
HRGs	High Risk Groups
ICTC	Integrated Counseling Testing Center
ICF	Intensified tuberculosis Case Finding
IDU	Injecting Drug Users
IPT	Isoniazid Preventive Therapy
MoCN	Ministry of Counter Narcotics
MoPH	Ministry of Public Health
MARPs	Most At Risk Populations
MTCT	Mother-To-Child Transmission
MSM	Men who have Sex with Men
NAP	National AIDS Control Program
NACPs	National AIDS Control Programs
NTPs	National Tuberculosis Control Programs
NGO	Non Governmental Organization
NSF	National Strategic Framework
PLHIV	People Living with HIV
PWIDs	People Who Inject Drugs
PPTCT	Prevention of Parent-To-Child Transmission
RNTCP	Revised National Tuberculosis Control Programme
STAC	SAARC Tuberculosis and HIV/AIDS Centre
SAARC	South Asian Association for Regional Cooperation
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1 INTRODUCTION

1.1 INTRODUCTION: SAARC

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.

1.2 INTRODUCTION TO STAC

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 and AIDS and TB/HIV co infection in the Region. The Centre has been renamed as **SAARC TB and HIV/AIDS Centre** in November 2005. Since then the centre has been working for prevention and control of TB and HIV and 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 and AIDS control in the region. In this regard the Centre has been publishing annual SAARC Regional Epidemiological Reports on HIV and AIDS since 2003. This update is on the HIV and AIDS and TB/HIV Co-Infection situation in the SAARC Region and is the tenth in the series.

1.3 OVERVIEW

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 the 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 surveillance for 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 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. 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 epidemic and a more detailed description of its epidemiology within the SAARC region. In addition, this report also contains progress in HIV and AIDS control in, impact of HIV and AIDS and contribution of STAC towards control of HIV and AIDS in the region.

2 GLOBAL SITUATION OF HIV & AIDS

2.1 Global HIV Epidemic

Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in 2012. This is an increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 (1.9–2.7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1–3.7) million in 2001. At the same time the number of AIDS deaths is also declining with 1.6 (1.4–1.9) million AIDS deaths in 2012, down from 2.3 (2.1–2.6) million in 2005 (see Figure A).

Figure A: Numbers of people living with HIV, new HIV infections, and AIDS deaths, 2001-2012, globally

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

UNAIDS report on the global AIDS epidemic 2013, GLOBAL REPORT states that striking gains have been made towards many of the 2015 targets and elimination commitments, although significant challenges remain. Some of these targets with the progress made and the remaining challenges are highlighted below:

2.2 Reduce sexual transmission of HIV by 50% by 2015

The annual number of new HIV infections among adults and adolescents decreased by 50% or more, in 26 countries between 2001 and 2012. However, other countries are not on track to halve sexual HIV transmission, which underscores the importance of intensifying prevention efforts. Although trends in sexual behaviors in high prevalence countries have generally been favorable over the last decade, recent surveys in several countries in sub-Saharan Africa have detected decreases in condom use and/or an increase in the number of sexual partners. Efforts to reduce transmission related to sex work and men who have sex with men remain insufficient, as evidence by recent trends in prevalence among these groups.

However, prospects for strengthening prevention efforts have never been more promising, as a series of highly effective biomedical prevention tools have emerged in recent years to buttress the prevention benefits of behavioural and structural approaches. Momentum accelerated in 2012 towards the scale-up of one such biomedical intervention – voluntary medical male circumcision.

Trends in sexual HIV transmission

Trends in new adult infections differ among regions. The epidemic continues to disproportionately affect sub-Saharan Africa, home to 70% of all new HIV infections in 2012.

However, since 2001, the annual number of new HIV infections among adults in sub- Saharan Africa has declined by 34%. The most pronounced decline in new infections since 2001 (49%) has occurred in the Caribbean. New HIV infections have been on the rise in Eastern Europe and Central Asia in recent years despite declines in Ukraine. By contrast, new HIV infections continue to rise in the Middle East and North Africa.

2.3 Halve the transmission of HIV among people who inject drugs by 2015

The world is not on track to reduce HIV transmission among people who inject drugs by 50%, as recent evidence suggests little change in the HIV burden in this population. HIV prevalence among people who inject drugs remains high – up to 28% in Asia. HIV prevention coverage for people

who inject drugs remains low, with only two of 32 reporting countries providing the recommended minimum of at least 200 sterile syringes per year for each person who injects drugs. Among 35 countries providing data in 2013, all but four reached less than 10% of opiate users with substitution therapy. In addition to exceptionally low coverage, an effective AIDS response among people who inject drugs is undermined by punitive policy frameworks and law enforcement practices, which discourage individuals from seeking the health and social services they need.

2.4 Eliminate HIV infections among children and reduce maternal deaths

As a result of sustained progress, the world has the potential to reach at least 90% of pregnant women living with HIV with antiretroviral interventions by 2015. Antiretroviral coverage among pregnant women living with HIV reached 62% in 2012, and the number of children newly infected with HIV in 2012 was 35% lower than in 2009. However, achieving the global goal of reducing the number of children newly infected by 2015 will require similar scale-up of other prevention strategies, including primary HIV prevention for women and access to contraception and other family planning services. However, substantially greater efforts are needed to link pregnant women and children to HIV treatment and care; pregnant women living with HIV are less likely than treatment-eligible adults overall to receive antiretroviral therapy, and treatment coverage among children living with HIV in 2012 was less than half the coverage for adults.

2.5 Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

The world is within reach of providing antiretroviral therapy to 15 million people by 2015. In 2012, 9.7 million people in low- and middle-income countries received antiretroviral therapy, representing 61% of all who were eligible under the 2010 World Health Organization (WHO) HIV treatment guidelines. However, under the 2013 WHO guidelines, the HIV treatment coverage in low- and middle-income countries represented only 34% (32-37%) of the 28.3 million people eligible in 2013. Antiretroviral therapy not only prevents AIDS-related illness and death: it also has the potential to significantly reduce the risk of HIV transmission and the spread of tuberculosis. From 1996 to 2012, antiretroviral therapy averted 6.3 million AIDS-related deaths worldwide, including 5.2 million deaths in low- and middle-income countries. But despite historic gains in expanding treatment services, efforts to reach universal treatment access face considerable challenges. In addition to persistent low treatment coverage for children, men are notably less likely than women worldwide to receive antiretroviral therapy, and key populations often experience major barriers to obtaining treatment and care services.

Only relatively modest gains in treatment access have occurred in Eastern Europe and Central Asia and in North Africa and the Middle East, underscoring the need to extend recent coverage gains to all parts of the world.

2.6 Halve tuberculosis deaths among people living with HIV by 2015

As a result of sustained progress in meeting the needs of tuberculosis patients living with HIV, the world is within reach of achieving the 2015 target of reducing by 50% tuberculosis-related deaths among people living with HIV. Since 2004, tuberculosis related deaths among people living with HIV have declined by 36% worldwide and slightly less in Africa, home to 75% of all people living with tuberculosis and HIV.

WHO estimates that the scale-up of collaborative HIV/TB activities (including HIV testing, antiretroviral therapy and recommended preventive measures) prevented 1.3 million people from dying from 2005 to 2012. However, challenges persist, as progress in reducing tuberculosis-related deaths among people living with HIV has slowed in recent years. While antiretroviral therapy reduces the risk that a person living with HIV will develop tuberculosis, inadequate use is currently being made of this life-saving tool; among the 10 reporting countries with the largest number of HIV/TB patients, only two (Kenya and Malawi) were delivering antiretroviral therapy in 2012 to more than 50% of HIV-positive TB patients, while the pace of treatment scale-up for HIV/TB patients has slowed. Less than half (46%) of notified tuberculosis patients were tested for HIV in 2012, and the number of people with HIV/TB co-infection receiving isoniazid preventive therapy (500 000) represented a mere fraction of those who could benefit from the intervention.

2.7 Close the global AIDS resource gap

Continued gains were made in mobilizing financial resources for the AIDS response in 2012, although AIDS expenditures remain short of the global target of US$ 22-24 billion in annual financial resources. In 2012, an estimated US$ 18.9 billion were available for HIV programmes in low- and middle-income countries – a 10% increase over 2011. Although international HIV assistance remained flat in real terms in 2012, many low- and middle-income countries have increased financial outlays for HIV; domestic spending accounted for 53% of all HIV-related spending in 2012. Although increases in domestic investments have occurred among countries at all income levels, spending has risen most sharply among upper middle-income countries, with many lower middle income and low-income countries remaining heavily dependent on international assistance. In 2012, 51 countries looked to international sources for more than 75% of HIV-related spending. Whereas domestic resources account for the majority of spending for treatment and care, international spending financed the majority of prevention efforts. In an effort to promote long-term sustainability of national responses,

a growing number of countries are exploring innovative financing methods, including dedicated tax levies and AIDS trust funds.

2.8 Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

Gender inequalities and harmful gender norms continue to contribute to HIV-related vulnerability. As one manifestation of the role of gender issues in national epidemics, a recent review found that women who have experienced intimate partner violence are 50% more likely to be living with HIV. Nearly all countries (92%) that conducted midterm reviews of their national AIDS response acknowledged the central importance of addressing gender inequalities. However, mid-term reviews indicate that less than half of countries allocate funds for women's organizations, broadly integrate HIV and sexual and reproductive health services, or have scaled-up initiative to engage men and boys in national responses.

2.9 Eliminate HIV-related stigma, discrimination, punitive laws and practices

HIV-related stigma and discrimination persist as major obstacles to an effective HIV response in all parts of the world, with national surveys finding that discriminatory treatment of people living with HIV remains common in multiple facets of life, including access to health care. In 2012, 61% of countries reported the existence of anti-discrimination laws that protect people living with HIV. The proportion of countries reporting the existence of HIV-related legal services increased from 45% in 2008 to 55% in 2012, but the frequent lack of accessible legal services means that many instances of HIV-related discrimination are never addressed. As of 2013, 63 countries have in at least one jurisdiction specific provisions that allow for the prosecution of HIV non-disclosure, exposure and/or transmission. Criminalisation of key populations also remains widespread, and 60% of countries report having laws, regulations or policies which present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups.

2.10 Eliminate HIV-related restrictions on entry, stay and residence

Since 2010, eight countries, territories or areas have eliminated restrictions on entry, stay and residence for people living with HIV. However, eliminating the remaining HIV related restrictions on freedom of movement will require intensified action to remove such counterproductive and discriminatory laws that remain in force in 44 countries. Removing HIV-related restrictions to entry stay and residence is a priority for both symbolic and practical reasons. In addition to reflecting and reinforcing the stigma and discrimination that impedes an effective AIDS response, such restrictions also impose severe

hardship on many people living with HIV. Increasingly, business leaders are encouraging countries to repeal HIV-related travel restrictions on economic grounds, arguing that in a globalized world companies require flexibility to recruit and deploy workers where they are most needed.

2.11 Strengthen HIV integration

Although a clear trend towards integration of HIV with diverse systems and sectors is apparent, greater efforts are needed to eliminate parallel structures and systems and to ensure integration of HIV in broad health and development efforts. Nearly all countries (90%) recognize integration as a core HIV priority, 82% address integration in their national strategic plans and 45% report that HIV has been aligned with other disease specific planning. More than half (53%) of countries have either fully integrated HIV and tuberculosis services or strengthened joint service provision, 70% of countries have integrated services to prevent mother-to-child HIV transmission in antenatal care, and two-thirds have integrated HIV and sexual and reproductive health services. Nearly one in four (23%) countries have linked HIV and management of chronic non communicable diseases, and more than half have integrated HIV testing and counseling and/or antiretroviral therapy in general outpatient care.

Table 01 **Global Summary of HIV/AIDS, 2001 – 2012**

Year	Adults and children living with HIV	Adults and children newly infected with HIV	Adults (15- 49) prevalence (%)	Adults and child deaths due to AIDS
2012	35.3 million	2.3 million	0.8	1.6 million
2011	34.2 million	2.5 million	0.8	1.7 million
2010	34.0 million	2.7 million	0.8	1.8 million
2001	28.6 million	3.1 million	0.8	1.9 million

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

3 HIV & AIDS SITUATION IN THE SAARC REGION

The HIV situation epidemic in SAARC region is a collection of diverse epidemics in countries, provinces & districts. HIV and 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 2.24 million HIV infected people and 1.56 lakh AIDS deaths in 2012. Table 02 shows the estimated number of People Living with HIV (PLHIV) in eight Member States of the SAARC Region in the year 2012. Three countries, namely India, Nepal and Pakistan account for majority of the regional burden. The first HIV 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.

Table 02 **Adult HIV Prevalence Rates and Estimated Number of PLHIV in SAARC Region, 2012**

Country	Estimated No. of PLHIV (all ages)	Estimated New HIV infections in 2012 (all ages)	Estimated Adult (ages 15-49) HIV Prevalence	Estimated Number of AIDS Deaths	First HIV Positive Case Detected (Year)
Afghanistan	4592*	<1000	0.03*	295*	1989
Bangladesh	8000	<1000	< 0.1	< 500	1989
Bhutan	1,100	<200	0.2	< 100	1993
India**	2.09 million	1.16 lakh	0.27	1.48 lakh	1986
Maldives	< 100	<100	< 0.1	< 100	1991
Nepal	49000	1200	0.3	4100	1988
Pakistan	87000	19000	< 0.1	3500	1986
Sri- Lanka*	4,550*	<500	< 0.1	271*	1987
Regional	2.24 million			1.56 lakh	

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

** Country Report, 2013 ** Annual Report 2012-13, NACO, India*

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 the key affected populations. Of the estimated number of 2.24 million PLHIV in SAARC region, 2.09 million were living in India in 2012.

Table 03 **Estimated number of adults and children receiving and needing antiretroviral therapy, and coverage, 2012**

Country	Estimated number of adults needing ART	Reported number of adults on ART	Estimated adults ART coverage (%)	Reported number of children 0-14 years receiving ART	Adults and children with HIV known to be on treatment 12 months after initiation of ART (%)
Afghanistan	1200	150	9	8	100
Bangladesh	2900	783	27	48	91
Bhutan	< 500	33	11	5	....
India	1 000 000	570 620	51	34 367	....
Maldives	< 100	5	27	0	86
Nepal	22 000	7168	33	551	....
Pakistan	21 000	2996	14	139	....
Sri Lanka	1100	363	35	24	76
Regional	1 048 200	582 118	55	35 142	

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

On the basis of latest available information (Global Report, UNIADS 2013), this region has 1.04 million estimated numbers of adults needing ART while in the region 0.58 million reported number of adults and 35142 numbers of children on ART in 2012. Table 03 shows three countries, namely India, Nepal and Pakistan account for majority of the regional burden.

Table 04 Tuberculosis among People Living with HIV in 2012

Country	HIV positive Tuberculosis Patients on ART	Estimated HIV positive incident TB cases that received treatment for both TB and HIV (%)
Afghanistan	5	2
Bangladesh	63	26
Bhutan	0	0
India	25790	20
Maldives	0	0
Nepal	217	20
Pakistan	22	1
Sri Lanka	11	65
Regional	**26108**	

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

Table 04 shows Tuberculosis among People Living with HIV in eight Member States of the SAARC Region in the year 2012. There are 26108 HIV positive tuberculosis patients on ART in the region. In Sri Lanka 65 % of estimated HIV positive incident TB cases received treatment for both TB and HIV in the year 2012.

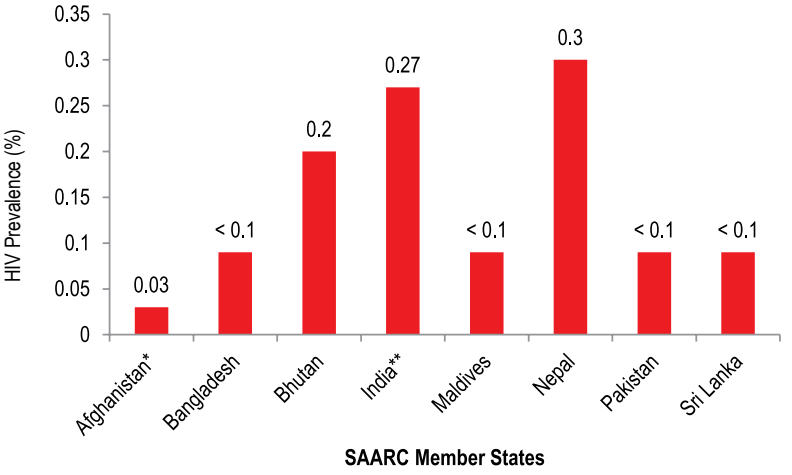
Table 05 Number of HIV infected Female Adults, 2001-2012

Country	2001	2012
Afghanistan	<1000	1400
Bangladesh	<1000	2700
Bhutan	<100	<500
India*	800 000	750 000
Maldives	<100	<100
Nepal	14000	14000
Pakistan	2400	24000
Sri Lanka	<500	<1000
Regional	**816 400**	**792 100**

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

Table 05 shows number of HIV infected female adults is in the slightly decreasing order in the year 2012 in comparison to 2001

Figure 01: Estimated HIV Prevalence – adult (ages 15-49) in the SAARC Region, 2012



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013,

** Country Report, 2013*

*** Annual Report 2012-13, NACO, India*

Figure 01 shows the estimated adult (15- 49) HIV prevalence of SAARC Member States. The overall HIV prevalence in the region still remains below 1%.

4 COUNTRY PROFILES

- Afghanistan
- Bangladesh
- Bhutan
- India
- Maldives
- Nepal
- Pakistan
- Sri Lanka

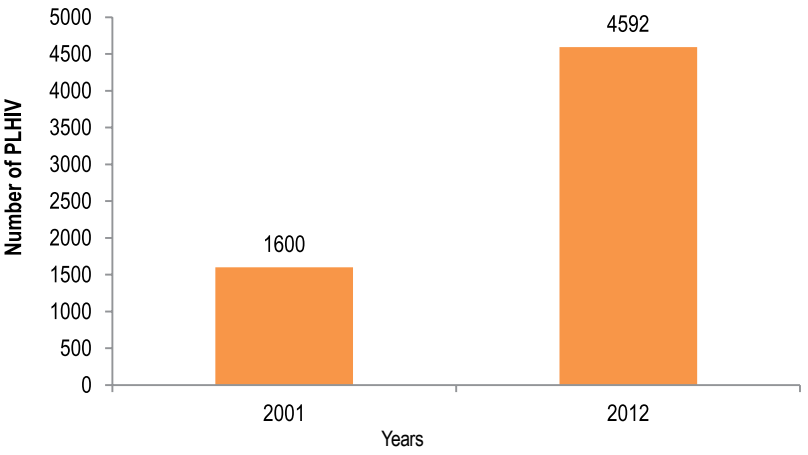
Afghanistan

Islamic Republic of Afghanistan is one of the eight member countries of SAARC. It is a land-locked country, bordered by Pakistan in the south and 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 and has a population of 29.82 million. Afghanistan consists of 34 provinces and 398 districts. Afghans comprise the second largest number of refugees and internally displaced people in the world.

Overview of the HIV & AIDS epidemic

Afghanistan has a low and concentrated HIV epidemic. 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 (PWID). Afghanistan's emerging epidemic likely hinges on a combination

Figure 02: Estimated Number of PLHIV, Afghanistan, 2001-12

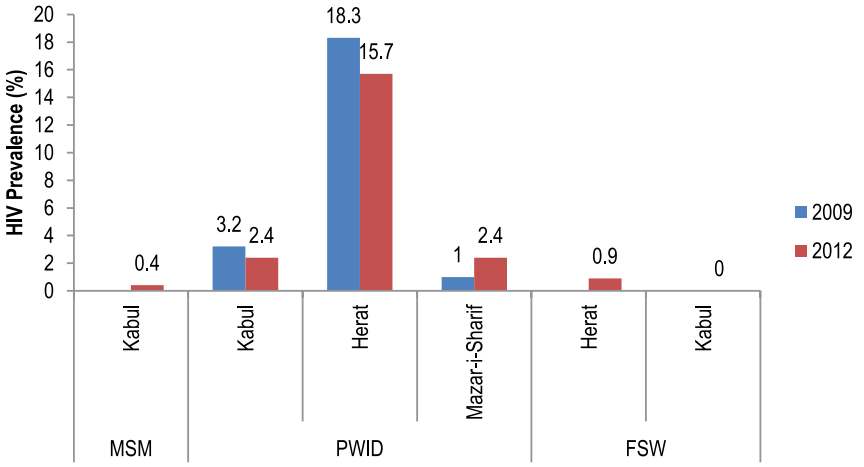


Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, Country report, Afghanistan2013& AIDS Data Hub

of injecting drug use and unsafe paid sex. 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 the IBBS, 2009).

The number of PLHIV has increased in 2012 in comparison to 2001 (figure 2). Estimated adult HIV prevalence in Afghanistan is 0.03 in 2012. HIV prevalence among key affected populations in the different cities of Afghanistan is shown in (figure 3).

Figure 03: HIV prevalence among key affected populations, 2009 and 2012

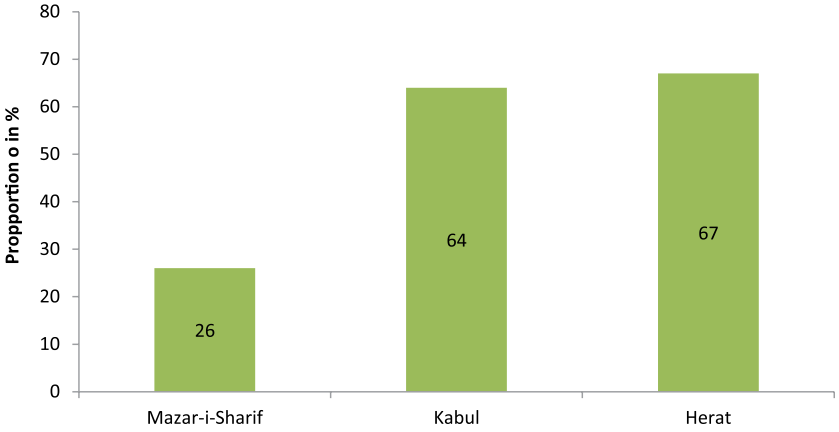


Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013,Country report, Afghanistan2013& AIDS Data Hub

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.

The Proportion of FSW reported condom use at last sex with any partner in different cities is shown in figure 04.

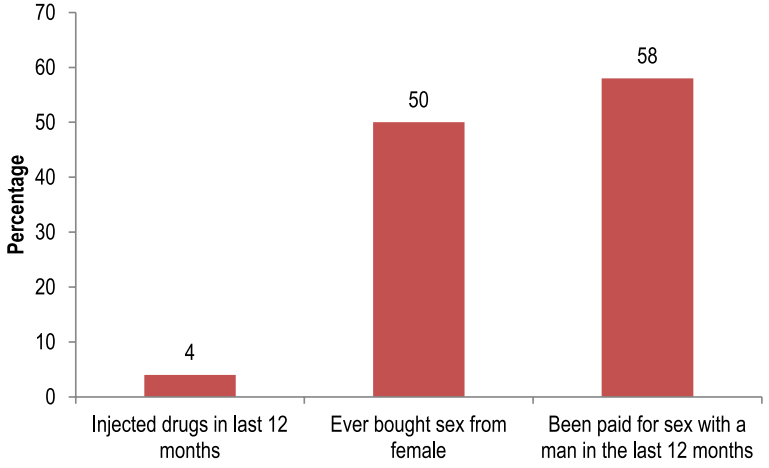
Figure 04: Proportion of FSW reported condom use at last sex with any partner, 2012



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, Country report, Afghanistan2013& AIDS Data Hub

Knowledge is increasing about the factors that influence the spread of HIV in Afghanistan. The Proportion of Men who have Sex with Men (MSM) with reported risk behaviors is high in paid for sex with a man in the last 12 months than injected drugs and ever bought sex from female (Figure 05).

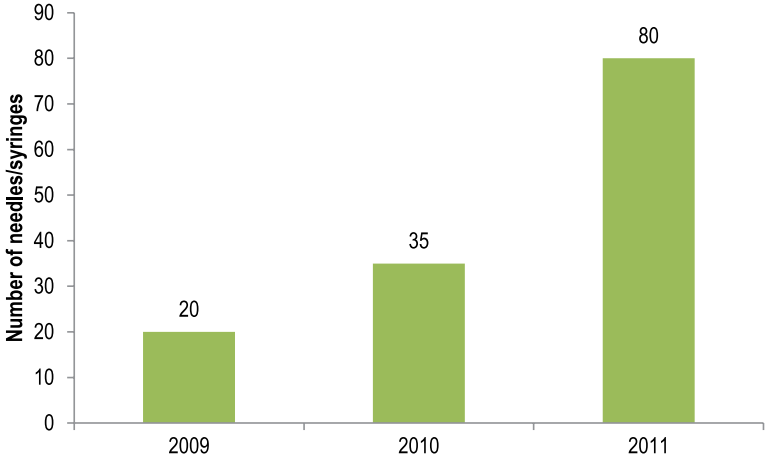
Figure 05: Proportion of MSM with reported risk behaviors, 2012



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, Country report, Afghanistan2013& AIDS Data Hub

Although 100 MSM were reached by a study in 2009, there are no robust estimates or behavioral or biological measures of this population. The Afghanistan National Strategic Framework (NSF)-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.

Figure 06: Number of needles/syringes distributed per person who inject drugs per year, 2009-2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, Country report, Afghanistan2013& AIDS Data Hub

Figure 06 shows the trend of increment in number of needles/syringes distributed per person who inject drugs per year. It is significantly higher in 2011 than 2009.

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'.

Epidemic Overview, 2012	
Population(mid-year)	29.82 million
Estimated Number of people living with HIV	4592*
HIV Prevalence	
Adult (15 - 49)	0.03%*
Female sex workers (FSW)	0.30%
Men who have Sex with Men (MSM)	0.50%
People Who Inject Drugs (PWID)	4.40%
Estimated newly infected	<1000
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	295*
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	2% - 9%
Condom use at last sex	
FSW	51%
MSM	17%
PWID	23%
HIV Testing Coverage	
FSW	4%
MSM	n/a
PWID	22%

*Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, *Country report, Afghanistan2013& AIDS Data Hub*

Bangladesh

Bangladesh is a relatively small coastal country in South 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 154.69 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.

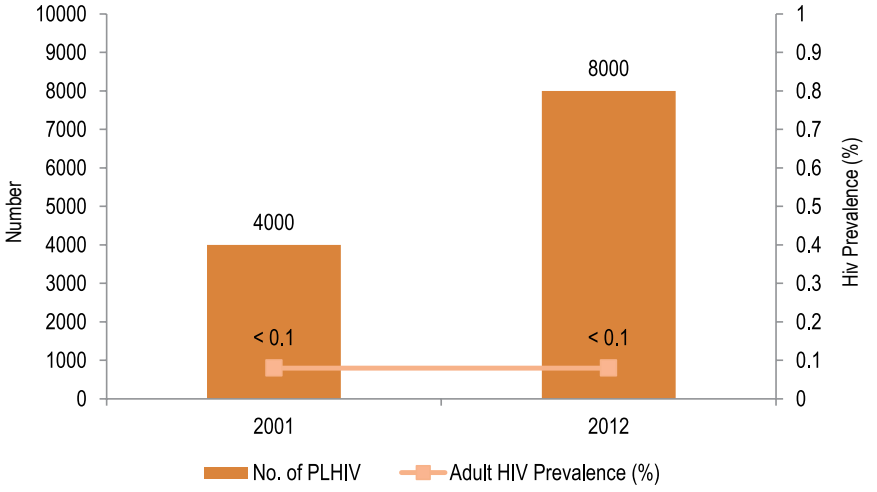
Overview of the HIV and AIDS epidemic

HIV in Bangladesh has continued to remain at relatively low levels in the key affected populations. The main reason for this low prevalence could be the early and sustained HIV prevention programs targeting high risk groups backed by a state-of-the-art surveillance system. Another contributing protective factor could be the high rates of male circumcision. There is, however, a concentrated HIV epidemic among people who inject drugs (PWID), primarily due to sharing of unclean syringes and needles. As a result, the rate of new infections is still on the rise.

Bangladesh's latest round of serological surveillance (2011) showed that HIV prevalence among all key populations remained below 1 percent with the exception PWID. The overall prevalence of HIV was 1.2% among PWID in 2007/08, there is a concentrated epidemic among male PWID in Dhaka. The prevalence of HIV in this cluster increased from 4% in 2002 to 7% in 2007/08, which fell slightly in 2010 to 5.3%.

The total number of people living with HIV (PLHIV) in Bangladesh is estimated at around 8000 in 2012.

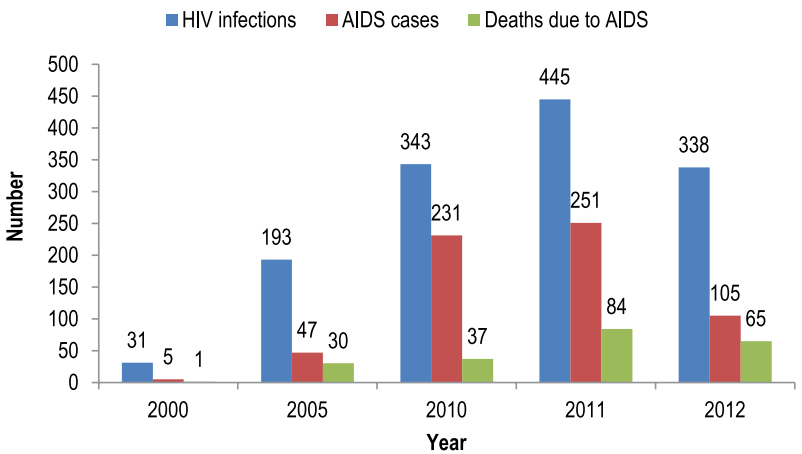
Figure 07: Estimated Adult HIV Prevalence & Estimated Number of PLHIV, Bangladesh, 2001-12



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & AIDS Data Hub

The estimated number of PLHIV in Bangladesh maintains a steady increasing trend from 4000 in 2001 to 8000 in 2012 (Figure 07). Bangladesh is estimated to have less than 1000 annual new HIV infections among adults.

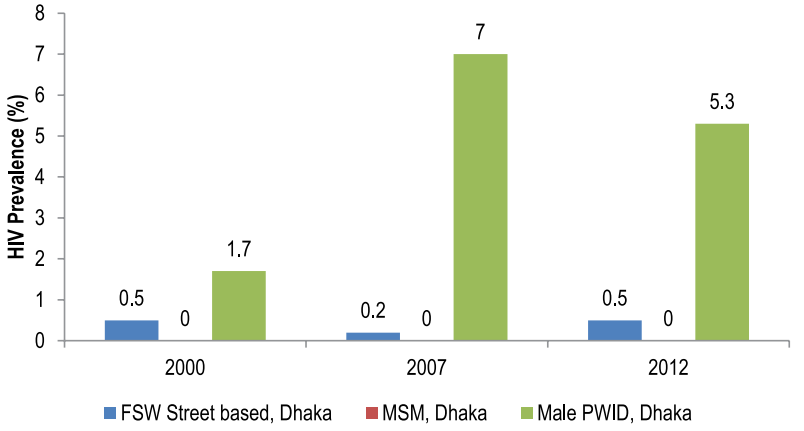
Figure 08: Annual reported number of HIV infections, AIDS cases and deaths, 2000-2012



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & AIDS Data Hub

The annual reported number of HIV infections, AIDS cases and deaths due to AIDS is in decreasing trend in 2012 compared to 2011. However in Figure 08 it shows an increasing trend from 2000 to 2011.

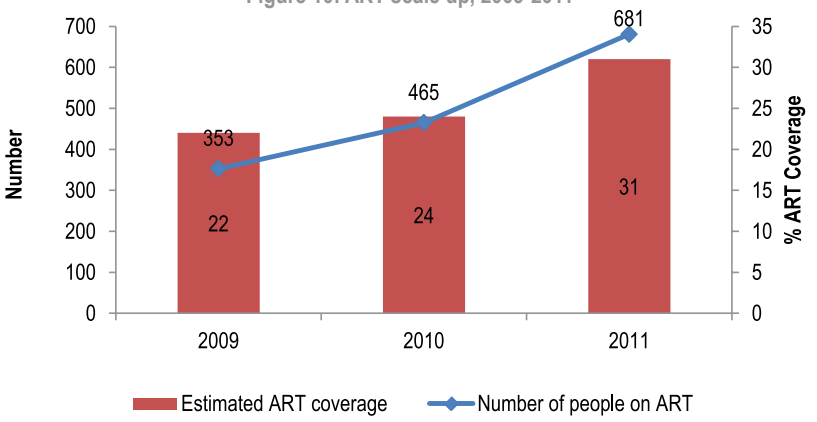
Figure 09: HIV prevalence among key affected populations, 2000 - 2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & AIDS Data Hub

The prevention programs continue to be focused on the key affected populations such as PWID, FSW, MSM, MSW, Transgender (Hijras) and their intimate partners. In Bangladesh, as in other countries in the region, HIV risk arises mainly from unprotected paid sex, sharing of used needles and syringes by PWID, and unprotected sex between men who have sex with men. Recent data suggest that there are two high risk groups, which are PWID and international returned migrant workers.

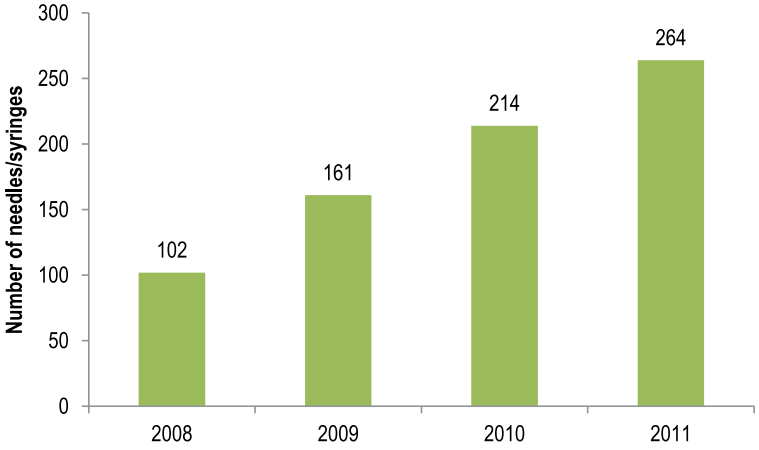
Figure 10: ART scale up, 2009-2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & AIDS Data Hub

Figure 10 shows the scaling up of number of people on ART from 353 in 2009 to 681 in 2011. The percentage ART coverage also increased from 22% in 2009 to 31% in 2011.

Figure 11: Number of needles/syringes distributed per person who inject drugs per year, 2008-2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & AIDS Data Hub

The numbers of needles/syringes distributed per person who inject drugs per year have been in increasing trend from 102 in 2008 to 264 in 2011 (Figure 11).

Epidemic Overview, 2012	
Population(mid-year)	154.69 million
Estimated Number of people living with HIV	8000
HIV Prevalence	
Adult (15 - 49)	< 0.1 %
Female sex workers (FSW)	0.3%
Men who have Sex with Men (MSM)	-
People Who Inject Drugs (PWID)	1.1%
Estimated newly infected	< 1000
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	< 500
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	18% to 75%
Condom use at last sex	
FSW	67%
MSM	26%
PWID	45%
HIV Testing Coverage	
FSW	4%
MSM	9%
PWID	5%

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & AIDS Data Hub

Bhutan

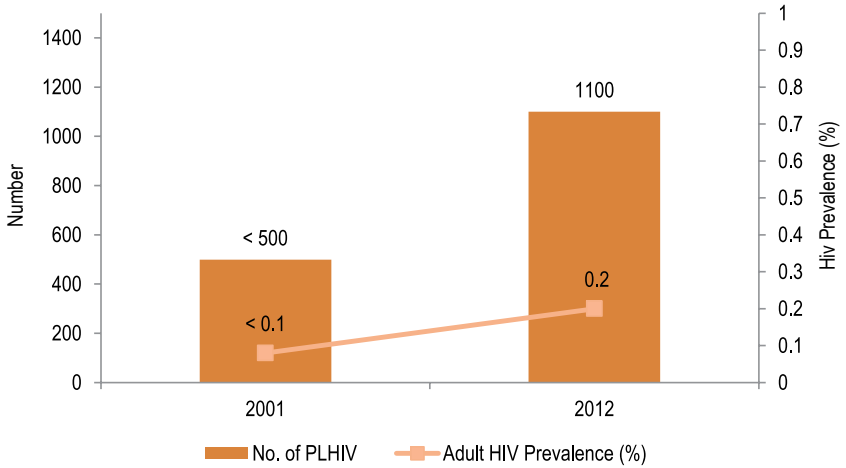
Bhutan is a land locked country situated in the Himalayas, it has border with China and India. Bhutan has an area of 38,394 sq km and the altitude varying from 180 m to 7,550 m above sea level. The total population of Bhutan is 7, 20,679 with a population density of 16.36 person/km. The country is divided 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 spread of HIV. As the epidemic is at a very early stage, there is still time for vigorous action to stop its spread.

Overview of the HIV & AIDS epidemic

Bhutan is a low HIV prevalence country 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 2012 stands at 297. 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 followed by mother-to-child transmission (MTCT) and less than 2 per cent of the transmission is through blood transfusion and injecting drug use.

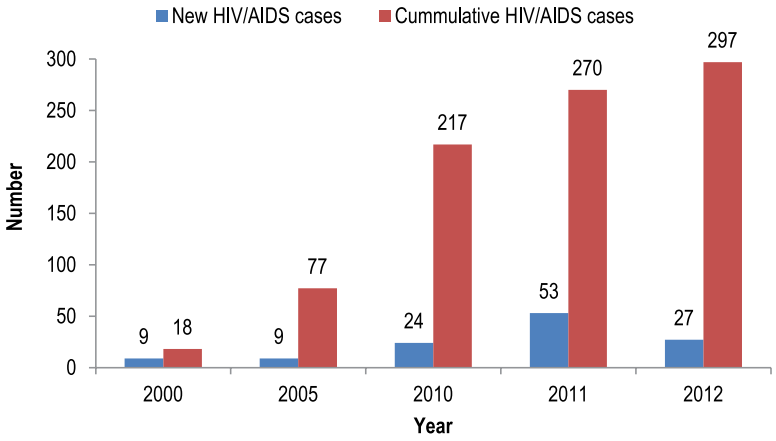
Figure 12: Estimated Adult HIV Prevalence & Estimated Number of PLHIV, Bhutan, 2001-12



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

The total number of people living with HIV (PLHIV) in Bhutan is estimated at around 1100 in 2012. The estimated number of PLHIV in Bhutan shows an increase from < 500 in 2001 to 1100 in 2012 (Figure 12).

Figure 13: Reported cumulative and new HIV/AIDS cases, 2000-2012

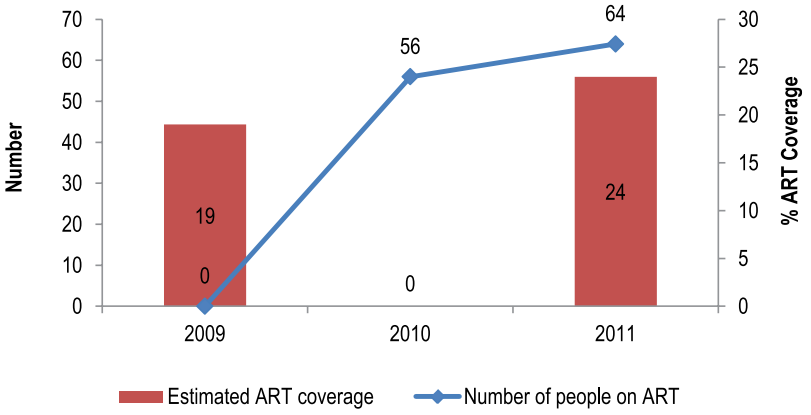


Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

By 2012, a total of 297 reported HIV cases have been detected with a total increase of 27 new cases as compared to the previous report updates of December, 2011 (Figure 13). Now, Bhutan has the

total of 297 HIV positive reported confirmed cases with 225 people currently living with HIV and 52 reported deaths due to AIDS related complications and other factors.

Figure 14: ART scale up, 2009-2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

In Bhutan 64 PLHIV are on ART in 2011. Figure 14 shows the scaling up of number of people on ART from zero in 2009 to 64 in 2011. However percentage ART coverage also scales up from 19 in 2009 to 24 in 2011.

Epidemic Overview, 2012	
Population(mid-year)	720679
Estimated Number of people living with HIV/AIDS	1100
HIV Prevalence	
Adult (15 - 49)	0.2%
Female sex workers (FSW)	N/A
Men who have Sex with Men (MSM)	N/A
People Who Inject Drugs (PWID)	N/A
Estimated newly infected	N/A
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	< 100
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	13% - 38%
Condom use at last sex	
FSW	38%
MSM	N/A
PWID	54%
HIV Testing Coverage	
FSW	N/A
MSM	N/A
PWID	N/A

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

India

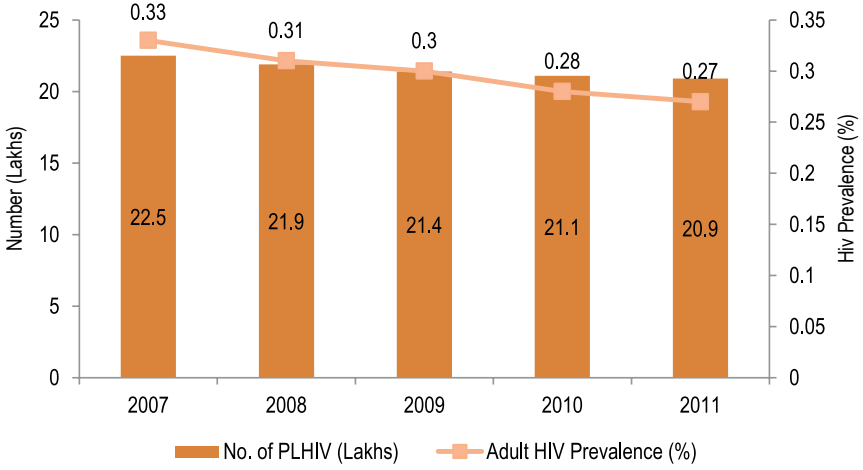
India is the largest country in South Asia. Geographically it is the seventh largest and second most populous country in the world. Its estimated total population was 1.2 billion (Global TB report WHO, 2013). Bounded by the Indian Ocean on the south, the Arabian Sea on the south-west, and the Bay of 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.

Overview of the HIV & AIDS epidemic

HIV epidemic in India is concentrated among High Risk Groups and heterogeneous in its distribution. The vulnerabilities that drive the epidemic are different in different parts of the country. Overall trends of HIV portray a declining epidemic at national level, though inter-state variations exist. Both prevention and treatment strategies have yielded good impacts as reflected in the reduction in new infections as well as AIDS-related deaths in the country.

The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011 (Figure 15). HIV prevalence among the young population (15-24 years) at national level has also declined from 0.30% in 2000 and has stabilized over the last four to five years at around 0.11%. Stable to declining trends in HIV prevalence among the young population (15-24 years) are also noted in most of the States. The total number of people living with HIV (PLHIV) in India is estimated at around 2.09 million in 2011.

Figure 15: Estimated Adult HIV Prevalence & Estimated Number of PLHIV, India, 2007-11

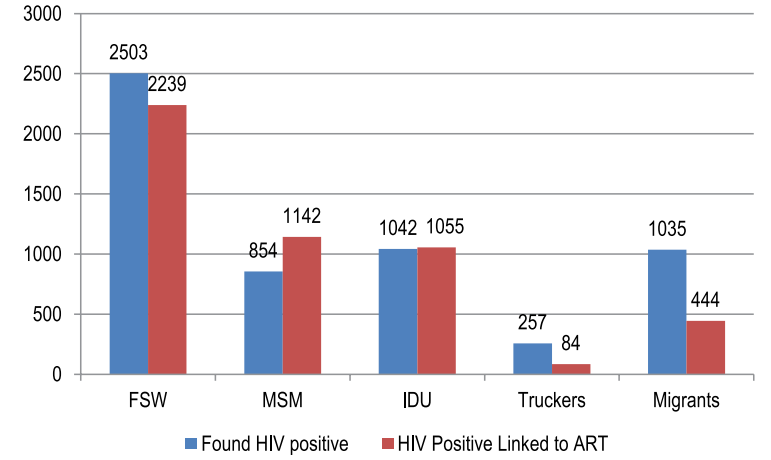


Source: Annual Report 2012-13, NACO, India

The estimated number of PLHIV in India maintains a steady declining trend from 23.2 lakh in 2006 to 20.9 lakh in 2011 (Figure 15). India is estimated to have around 1.16 lakh annual new HIV infections among adults. India continues to portray a concentrated epidemic. Considerable decline in HIV prevalence has been recorded among Female Sex Workers at national level (5.06% in 2007 to 2.67% in 2011) and in most of the States where long-standing targeted interventions have focussed on behaviour change and increasing condom use.

Declines have been achieved among men who have sex with men (7.41% in 2007 to 4.43% in 2011) also, though several pockets in the country show higher HIV prevalence among them with mixed trends. At the national level, the prevalence of HIV for general population (ANC attendees) and among different risk groups in 2010-11 is given in (Figure 16).

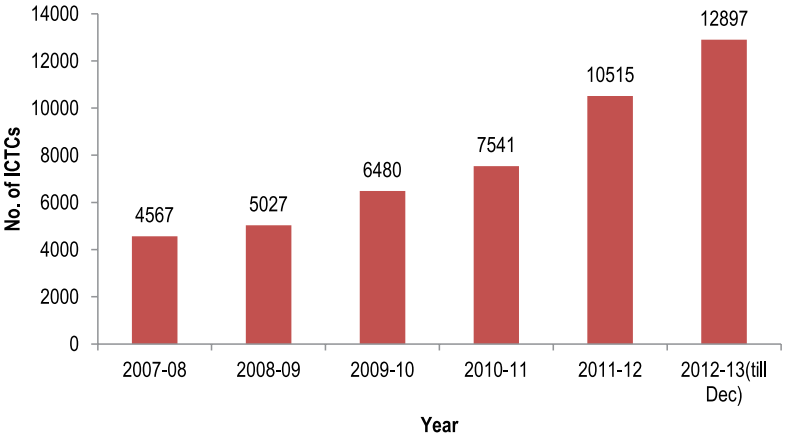
Figure 17: HRGs found HIV Positive and Linked to ART during 2012-13 (till Dec, 2012)



Source: Annual Report 2012-13, NACO, India

NACO guidelines specify that all core group High Risk Groups (HRGs) should be tested for HIV once every six months. All HRGs found positive for HIV are required to be referred to a nearby ART centre for pre-ART registration after which they are tracked by the ART centre staff for regular follow-up. As seen from figure 17 more than 90% of the HIV positive HRGs have been linked with ART centres during 2012-13. However, there is scope for improvement in the Targeted Interventions-ART linkages in case of migrants and truckers.

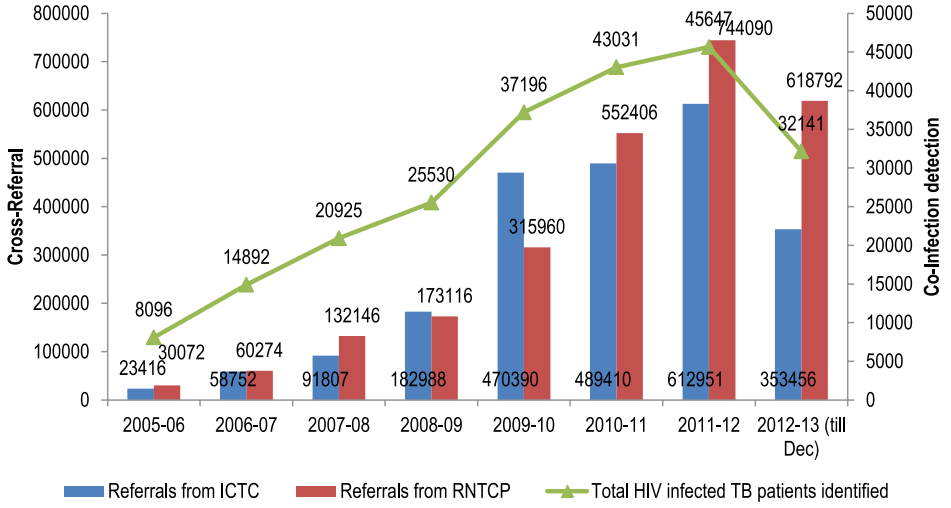
Figure 18: Scale up of ICTCs during the period 2007-08 to 2012-13



Source: Annual Report 2012-13, NACO, India

HIV Counseling and Testing facilities have been rapidly scaled up (Figure 18) and are now provided through 4,508 SA-ICTCs, and 8,389 FICTCs including those under Public Private Partnership model.

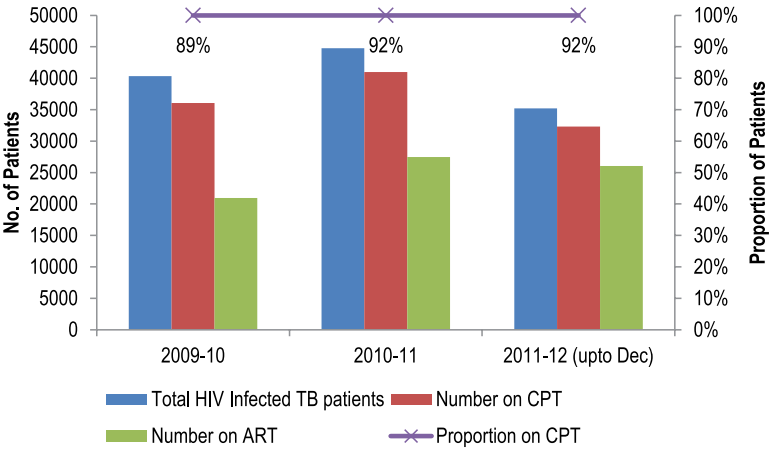
Figure 19: Trend of HIV/TB co-infections identified, 2005-2012



Source: Annual Report 2012-13, NACO, India

Figure 19 shows the progress made in HIV/TB cross-referrals over last few years. The cross-referral between NACP and RNTCP consistently show improvement, with 9.7 lakh cross-referrals and detection of about 32,141 HIV infected TB patients in 2012-13 (up to Dec, 2012). While referrals from RNTCP to ICTC show consistent increase, referrals from ICTC for ICF has plateaued at around 3.53 lakhs referrals in 2012-13 (up to Dec, 2012). Strengthening ICF at ICTC, therefore, remains a priority activity for NACP.

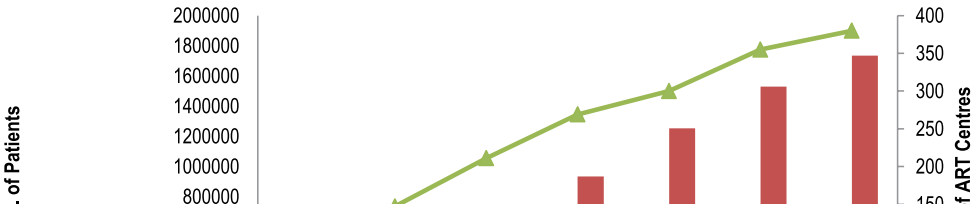
Figure 20: Trend of linkage of HIV infected TB patients to CPT and ART



Source: Annual Report 2012-13, NACO, India

NACP and RNTCP consistently achieved linkage of more than 90% HIV/TB cases to Co-trimoxazole Prophylaxis Therapy (CPT). Linkage to ART is more challenging considering low number of ART centres compared to TB treatment centres. But joint efforts of both programme staff and close monitoring of the activity has resulted in consistent improvement with about 75% HIV infected TB patients receiving ART in 2011-12 (Figure 20).

Figure 21:ART Scale up for PLHIV in India, 2007-2012



	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	Dec-12
No. of patients on 1st line	69016	140654	223223	315640	404882	516412	604987
Ever Registered	194607	428056	686913	933540	1253498	1529031	1735544
No. of ART centres	107	147	211	269	300	355	380

Source: Annual Report 2012-13, NACO, India

Figure 21 shows the scaling up of service provisioning under care support and treatment (CST) component since March 2005. All measures of service provisioning which is; number of ART centres, PLHIV ever registered and PLHIV on 1st line treatment have increased exponentially.

Epidemic Overview, 2012	
Population(mid-year)	1.2 billion
Estimated Number of people living with HIV	2.09 million
HIV Prevalence	
Adult (15 - 49)	0.27%
Female sex workers (FSW)	2.67%
Men who have Sex with Men (MSM)	4.43%
People Who Inject Drugs (PWID)	7.14%
Estimated newly infected	1.16 lakh
Estimated number of deaths due to AIDS	1.48 lakh
No. of patients on 1st line	604,987
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	> 12500
Condom use at last sex	
FSW	83%
MSM	58%
PWID	16%
HIV Testing Coverage	
FSW	47%
MSM	47%
PWID	47%

Source: Annual Report 2012-13, NACO, India & AIDS Data Hub

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. Maldives is situated in the Indian Ocean, close to India and Sri Lanka. It is 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. It consists of nearly 1,190 islands, of which around 200 are inhabited. In addition, there are around 90 uninhabited islands that have been developed as tourist resorts.

The population of Maldives was over 330,652 as at the end of year 2012. 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.

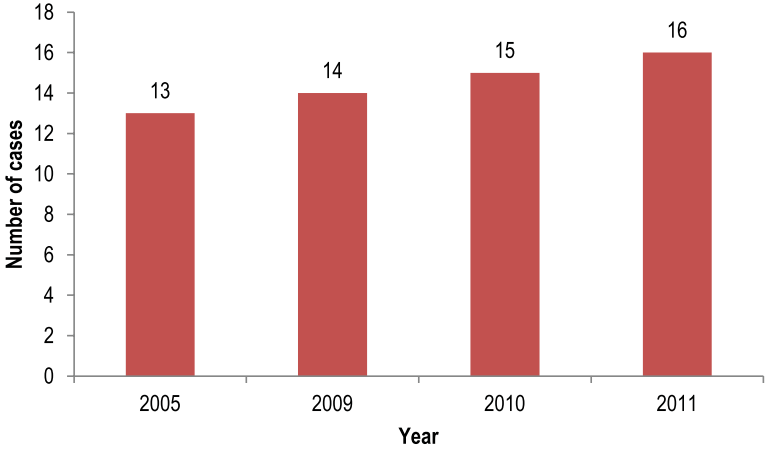
Overview of the HIV & AIDS epidemic

The Maldives still has very few people living with HIV. However, with considerable vulnerability and risk, there is a potential for a concentrated HIV epidemic. The most likely trigger for an HIV epidemic in the Maldives is injecting drug use, because of the 'efficiency' of sharing contaminated needles as an HIV transmission route compared to sexual transmission, the relatively large number of Maldivians using drugs, the apparently increasing share of drug users shifting towards injecting rather than smoking, and the high prevalence of needle sharing (according to the BBS 2008).

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 Health Protection Agency (HPA) under the Ministry of Health 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.

The first HIV positive person in Maldives was reported in 1991. UNAIDS estimated in 2012 that less than 100 people were infected with the virus. There were 257 cumulative number of HIV positives among expatriate workers reported to the National AIDS Programme in Maldives as of December 2009. Only 16 cumulative cases of Maldivians with HIV infection was reported to NAP as of December 2011 (Figure 22). 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.

Figure 22: Cumulative number of reported HIV and AIDS cases, 2000-2011



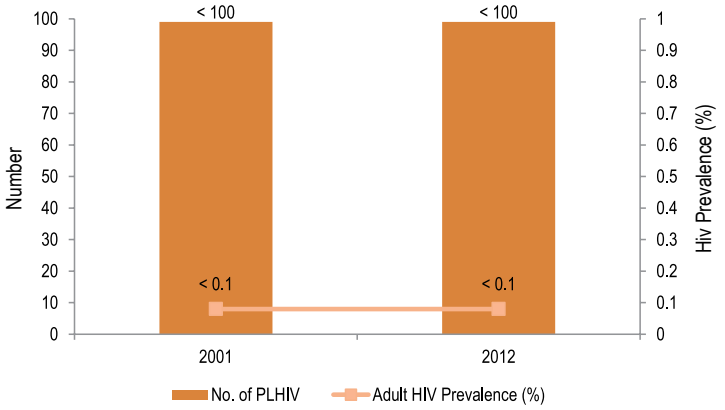
Source: HIV/AIDS SAARC region, update, 2012

All infections were reportedly acquired through sexual transmission. Maldives being a low prevalence country, major efforts have been put on prevention and maintaining the low level of HIV infection in the Maldives.

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. 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 total number of people living with HIV (PLHIV) in Maldives is estimated less than 100 in 2012 which is same as in 2001(Figure 23).

Figure 23: Estimated Adult HIV Prevalence & Estimated Number of PLHIV, Maldives, 2001-12



Source: HIV/AIDS SAARC region, update, 2012

Epidemic Overview, 2012	
Population(mid-year)	330652
Estimated Number of people living with HIV/AIDS	<100
HIV Prevalence	
Adult (15 - 49)	< 0.1 %
Female sex workers (FSW)	0%
Men who have Sex with Men (MSM)	0%
People Who Inject Drugs (PWID)	0%
Estimated newly infected	N/A
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	< 100
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	-
Condom use at last sex	
FSW	N/A
MSM	N/A
PWID	N/A
HIV Testing Coverage	
FSW	14%
MSM	10%
PWID	17%

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

Nepal

Nepal is a landlocked country and is located in the Himalayas and bordered to the north by China and to the south, east, and west by 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 28.48 million. The urban population is largely concentrated in the Kathmandu valley. Nepal has a market economy mainly based on farming and tourism.

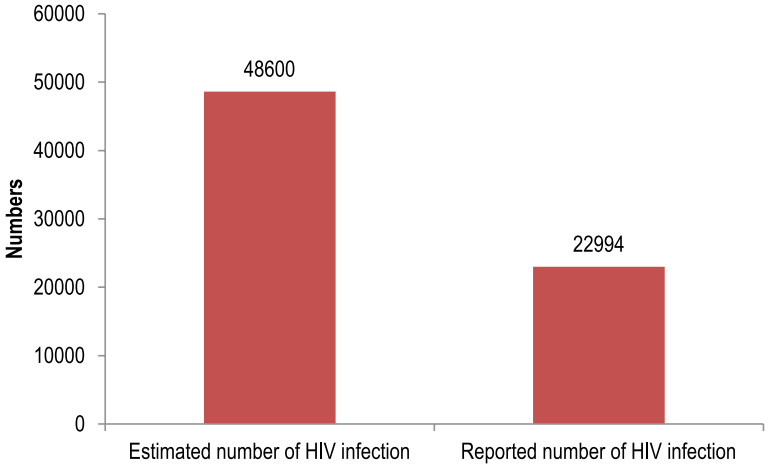
Overview of the HIV & AIDS epidemic

HIV in Nepal is characterized as a concentrated epidemic with a prevalence of 0.3 per cent among adult aged 15–49 years in 2012. There are approximately 48,600 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 affected 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.

Figure 24: Estimated numbers of people living with HIV and reported number of HIV infections, 2012



Source: NCASC Annual Report, 2010/12, Nepal

According to National estimates of HIV infection report, a total of 48,600 individuals with aged 15 years and above are living with HIV (Figure 24). In 2010- 2012 July, 5540 HIV positive cases were detected. The gap between estimated and detected HIV cases raises questions about the accessibility and uptake of testing and counseling services.

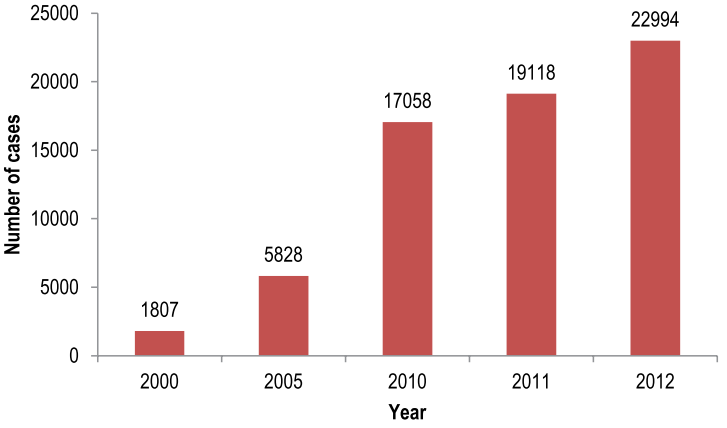
Table 06 **HIV testing and counseling status, 2010 - 2012**

Counseling and Testing	2010	2011	2012
Clients pre-test counseled	116944	99112	70513
Clients tested	106325	93743	67275
Clients HIV +ve	2015	2060	1465
Clients post-test counseled	104790	92457	65971

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013

HIV testing and counseling status shows that clients post-test counseled is less than clients pre-test counseled. However counseling and testing has decreased in 2012 in comparison to 2010 and clients who tested clients HIV positive is 2.1 % in 2012. Figure 25 shows the increment of reported HIV positive cases in Nepal.

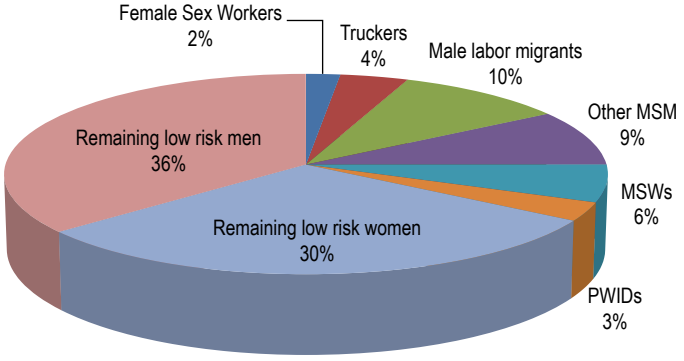
Figure 25: Trend of Cumulative Reported HIV positive cases in Nepal (2000 – 2012)



Source: NCASC Annual Report, 2010/12, Nepal

Estimated HIV Infections by Sub Population Groups, 2012 shows around 66% occur in low risk followed by male labor migrants which is 10 % and less in female sex workers 2% shown in (Figure 26).

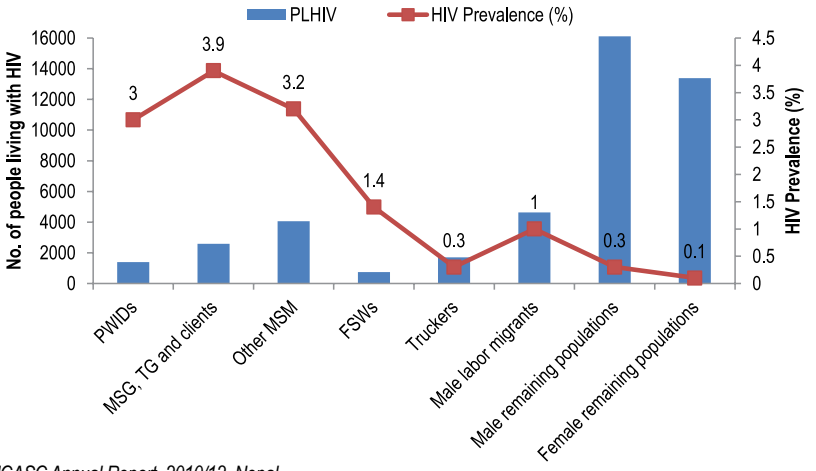
Figure 26: Estimated HIV Infections by Sub Population Groups, 2012



Source: NCASC Annual Report, 2010/12, Nepal

Estimated Number of people living with HIV/AIDS in 2012 is 48,600. Estimated HIV Prevalence and number of people living with HIV by Key affected populations in 2012 are shown in figure 24. HIV Prevalence is in decreasing order from PWIDs to female remaining population (Figure 27).

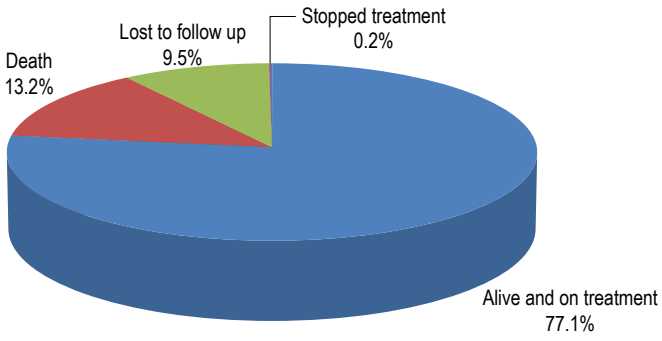
Figure 27: Estimated HIV Prevalence and number of people living with HIV by Key affected populations, 2012



Source: NCASC Annual Report, 2010/12, Nepal

As of July 2013, total ART need (CD4 < = 350) is 26100 and 8546 is its coverage. Patients on 1st line regimen is 5821 and substituted on 1st line is 2609, however 116 patients switched on 2nd line. Figure 28 shows outcomes of ART programme in Nepal in which 77.1% alive on treatment.

Figure 28: Outcomes of ART Programme in Nepal, As of July 2013



Source: NCASC Annual Report, 2010/12, Nepal

Epidemic Overview, 2012	
Population(mid-year)	28.48 million
Estimated Number of people living with HIV/AIDS	48600
HIV Prevalence	
Adult (15 - 49)	0.3%
Female sex workers (FSW)	1.7 %
Men who have Sex with Men (MSM)	3.8 %
People Who Inject Drugs (PWID)	6.3 %
Estimated newly infected	1186
Cumulative number of reported HIV infections	22994
Estimated number of deaths due to AIDS	4136
Currently on ART	8,546
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	7 % to 29 %
Condom use at last sex	
FSW	83%
MSM	75%
PWID	47%
HIV Testing Coverage	
FSW	55%
MSM	42%
PWID	21%

Source: NCASC Annual Report, 2010/12, Nepal, & AIDS Data Hub

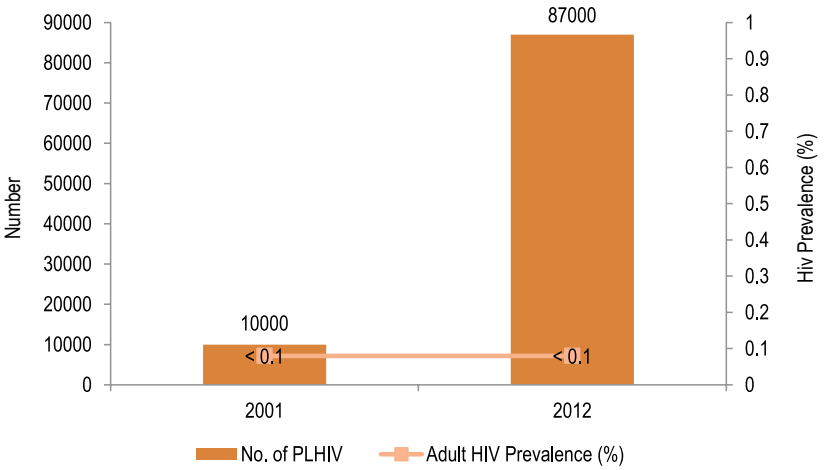
Pakistan

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^2. The estimated population is 179.16 million in 2012 (as per WHO Global Tuberculosis Report 2013) and is the sixth most populous country in the world. Pakistan comprises of four provinces and 129 districts.

Overview of the HIV & AIDS epidemic

Pakistan's Federal Ministry of Health initiated a National AIDS Prevention and Control Program (NACP) in 1987. Pakistan had an estimated 87,000 people living with HIV by the end of 2012, with 19,000 estimated new HIV infection and 3500 deaths due to AIDS. 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 key affected populations, imprisoned populations, at-risk adolescents and in certain occupational settings, including in some cases through nosocomial infection.

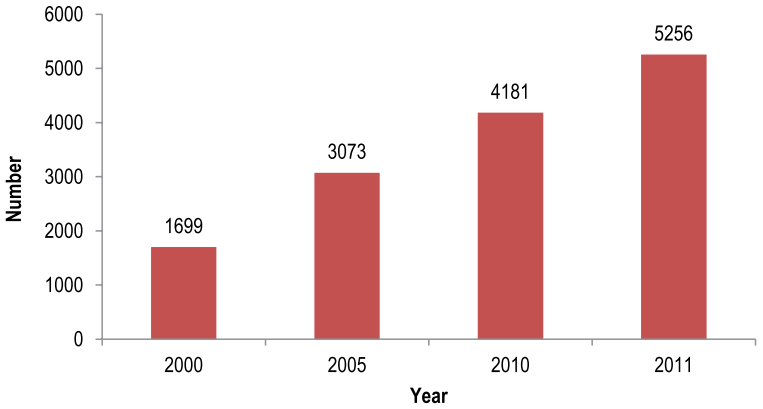
Figure 29: Estimated Adult HIV Prevalence & Estimated Number of PLHIV, Pakistan, 2001-12



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

The estimated adult HIV prevalence in 2012 is < 0.1 which is same as of 2001 (Figure 29). The total number of people living with HIV/AIDS (PLHIV) in Pakistan is estimated around at 87, 000 in 2012 which is an increase from 10,000 of 2001.

Figure 30: Cumulative number of reported HIV and AIDS cases in Pakistan, 2000-2011

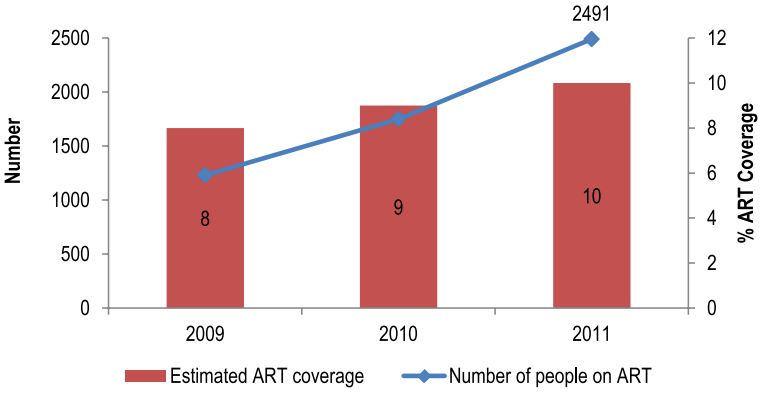


Source: HIV/AIDS SAARC region, update, 2012

The reported cases in 2011 is 5256 which is higher in comparison to the year 2001 (Figure 30).

In Pakistan 2491 are living on ART in 2011. Figure 31 shows the scaling up of number of people on ART. The percentage ART coverage also scales up slowly from 8 in 2009 to 10 in 2011.

Figure 31: ART scale up 2009-2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

Despite various preventive efforts, infection rates among PWIDs have steadily increased from 10.8% in 2005 to 37.8% (95%CI: 37.3%, 38.3%) in 2011. Not only has the overall prevalence increased, but the number of sites with relatively advanced epidemics has also expanded. The frequency of injecting was also high with almost three-quarters of PWID surveyed (71.5%) reported injecting between two to three times a day in the past month and 21.1% reported injecting more than three times a day. Approximately 90.5% of PWID reported injecting in public spaces and 80.9% reported injecting with friends/family; about and exceptionally high proportion (70.3%) reported that they had sought help in injecting by “professional injectors/street doctors” during the past month.

Epidemic Overview, 2012	
Population(mid-year)	179.16 million
Estimated Number of people living with HIV/AIDS	87000
HIV Prevalence	
Adult (15 - 49)	< 0.1%
Female sex workers (FSW)	0.6%
Men who have Sex with Men (MSM)	3.5%
People Who Inject Drugs (PWID)	27.2%
Estimated newly infected	19000
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	3500
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	1 % to 5 %
Condom use at last sex	
FSW	41%
MSM	32%
PWID	23%
HIV Testing Coverage	
FSW	6%
MSM	9%
PWID	9%

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

Sri-Lanka

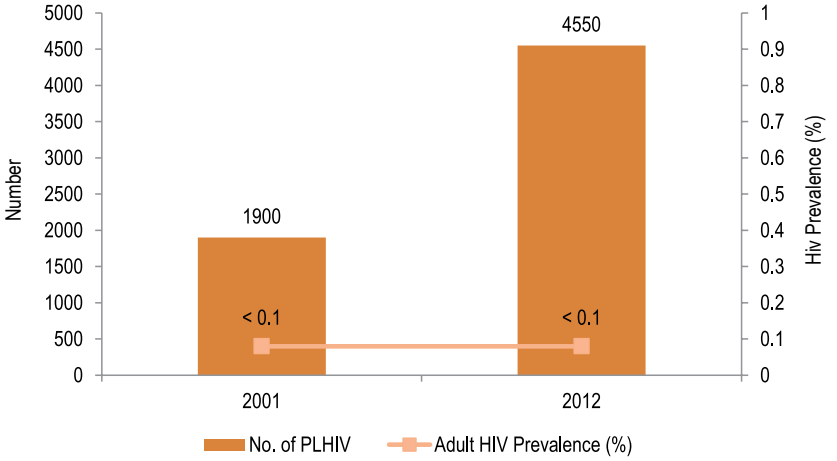
Sri-Lanka is an island country in the Indian Ocean, separated from the south- eastern coast of peninsular India. Its estimated population is 20.26 million in 2012. There are two ethnic groups which are Sinhalese and Tamils of which the Sinhalese are the predominant ethnic group, constituting about three quarters of the population.

Overview of the HIV & AIDS epidemic

Sri Lanka is experiencing a low prevalence HIV epidemic. The estimated number of people living with HIV at the end of 2012 was 4,550 and the number of deaths due to AIDS was 271. As at end of December 2011, a cumulative total of 1463 HIV positive people 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%).

Sixty percent of reported HIV cases are males, and more than half are from Colombo. Underreporting of cases is mainly due to low knowledge about how HIV is spread and barriers to seeking services due to stigma and discrimination.

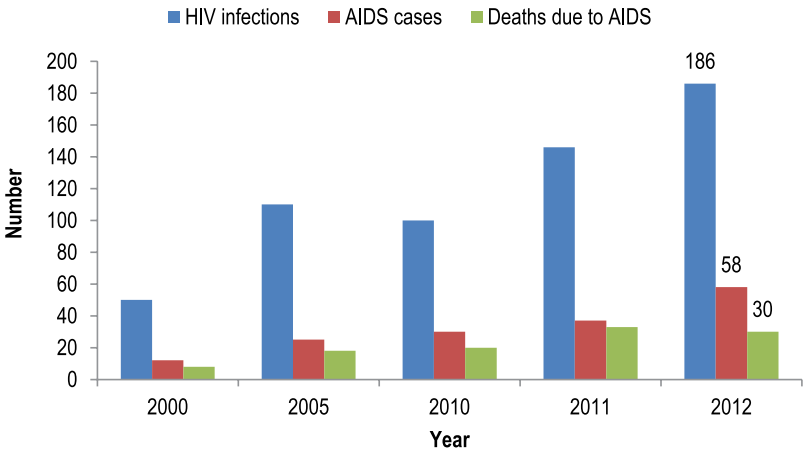
Figure 32: Estimated Adult HIV Prevalence & Estimated Number of PLHIV, Sri Lanka, 2001-12



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

The estimated number of PLHIV in Sri-Lanka maintains an increasing trend from 1900 in 2001 to 4550 in 2012 (Figure 32).

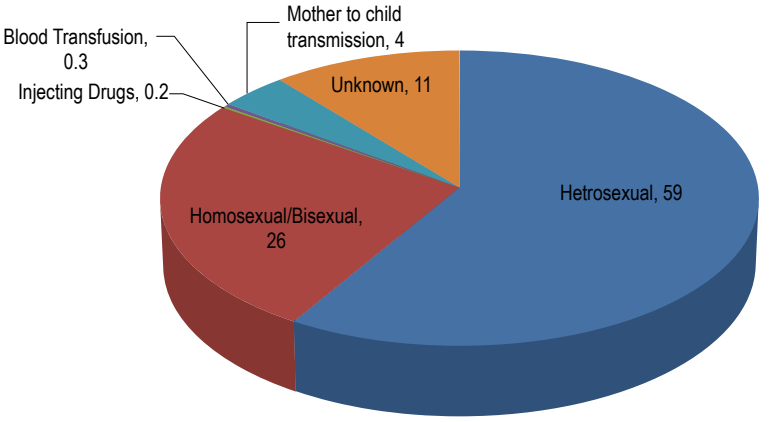
Figure 33: Annual reported number of HIV infections, AIDS cases and deaths, 2000-2012



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

The annual reported number of HIV infections, AIDS cases and deaths due to AIDS is in increasing trend in 2012 compared to 2001 (Figure 33).

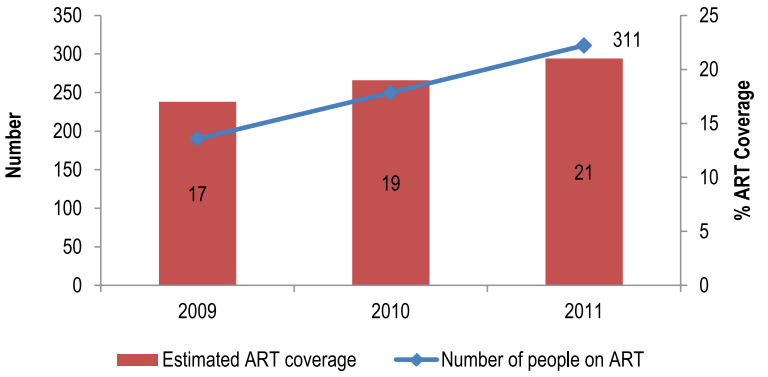
Figure 34: Cumulative HIV cases by mode of transmission, 2012



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

In Sri-Lanka cumulative HIV cases by mode of transmission is high in heterosexual followed by homosexual and very less in PWID in 2012 (Figure 34) .

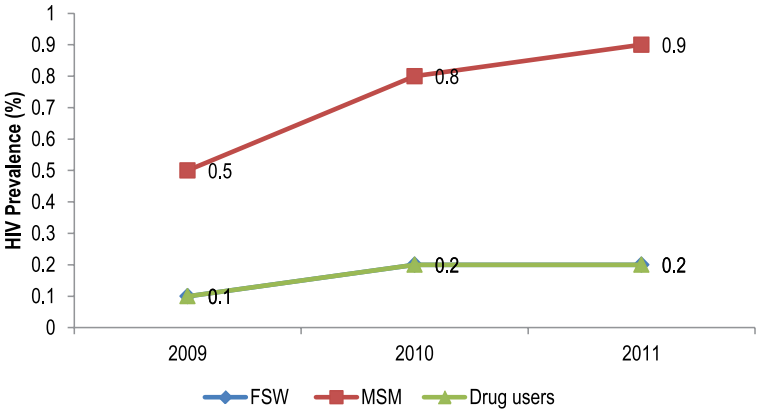
Figure 35: ART scale up, 2009-2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

In Sri-Lanka 311 are living on ART in 2011. Figure 35 shows the scaling up of number of people on ART. The percentage ART coverage also scales up slowly from 17 in 2009 to 21 in 2011.

Figure 36: HIV prevalence among key populations, 2000 - 2011



Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

Figure 36 shows that the HIV prevalence is high in MSM in 2011 while almost equal in female sex workers and PWID.

Epidemic Overview, 2012	
Population(mid-year)	20.26 million
Estimated Number of people living with HIV/AIDS	4550*
HIV Prevalence	
Adult (15 - 49)	<0.1%
Female sex workers (FSW)	0.2%
Men who have Sex with Men (MSM)	0.9%
People Who Inject Drugs (PWID)	N/A
Estimated newly infected	N/A
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	271*
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	6 % to 14 %
Condom use at last sex	
FSW	89%
MSM	61%
PWID	N/A
HIV Testing Coverage	
FSW	44%
MSM	14%
PWID	N/A

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013 & AIDS Data Hub

** Country report 2013Srilanka*

5 TB HIV CO-INFECTION

TB HIV Co-infection poses a critical challenge for the health-sector and for people living with HIV and TB. People living with HIV who are also infected with TB are much more likely to develop TB disease than those who are HIV-negative. Starting in the 1980s, the HIV epidemic led to a major upsurge in TB cases and TB mortality in many countries.

In 2012, 1.1 million (13%) of the 8.6 million people who developed TB worldwide were HIV-positive. The African Region accounted for 75% of the estimated number of HIV-positive incident TB cases. The number of people dying from HIV-associated TB has been falling since 2003. However, there were still 320 000 deaths from HIV-associated TB in 2012 and further efforts are needed to reduce this burden.

Globally, the percentage of notified TB patients with a documented HIV test result was 46% in 2012, up from 40% in 2011 and 15 times higher than the 2004 level. WHO recommendations on the interventions needed to prevent, diagnose and treat TB in people living with HIV have been available since 2004 and are collectively known as collaborative TB/HIV activities. They include establishing and strengthening coordination mechanisms for delivering integrated TB and HIV services, testing TB patients for HIV, providing ART and CPT to TB patients living with HIV, providing HIV prevention services for TB patients, intensifying TB case-finding among people living with HIV, offering IPT to people living with HIV who do not have active TB, and controlling the spread of TB infection in health care and congregate settings (the latter three activities are referred to as the Three 'Is' for HIV/TB). Since December 2010, the rapid molecular test Xpert MTB/RIF has been recommended as the primary diagnostic test for TB among people living with HIV who have TB signs and symptoms.

There was an encouraging increase in ART coverage among HIV-positive TB patients between 2011 and 2012, from 49% worldwide in 2011 to 57% in 2012. Nonetheless, given the WHO recommendation that all HIV-positive TB patients are eligible for ART, the coverage of ART for HIV-positive TB patients still needs to be greatly improved.

In 2012, 80% of HIV-positive TB patients were provided with co-trimoxazole preventive therapy (CPT), a level similar to recent years and 4.1 million people enrolled in HIV care were reported to have been screened for TB, up from 3.5 million in 2011. Of the reported 1.6 million people newly enrolled in HIV care in 2012, almost 520 000 were provided with isoniazid preventive therapy (IPT). Coverage needs to be increased, since about 50% of those newly enrolled in HIV care and screened for TB are likely to be eligible for IPT.

ART is a critical intervention for reducing the risk of TB morbidity and mortality among people living with HIV. It reduces the individual risk of TB disease by 65%, irrespective of CD4 cell count and when combined with IPT it can have a significant impact on TB prevention. In the latest WHO guidelines released in July 2013 the threshold CD4 count at which starting ART is recommended has been raised from a CD4 count of ≤350 to ≤500 CD4/mm. Implementation of these guidelines on a large scale should substantially reduce morbidity and mortality resulting from HIV-associated TB. As in previous guidelines, ART is recommended for all TB patients living with HIV, irrespective of their CD4 cell count. CPT also helps to reduce mortality among HIV-positive TB patients.

The number of HIV-positive TB patients on ART has grown from a very low level in 2004 to reach 0.3 million in 2012. Among TB patients notified in 2012 and who had a documented HIV-positive test result, 57% were on ART globally this is a considerable improvement from 49% in 2011.

Globally, 0.4 million TB patients living with HIV were enrolled on CPT in 2012, up from a negligible number in 2004. The absolute number fell between 2011 and 2012, which is at least partly explained by the decrease in the number of HIV-positive TB cases reported between 2011 and 2012. The coverage of CPT among TB patients with a documented HIV-positive test result was 80% in 2012, similar to the level of 2010 and 2011.

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 07 HIV testing and provision of CPT, ART and IPT in the SAARC Region, 2012

Country	TB patients with known HIV status		Tested TB patients that are HIV-positive		% HIV-positive TB patients started on		HIV-positive people Provided with IPT
	No.	%	No.	%	CPT	ART	
Afghanistan	7275	25	5	< 0.1	100	100	25
Bangladesh	2086	1.2	63	3	100	100	-
Bhutan	-	-	-	-	-	-	-
India	821807	56	44063	5.4	92	59	-
Maldives	1	0.9	1	100	-	-	-
Nepal	15057	42	217	1.4	100	100	-
Pakistan	10419	3.8	30	0.29	100	73	-
Sri Lanka	3379	36	23	0.68	22	48	8
Regional	**850663**	**-**	**44334**	**5.21**	**92.16**	**59.4**	**-**

Source: Global TB Report WHO, 2013

In 2012, a total 8,506,63 TB patients with known HIV status was tested in which 44,334 (5.21%) tested TB patients are HIV-positive among them 92.16% and 59.4 % are started CPT and ART in the SAARC region.

In the SAARC region, India accounts for highest TB patients with known HIV status followed by Nepal and Pakistan. Around 92% of HIV-positive TB patients started CPT and 59% started ART in India at the end of 2012. However Nepal, Afghanistan and Bangladesh has 100 % HIV-positive TB patients started on CPT and ART. Only in Afghanistan and Sri-Lanka HIV-positive people provided with IPT and they are 25 and 08 respectively.

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