SAARC EPIDEMIOLOGICAL RESPONSE ON HIV/AIDS

2014

SAARC Tuberculosis and HIV/AIDS Centre (STAC)

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Foreword

HIV epidemic remains one of the major challenges to public health globally and in the region. With 35 million people living with HIV globally in 2013, there are 2.1 million new HIV infections annually. The new cases have been declined by 38 percent in comparison to 2001. Similarly, the AIDS related death has been declined by 35 percent since 2005, when the highest number of deaths was recorded.

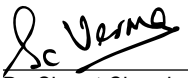
SAARC Region comprising eight member states has an estimated 2.20 million People Living with HIV with less than a million AIDS related deaths. Three countries in the region (India, Nepal and Pakistan) account for the majority of the regional burden. The prevalence of HIV in the region remains below one percent. However, regional variation exists in different group of populations.

The HIV/AIDS epidemic in the region can be curtailed with increased and concerted effort of the member states. The member states and the region as a whole require accurate and reliable data on the magnitude and trends of HIV infection along with the behaviors fuelling its spread to effectively and appropriately control the epidemic. Member states with high burden of disease have made considerable efforts to improve their biological and behavioral surveillance system to generate evidences.

The SAARC TB & HIV/AIDS Centre has been coordinating and supporting the National AIDS Control Program of the member states in this regard. The centre has been disseminating updated data and information to the member states in the HIV/AIDS in the region as its core function. 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.

This 12th report incorporates, as of December 2013, updated information on the HIV / AIDS situation globally and in the SAARC region.

It is my expectation that readers of this report will use it as an advocacy tool for strengthening and scaling up HIV and AIDS interventions, including consolidating and improving HIV surveillance, monitoring and evaluation systems in the Region through concerted efforts.



Dr. Sharat Chandra Verma
Director

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Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ANC	Antenatal Care
ART	Anti Retroviral Therapy
BBS	Biological Behavioral Survey
CMIS	Computerized Management Information System
CPT	Co-trimoxazole Preventive Therapy
CST	Care, Support &Treatment
DNA	Deoxyribonucleic Acid
FSW	Female Sex Worker
GoA	Government of Afghanistan
HCV	Hepatitis C Virus
HISC	Health Information Service Centers
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HRG	High Risk Groups
HRGs	High Risk Groups
HSS	HIV Sentinel Surveillance
IBBS	Integrated Biological Behavioral Surveillance Survey
ICF	Intensified Case Finding (tuberculosis)
ICTC	Integrated Counseling Testing Center
IDU	Injecting Drug Users
IPT	Isoniazid Preventive Therapy
JDWNRH	JigmeDorjiWangchuck National Referral Hospital
MARPs	Most At Risk Populations
MoCN	Ministry of Counter Narcotics
MoPH	Ministry of Public Health
MSM	Men who have Sex with Men
MSW	Male sex worker
MTCT	Mother-To-Child Transmission

NACO	National AIDS Control Organization
NACPs	National AIDS Control Programs
NAP	National AIDS Control Program
NASP	National AIDS and STD Programme
NGO	Non Governmental Organization
NSF	National Strategic Framework
NTPs	National Tuberculosis Control Programs
PLHIV	People Living with HIV
PPTCT	Prevention of Parent-To-Child Transmission
PWIDs	People Who Inject Drugs
PWUD	People who use drugs
RBA	Royal Bhutan Army
RBG	Royal Body Guard
RBP	Royal Bhutan Police
RNTCP	Revised National Tuberculosis Control Programme
SAARC	South Asian Association for Regional Cooperation
STAC	SAARC Tuberculosis and HIV/AIDS Centre
STI	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counseling and testing
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 the SAARC, located in Kathmandu, Nepal. The Fifth SAARC Summit of the Heads of State or Government of Member Countries held in Male' from 22 to 23 November 1990 decided to establish the SAARC Tuberculosis Centre in Nepal with a mandate to work for prevention and control of TB & TB-HIV Coinfection. In 2005, the scope of the centre was expanded further and mandated to work for HIV/AIDS as well. The centre was, then, renamed as SAARC TB and HIV/AIDS Centre to perform its role in the prevention and control of TB and HIV/AIDS in the Region by coordinating and supporting the National Tuberculosis Control Programs (NTPs) and National AIDS Control Programs (NACPs) of the Member Countries.

The centre has been disseminating updated information to the member states in the field of TB and HIV/AIDS in the region as its core function. In this regard the Centre has been

publishing SAARC Regional Epidemiological Reports on HIV and AIDS annually since 2003 and this update is the twelfth in the series.

The SAARC Member States have manifold epidemiological patterns of HIV/AIDS. In spite of different predominant HIV risk behaviors in different countries of the region, it has extremely diverse capabilities to develop and support prevention and control programmes. This diversity needs to be fully addressed and defined in line with the current epidemiology of HIV/AIDS in the SAARC region.

The HIV epidemic has a variable impact in countries of the region. The HIV epidemic is in different stages in each country. The HIV epidemic has been improved substantially through surveillance system and other innovative program management addressing the determinants in the region. The overall HIV prevalence rate in the SAARC Member States remains below one percent, however, there are major public health concerns regarding the future growth potential of HIV epidemic within the region including the most at risk population.

The HIV epidemic is heterogeneously distributed in the region and within countries. Some countries are more affected and has different determinants in the region whereas there are variation in states and provices, rural and urban, ethnic groups within the countries.

This report scrutinizes the HIV epidemic and a more detailed description of its epidemiology in the SAARC region. In addition, this report also includes the situation of HIV/AIDS in the region and the HIV/AIDS Control Program of member states of the region.

2

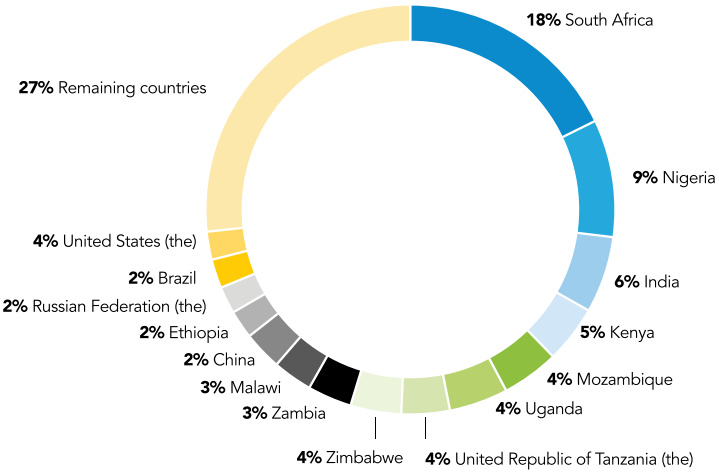
GLOBAL SITUATION OF HIV/AIDS

2.1 Global HIV Epidemic

Globally, an estimated 35 (33.2–37.2) million people were living with HIV in 2013. This number is rising as more people are living longer because of antiretroviral therapy, alongside the number of new HIV infections—which, although declining, is still very high. An estimated 0.8% [0.7–0.8%] of adults aged 15–49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between regions and countries. There are 3.2 million [2.9 million–3.5 million] children younger than 15 years living with HIV and 4 million [3.6 million–4.6 million] young people 15–24 years old living with HIV, 29% of whom are adolescents aged 15–19 years.

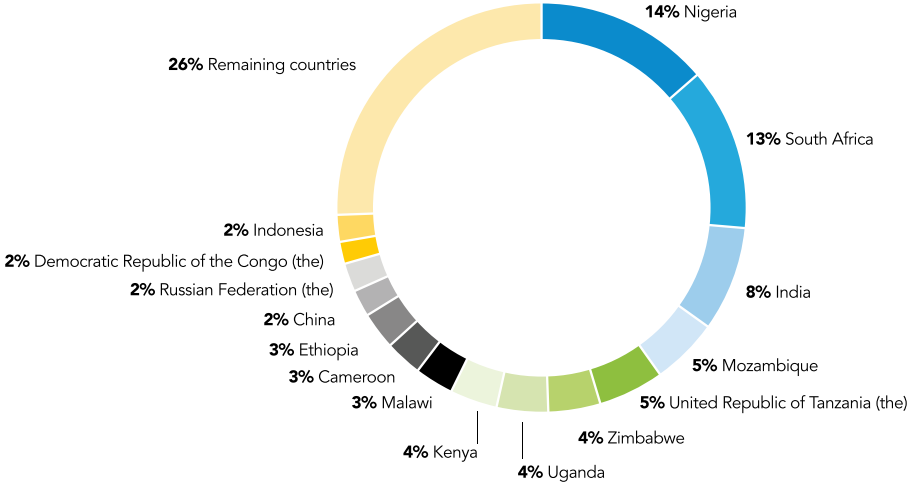
There were 2.1 million [1.9 million–2.4 million] new HIV infections in 2013—a decline of 38% from 2001, when there were 3.4 million [3.3 million–3.6 million] new infections. Fewer people are dying of AIDS-related illnesses. In 2013 there were 1.5 million [1.4 million–1.7 million] AIDS-related deaths. AIDS-related deaths have fallen by 35% since 2005, when the highest number of deaths was recorded. In the past three years alone, AIDS-related deaths have fallen by 19%, which represents the largest decline in the past 10 years.

Figure A: People living with HIV by country, 2013



Source: The Gap Report, UNAIDS

Figure B: AIDS Death Globally, 2013

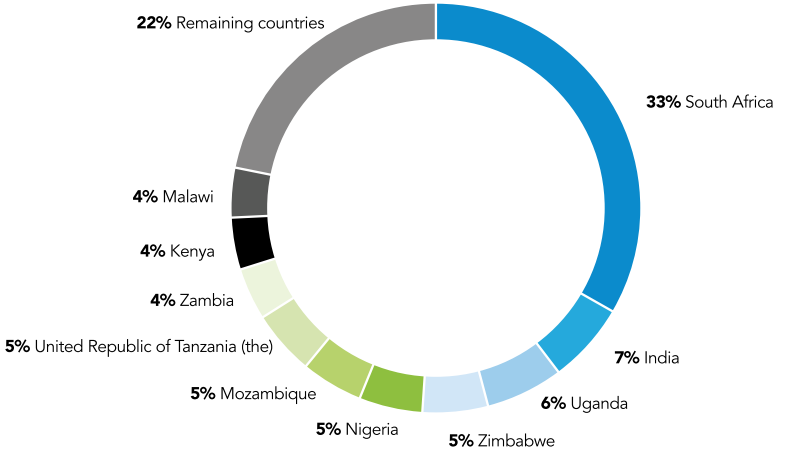


Source: The Gap Report, UNAIDS

2.2 Numbers on antiretroviral therapy

Almost 12.9 million people were receiving antiretroviral therapy globally at the end of 2013. The percentage of people living with HIV who are not receiving antiretroviral therapy (2) has been reduced from 90% [90–91%] in 2006 to 63% [61–65%] in 2013. Of these 12.9 million people, 5.6 million were added since 2010. The rapid increase in antiretroviral access has primarily occurred in a few countries. One third of the increase in the number receiving antiretroviral therapy was in South Africa, followed by India at 7%, Uganda 6%, and in Nigeria, Mozambique, the United Republic of Tanzania and Zimbabwe 5%. Three of four people receiving HIV treatment are living in sub-Saharan Africa, where the need is most acute.

Figure C: Number of people receiving antiretroviral therapy newly added during 2010–2013



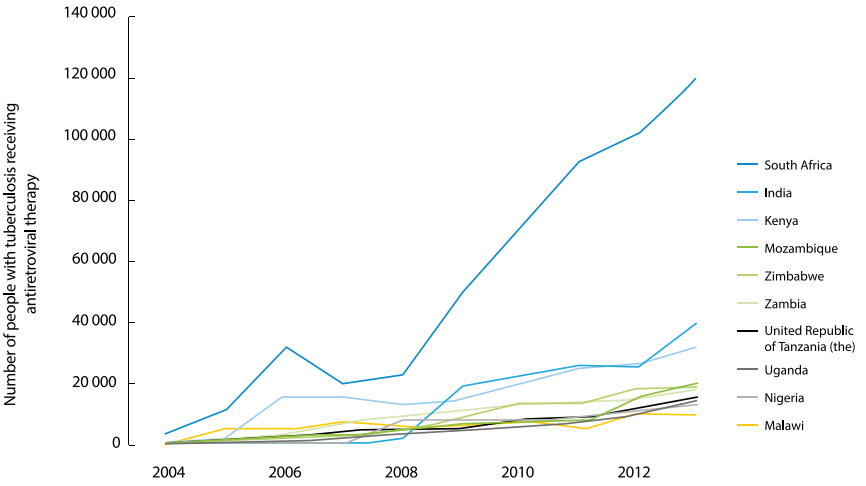
Source: The Gap Report, UNAIDS

2.3 Reductions in deaths related to tuberculosis (TB) and HIV

Since 2004, TB-related deaths among people living with HIV have declined by 36% worldwide at the end of 2012. WHO estimates that scaling up collaborative HIV and TB activities prevented about 1.3 million people from dying during 2005 to 2012. More people

with TB are now receiving antiretroviral therapy. Ten countries represent more than 80% of the global number of notified HIV positive people with TB receiving antiretroviral therapy.

Figure D: Increase in number of people with tuberculosis receiving antiretroviral therapy in 10 countries that represent more than 80% of the global number of HIV-positive people with tuberculosis



Source: The Gap Report, UNAIDS

Table 01: Global Summary of HIV/AIDS, 2001 – 2013

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
2013*	35 million	2.1 million	0.8	1.5 million
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, * The Gap Report, UNAIDS*

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 2.20 million HIV infected people and 1.53 lakh AIDS deaths in 2013. Table 02 shows the estimated number of People Living with HIV (PLHIV) in eight Member States of the SAARC Region in the year 2013. 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, 2013

Country	Estimated No. of PLHA	Estimated New HIV infection in 2013(all ages)	HIV Prevalence Rate (%)	Number of AIDS Deaths	First HIV Positive Case Detected (Year)
Afghanistan*	4500	< 1000	<0.1	<500	1989
Bangladesh	9500	1300	< 0.1	< 500	1989
Bhutan	<1000	< 100	0.1	< 100	1993
India**	2.08 million	116000	0.27	148000	1986
Maldives	< 100	< 100	< 0.1	< 100	1991

Country	Estimated No. of PLHA	Estimated New HIV infection in 2013(all ages)	HIV Prevalence Rate (%)	Number of AIDS Deaths	First HIV Positive Case Detected (Year)
Nepal	39000	1300	0.2	3300	1988
Pakistan	68000	14000	< 0.1	2200	1986
Sri- Lanka*	3000	< 500	< 0.1	310*	1987
Regional	2.20 million			1,53,000	

*Source: The Gap Report, UNAIDS, * Country Report, 2014, ** Annual Report 2013-14, 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 2.20 million PLHIV in SAARC region, 2.08 million were living in India in 2013.

Table 03: Estimated number of adults and children receiving and needing antiretroviral therapy, and coverage, 2013

Country	Estimated number of People needing ART(WHO 2013 Guidelines)*	Reported number of adults on ART	Estimated adults ART coverage (%)	Reported number of children 0-14 years receiving ART
Afghanistan	3900	195	5	16
Bangladesh	7100	1083	11	60
Bhutan	<1000	120	21	....
India*	1900000	705537	36	41638
Maldives	<100	5	19	....
Nepal	50000	8228	22	638
Pakistan	85000	4321	7	70
Sri Lanka	2700	492	18	....
Regional	2048700	719981	35	42422

*Source: The Gap report, UNAIDS, *UNAIDS report on the global AIDS epidemic 2013*

On the basis of latest available information (The Gap report & Global Report, UNIADS 2013), this region has 2.04 million estimated numbers of adults needing ART while in the region 0.71 million reported number of adults and 42422 numbers of children on ART in 2013. 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: 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. In the region 26108 number of HIV positive tuberculosis patients on ART in which Sri Lanka accounts for 65 % of estimated HIV positive incident TB cases that received treatment for both TB and HIV in the year 2012.

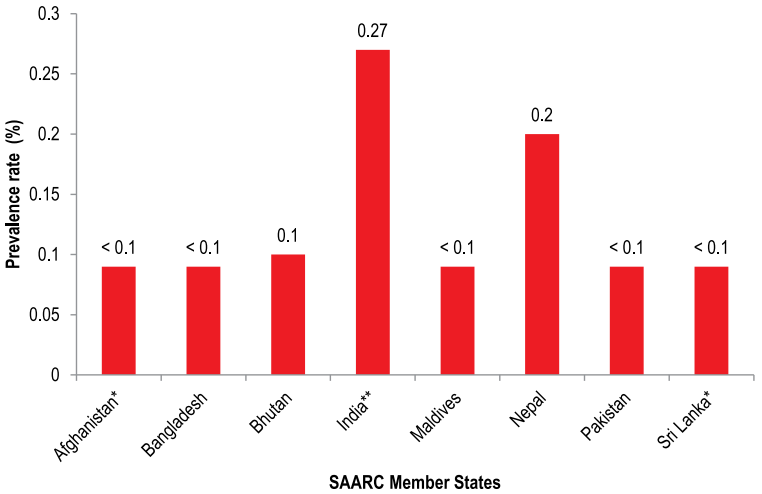
Table 05: Number of HIV infected Female Adults, 2001-2012

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: 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, 2013



Source: The Gap Report, UNAIDS,* Country Report, 2013, ** Annual Report 2013-14, NACO, India

Figure 01 shows the estimated adult (15- 49) HIV prevalence rate 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

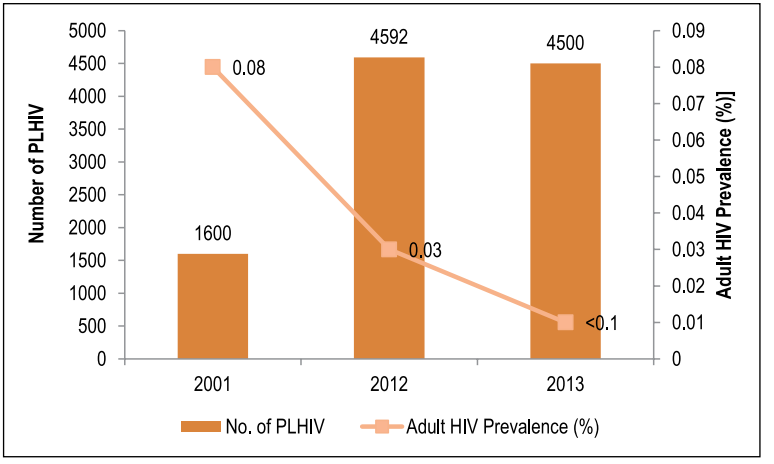
Afghanistan

Islamic Republic of Afghanistan is one of the eight member countries of SAARC R. 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 a population of 26 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

Based on available data HIV epidemic in Afghanistan seems to be low and step to concentrated, this means that HIV affected mainly PWIDs among key population at higher risk of contracting HIV. The recent Integrated Biological Behavioral Surveillance Survey (IBBS) in 2012 shows an overall 4.4% of HIV prevalence among PWIDs. This prevalence is varied from minimum 0.3% among PWIDs in Mazar city to maximum up to 13.3 percent in

Figure 02: Estimated Number of PLHIV, Afghanistan, 2001-13

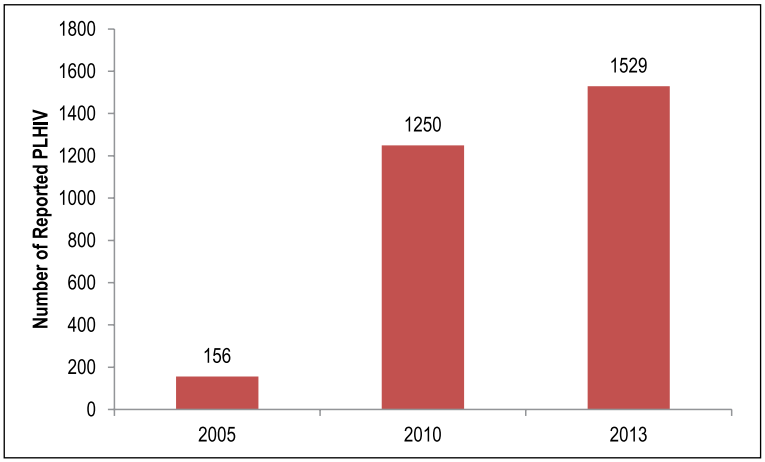


Source: Country report-2014, Afghanistan

Herat city. The study also found 0.3%, 0.4% and 0.7% among Female Sex Worker (FSW), Men who have Sex with Men (MSM) and Prisoner respectively.

Till the end of 2013, a cumulative number of 1529 (Figure 03) HIV infections were reported to the National AIDS Control Program (NACP) where male to female ratio among PLHIV is almost 6:1 respectively. However, the country estimates around 4500 PLHIV in the country and 35 cases are AIDS-related deaths. Estimated adult HIV prevalence in Afghanistan was < 01% in 2013 (Figure 02).

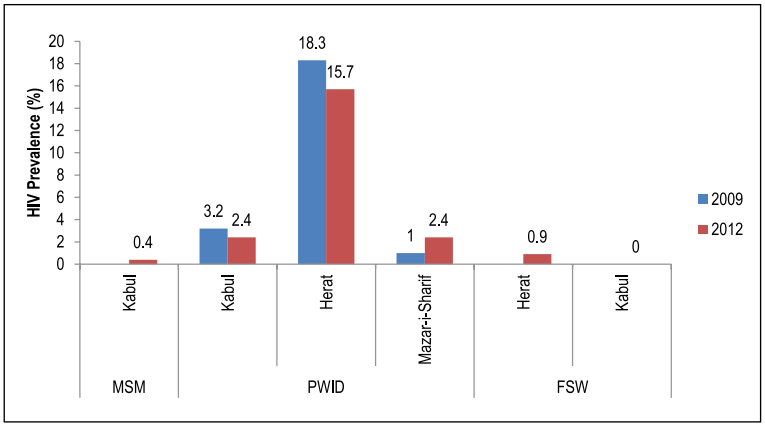
Figure 03: Reported PLHIV in the country from 2005-2013



Source: Country report-2014, Afghanistan

Figure 03 shows the reported number of PLHIV which has increased in 2013 in comparison to 2005.

Figure 04: HIV prevalence among key affected populations, 2009 and 2012



Source: HIV and AIDS Data Hub for Asia Pacific ,2013

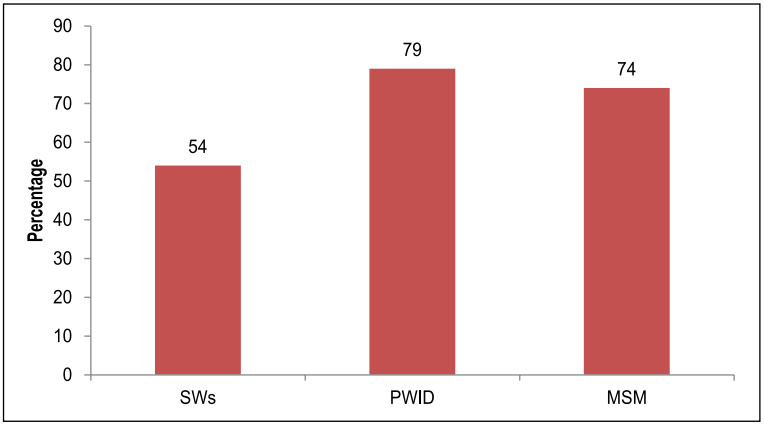
HIV prevalence among key affected populations in the different cities of Afghanistan is shown in (Figure 04).There are 23,800 prisoners and detainees in Afghanistan's 35 prisons as of March 2012. HIV prevalence among prisoners is rising and appears to be primarily related to the proportion of PWID in prison.

Figure 05: Proportion of MSM, PWID and FSWs who reported condom use at last sex, 2012

Source: HIV and AIDS Data Hub for Asia Pacific , 2013

The Proportion of FSW reported condom use at last sex with any partner in different cities is shown in figure 05.

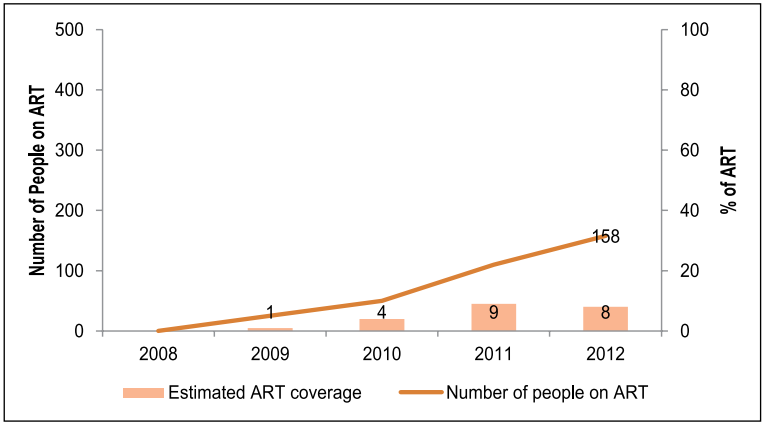
Figure 06: HIV testing coverage among key populations, 2012



Source: HIV and AIDS Data Hub for Asia Pacific , 2013

Figure 06 shows the HIV testing coverage among key populations was high in PWID followed by MSM and sex workers in 2012.

Figure 07: ART scale up, 2008-2012



Source: HIV and AIDS Data Hub for Asia Pacific , 2013

Figure 07 shows the trend of ART scale up from 2008 to 2012. The number of people on ART has reached 158 and its estimated ART coverage was 8% in 2012.

Epidemic Overview, 2013	
Population(mid-year)	26 million
Estimated Number of people living with HIV/AIDS	4500
HIV Prevalence	
Adult (15 - 49)	< 0.1 %
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	<500
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	1500 (1% to 7%)
Condom use at last sex	
FSW	52%
MSM	17%
PWID	23%
HIV Testing Coverage	
FSW	6%
MSM	17%
PWID	23%
Treatment	
Reported number of people on ART, 2013	211
ART Coverage (people on ARTas proportion of PLHIV)	5%

*Source: UNAIDS report on the global AIDS epidemic 2013, *Country report, Afghanistan2013& HIV and AIDS Data Hub for Asia Pacific*

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 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/AIDS epidemic

Prevention efforts in Bangladesh had been initiated much before the first HIV case was detected in 1989, till date data has indicated that Bangladesh is containing the HIV epidemic. Due to reportedly low prevalence there is no comprehensive national study to measure the prevalence of HIV among the general population, however, it is considered to be less than 0.1 percent14. In all of the nine HIV Serological Surveillance rounds conducted till date (Round 9, 2011) in Bangladesh, the HIV prevalence among the most affected key populations as a whole remained below 1 percent.15. Table 1 is a compilation of HIV prevalence among key affected populations over the years.

On December 1, 2013, on the occasion of World AIDS Day, the National AIDS/STD Program (NASP) had confirmed a total of 3,241 HIV cases reported in Bangladesh, of which 370 cases identified were new. In 2013, 95 persons had developed AIDS and a total of 82 deaths were reported. Cumulatively 1,299 people had developed AIDS in the country till date and 472 had died.

Key Affected Populations and HIV

The key affected populations included in the 9th serological surveillance in Bangladesh are female sex workers (Street, Hotel, and Residence based and Casual), male sex workers (MSW), men who have sex with men (MSM), transgender or Hijras, people who inject drugs (PWID) and heroin smokers.

The following table depicts the overall HIV prevalence among different KAP over the last nine rounds of HIV serological surveillance in Bangladesh.

Table 06: HIV prevalence among key affected populations over the years

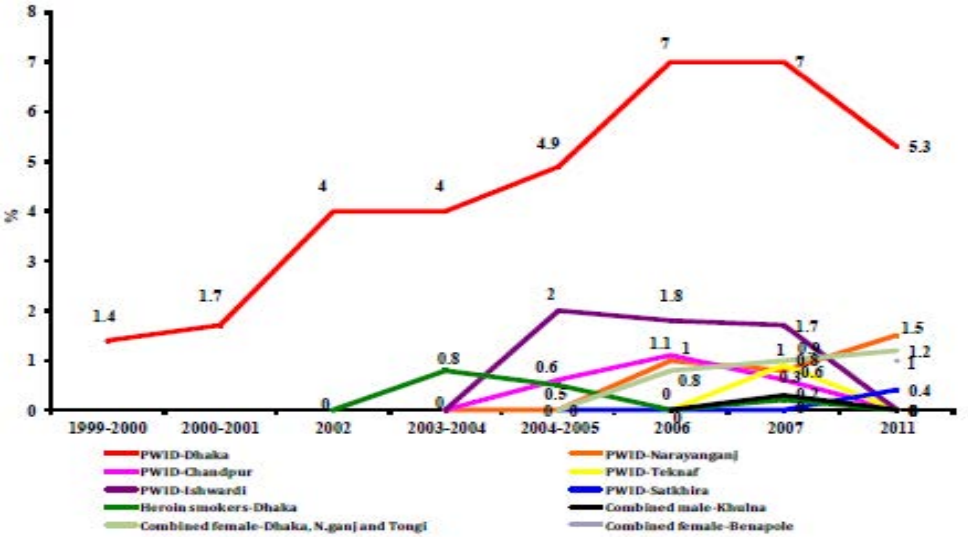
Survellance Rounds	Year	Total Sample	HIV Prevalence %
1st rounds	1998-1999	3871	0.4
2nd Round	1999-2000	4338	0.2
3rd Round	2000-2001	7063	0.2
4th Round	2002-2003	7877	0.3
5th Round	2003-2004	10445	0.3
6th Round	2004-2005	11029	0.6
7th Round	2006	10368	0.9
8th Round	2007	12786	0.7
9th Round	2011	12894	0.7

Source: Country Progress Report: Bangladesh-2014

Status of the Epidemic among the PWID – Indications of Progress in Dhaka

According to the 9th Serological Surveillance 2011 (NASP), the overall HIV prevalence among PWID was found to be stable. In Dhaka, overall prevalence was 5.3 percent. The HIV prevalence among IDUs in Dhaka rose up to five times in an interval of seven years (from 1.4 percent in the 2nd serological surveillance (1999-2000) to 7 percent in the 8th serological surveillance, 2007).

Figure 08: HIV in PWID over the rounds of the surveillance



Source: Country Progress Report: Bangladesh-2014

A marker for unsafe injection practices is the prevalence of Hepatitis C. In Dhaka this declined significantly over the years. Which confirms that safer injection practices are being adopted In other cities however, the scenario is mixed with decline in HCV rates being documented in some cities and increase in others. The most alarming is the high rates of HCV in four cities in northwest Bangladesh ranging from 67.7 to 95.7%.

Few cases of HIV among male PWID and female PWUD (which are a group of PWID and heroin smokers) were detected in four new cities, in 2011, where the prevalence rates ranged 0.4 to 1.5%

Female PWUD are particularly vulnerable as most sell sex to support their addiction, and depended on their male partners to buy their drugs and then shared injections with them.

From the status of the concentrated epidemic among PWUD it may be inferred that interventions to prevent HIV among PWUD (mainly PWID), are working in Dhaka, however,

similar efforts to those applied in Dhaka need to be implemented in other areas where high rates of either HCV or active syphilis have been found.

Vulnerability of FSWs to HIV in some cities

Data from 3,568 FSW from 13 cities reveal that the overall HIV prevalence is 0.3% among FSW in Bangladesh and HIV was detected among different groups of FSWs in five cities (Table 07). Over the rounds HIV prevalence among FSW has been low. For sites where HIV was detected over the rounds, the changes were not significant.

Table 07: HIV prevalence among FSW, 2007 and 2011

FSW and Site	Prevalence(%) 2011	Prevalence(%) 2007
Street based FSW in Dhaka	0.5	0.2
Hotel based FSW in Dhaka	0.2	0
Hotel based FSW in Sylhet	0.4	0.6
Casual FSW in Hilli	1.6	2.7
Combined residence and hotel based FSW in Jamalpur	0.5	0
Combined residence and hotel based FSW in Jessore	0.4	0.5

Source: Country Progress Report: Bangladesh-2014

Active syphilis rates had either declined or remained unchanged over the rounds of serological surveillance. In 5 cities approximately 5% or >5% of FSW had active syphilis.

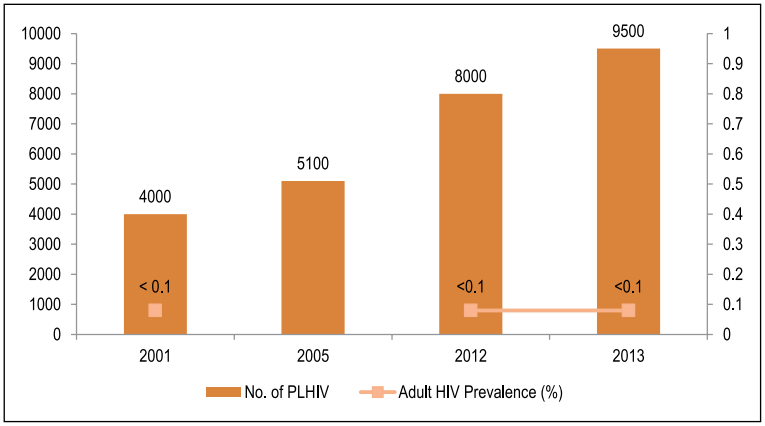
Vulnerability of Hijra, MSM and MSW

A midline assessment of the Global Fund supported interventions for MSM, MSW and TG was conducted in 2013 using the same methodology as the national surveillances. Till the reporting period information from Dhaka was available. The HIV prevalence among MSW was 0.6%, among MSM 0.7% and among TG/Hijras it was 0.5% Though in the previous

surveillance round, none of the MSM or MSW tested was positive for HIV; 0.7 MSW were tested positive in 2006 and 0.3 in 2007, and in 2006 0.2 MSM tested positive. Among the transgendered community (hijra) the HIV prevalence was 1% in two sites (Dhaka –the capital of Bangladesh and Manikganj-a peri-urban site adjacent to Dhaka) in 2011 and one person was detected as being HIV positive among a small sample from Hilli. The rates of active syphilis in MSW and hijra seemed to be declining, while it remained unchanged in case of MSM where the rates were low. Condom use increased in Dhaka among all three groups. MSMs are highly networked, so if HIV were to emerge, it could spread very rapidly in this population, if prevention efforts are not continued.

From the 9th serological surveillance, HIV was detected in both sites from where Hijra were sampled. Active syphilis from two cities were at 6.1% and cross-border mobility was common. Attention needs to be given to hijra so that HIV prevention services for hijra are appropriate and expanded. Active syphilis rates were at 1.7% among MSM, 2.2 among MSW and 3 among hijra in 2013.

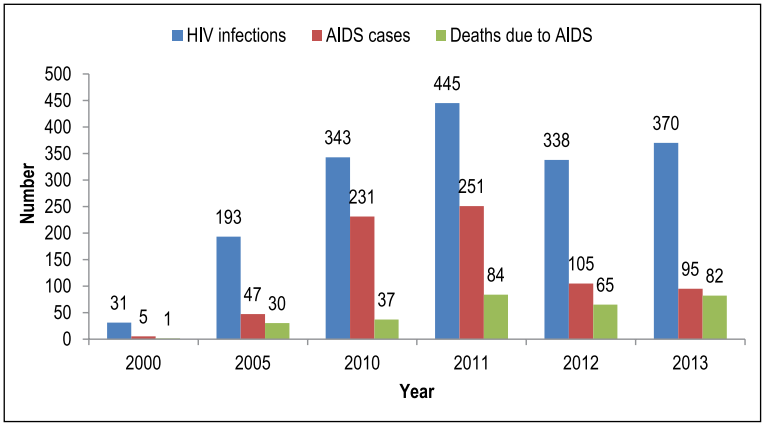
Figure 09: Estimated Adult HIV Prevalence & Number of PLHIV, Bangladesh, 2001-13



Source: The Gap Report, UNAIDS, & HIV and AIDS Data Hub for Asia Pacific

The estimated number of PLHIV in Bangladesh maintains a steady increasing trend from 4000 in 2001 to 9500 in 2013 (Figure 09). Bangladesh is estimated to have less than 1300 annual new HIV infections among adults.

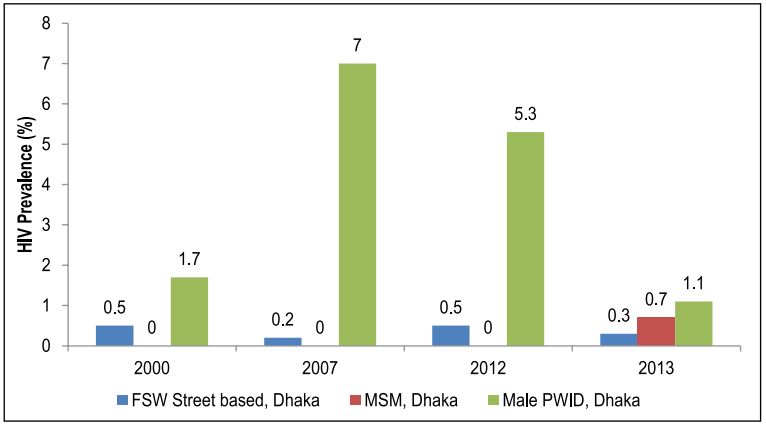
Figure 10: Annual reported number of HIV infections, AIDS cases and deaths, 2000-2013



Source: The Gap Report, UNAIDS, & HIV and AIDS Data Hub for Asia Pacific

Figure 10 shows annual reported number of HIV infections, AIDS cases and deaths due to AIDS an increasing trend from 2000 to 2011 and decreasing in 2012 However it has been again increase in 2013.

Figure 11: HIV prevalence among key affected populations, 2000 - 2013

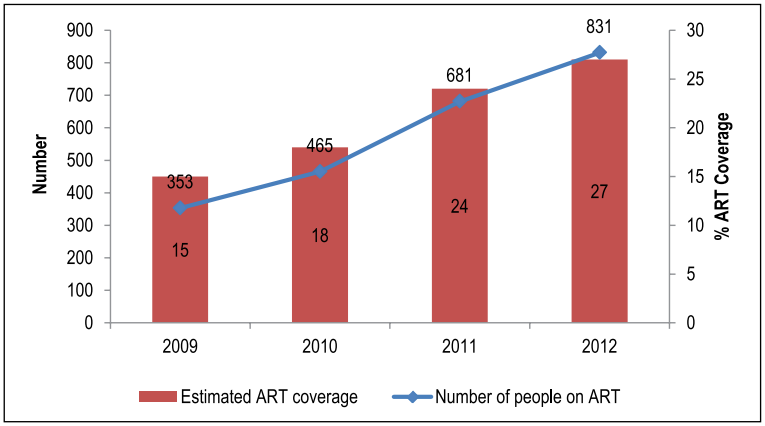


Source: The Gap Report, UNAIDS, & HIV and AIDS Data Hub for Asia Pacific

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.

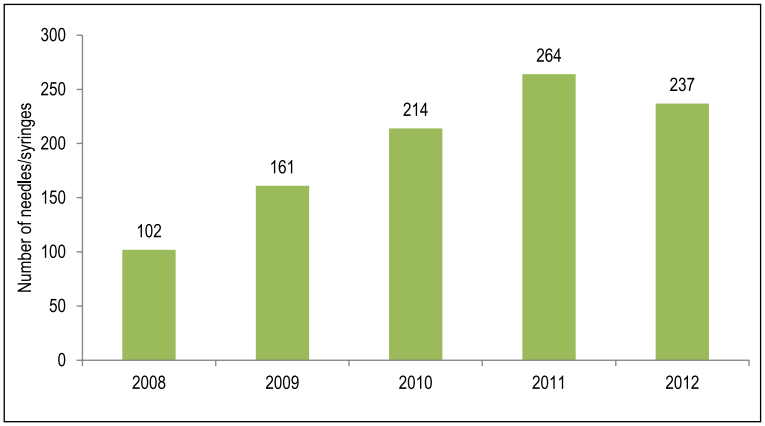
Figure 12: ART scale up, 2009-2012



Source: The Gap Report, UNAIDS, & HIV and AIDS Data Hub for Asia Pacific

Figure 12 shows the scaling up of number of people on ART from 353 in 2009 to 831 in 2012. The percentage ART coverage also increased from 15% in 2009 to 27% in 2012.

Figure 13: Number of needles/syringes distributed per person who inject drugs per year, 2008-2012



Source: The Gap Report, UNAIDS, & HIV and AIDS Data Hub for Asia Pacific

The numbers of needles/syringes distributed per person who inject drugs per year have been in increasing trend from 102 in 2008 to 237 in 2012 and decreased in 2012(Figure 13).

Epidemic Overview, 2013	
Population(mid-year)	154 million
Estimated Number of people living with HIV/AIDS	9500
HIV Prevalence	
Adult (15 - 49)	< 0.1 %
Female sex workers (FSW)	0.3%
Men who have Sex with Men (MSM)	0.7%
People Who Inject Drugs (PWID)	1.1%
Estimated newly infected	1300
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	< 500
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	3300 (1% to 33%)
Condom use at last sex	
FSW	67%
MSM	49%
PWID	45%
HIV Testing Coverage	
FSW	4%
MSM	16%
PWID	5%
Treatment	
Reported number of people on ART, 2013	1083
ART Coverage (people on ART)	11%

Source: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, & HIV and AIDS Data Hub for Asia Pacific

Bhutan

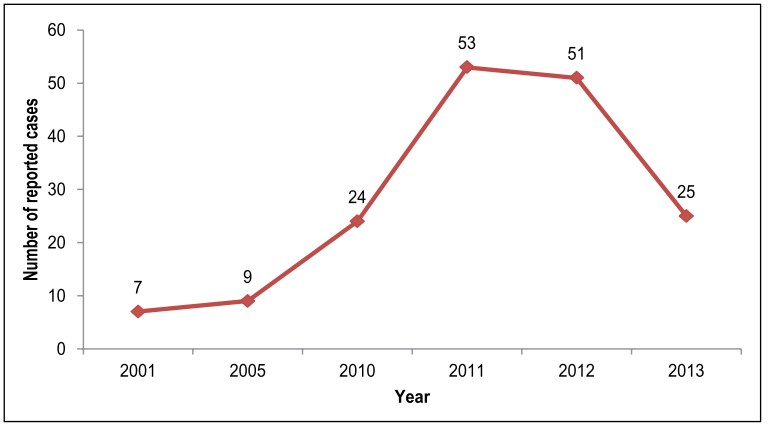
Bhutan is a land locked country situated in the Himalayas, it has border with China and India. Bhutan has an area of 38,394 sq km and the altitude varying from 180 m to 7,550 m above sea level. The total population of Bhutan is 7, 62,000 with a population density of 16.36 person/km. The country is divided 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 one of the few counties in South Asia that continue to experience a low adult (15-49years) HIV prevalence of below 0.2per cent (0.1-0.6%)Although, the UNAIDS estimate approximately about 1,100 (<1000-2700) HIV infection cases, the program data as of November 2013 shows a total case detection of 346 with equal proportion of male and female. Of the total 346, there are 27 children below the age of 15 years representing 7.8% of the total case. Till date there has been 74 deaths (including one child) amongst the total reported cases. Since the first detection of HIV in the country in 1993 the annual reported cases have substantially increased significantly starting from 2004 with a major funding support from the World Bank and the Global Fund. Of the total reported cases approximately 87% of the total HIV cases were reported between 2004 and 2013.

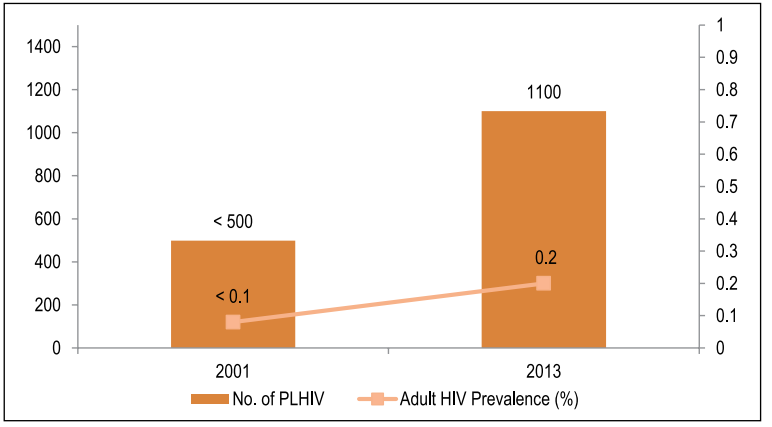
Figure 14: Total number of reported HIV cases, Bhutan, 2001-13



Source: HIV and AIDS Data Hub for Asia Pacific

Similar to many countries in the region the reported cases are predominantly (87%) are among the productive age group of 20-49 years with a significant bearing on the social and economic development of the country. Of the total, one-fifth is between the ages of 15–24 years. While there are equal proportions of male and female, relatively there are younger, below 24 years female infected compared to male in the same age category.

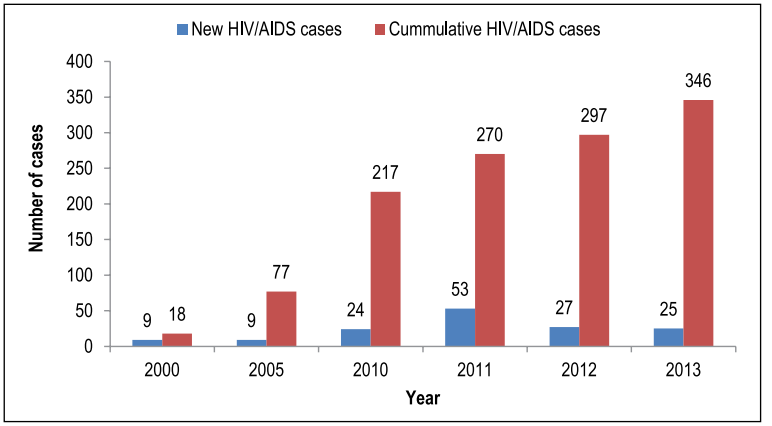
Figure 15: Estimated Adult HIV Prevalence & Number of PLHIV, Bhutan, 2001-13



Source: Bhutan Progress Report – 2014, Global AIDS Response Progress Report

The total number of people living with HIV (PLHIV) in Bhutan is estimated at around 1100 in 2013. The estimated number of PLHIV in Bhutan shows an increase from < 500 in 2001 to 1100 in 2013 (Figure 15).

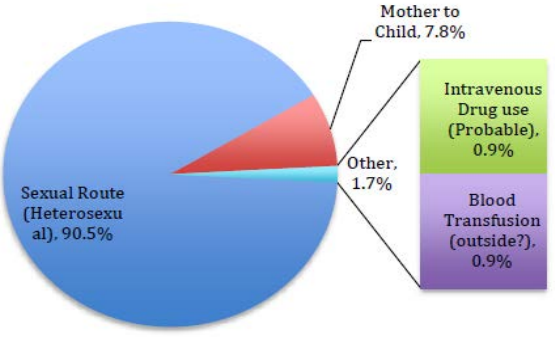
Figure 16: Reported cumulative and new HIV/AIDS cases, 2000-2013



Source: BHUTAN Progress Report – 2014, Global AIDS Response Progress Report

By 2013, a total of 346 reported HIV cases have been detected with a total increase of 25 new cases as compared to the previous report updates of December, 2012. Now, Bhutan has the total of 346 HIV positive reported confirmed cases with 272 people currently living with HIV and 74 reported deaths due to AIDS related complications and other factors (Figure 16).

Figure 17: Mode of transmission of the Cohort Data



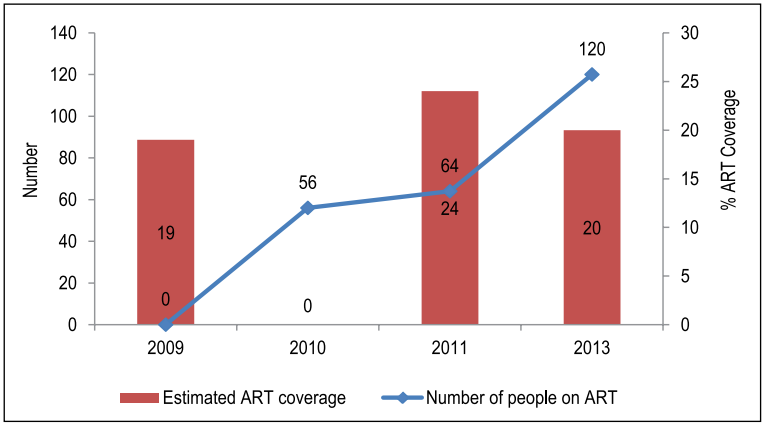
Source: BHUTAN Progress Report – 2014, Global AIDS Response Progress Report

The analysis of the current cohort data show that HIV predominantly transmitted through heterosexual intercourse (90.5%) followed by mother to child transmission (7.8%) and less than 2% through blood transfusion and injecting drug use.

With the decentralization and integration of the HIV services within the primary health delivery services, facility for voluntary counseling and testing (VCT) is available in all district hospitals and in four of the stand-alone Health Information Service Centers (HISC) located in major urban centers to improve access to services. Although the rapid test are available in all the hospital and four HISC, confirmatory tests is only available at the National Referral Hospitals in Thimphu. Analysis of the care and treatment data shows that almost half of the HIV cases (49%) are detected through the VCT service delivery points followed by medical screening / check up and blood donation screening and ANC care at 20%, 11% 9% respectively.

In terms of social background, the analysis of the cohort data shows that the total reported cases represent all major occupational background in the country from all 20 districts. Significantly majority reported as being housewives (31%) followed by uniform personal together (RBG/RBA/RBP) at 14.1% and private and business community accounting for one fourth of all cases detected.

Figure 18: ART scale up, 2009-2013



Source: UNAIDS report on the global AIDS epidemic 2013 & HIV and AIDS Data Hub for Asia Pacific

Till date, there are 120 PLHIV on ART based on the previous WHO guideline of CD4 count of less then 350. The analysis of the ART patients data maintain with the Case and Treatment Unit at JDWNRH show that of the total PLHIV on ART who died (n= 14) 23.5% were 29 years old or younger. Among those in the age group 30–39 years, 16.7% had died and among those in the age group 40 years or older, 30% had died. More women were on ART (56.3%) as compared to men. However, 22.2% of the women died as compared to 18.5% of the men and the gender difference was not statistically significant.

Epidemic Overview, 2013	
Population(mid-year)	762000
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	<100
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)	<500 (32% to >95%)
Condom use at last sex	
FSW	38%
MSM	N/A
PWID	54%
HIV Testing Coverage	
FSW	N/A
MSM	N/A
PWID	N/A
Treatment	
Reported number of people on ART, 2013	120
ART Coverage (%)	20

Source: Bhutan Progress Report – 2014, Global AIDS Response Progress Report & HIV and AIDS Data Hub for Asia Pacific

India

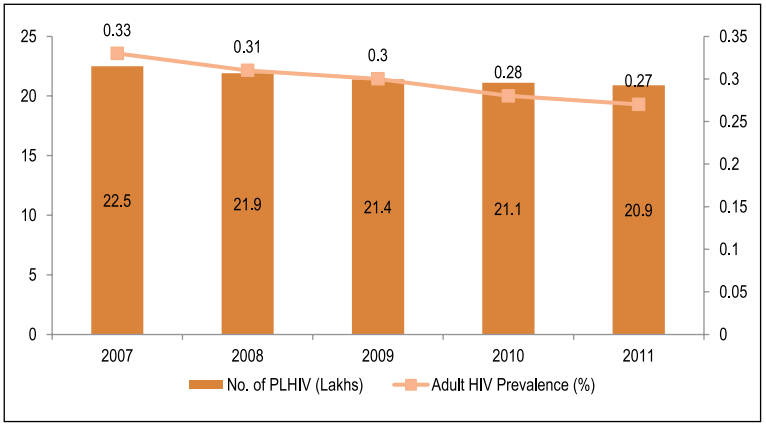
India is the largest countries in South Asia. Geographically it is the seventh largest and second most populous country in the world. Its estimated total population was 1247 million (RNTCP, India 2014). Bounded by the Indian Ocean on the south, the Arabian Sea on the south-west, and the Bay of Bengal 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

The HIV epidemic in India is concentrated among High Risk Groups and is 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 regional variations exist. The Department of AIDS Control has been monitoring levels and trends of HIV among different population groups to craft effective responses to control HIV/AIDS in India through the HIV Sentinel Surveillance System since 1998.

India has the third highest number of estimated people living with HIV in the world. According to the HIV Estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakh, with an estimated adult (15-49 age group) HIV prevalence of 0.27% in 2011(Figure 15). India has demonstrated an overall reduction of 57% in the annual new HIV infections among adult population from 2.74 lakh in 2000 to 1.16 lakh in 2011, reflecting the impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme (NACP). The trend of annual AIDS deaths is showing a steady decline since roll out of the free Anti-Retroviral Therapy (ART) programme in India in 2004; it is estimated that around 1.5 lakh lives have been saved due to ART till 2011.

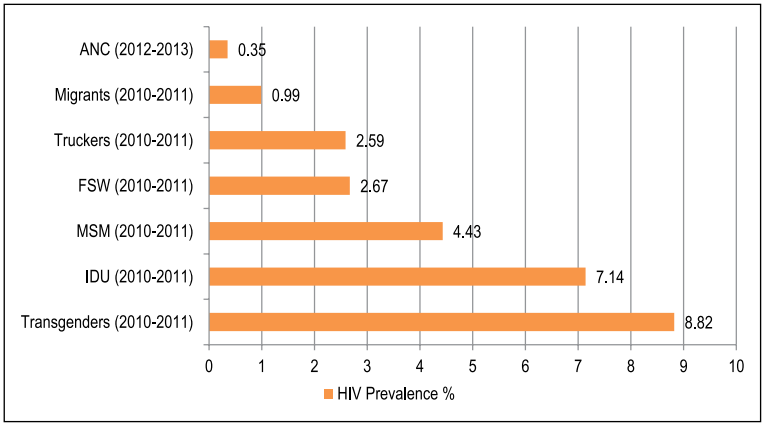
Figure 19: Estimated Adult HIV Prevalence & Number of PLHIV, India, 2007-11



Source: Annual Report 2013-14, NACO, India

According to HSS 2012-2013, the overall HIV prevalence among ANC attendees continued to be low at 0.35% in the country, with an overall declining trend at the national level. At the national level, the prevalence of HIV for general population (ANC attendees) in 2012- 2013 and among different risk groups in 2010- 2011 are shown in Figure 20.

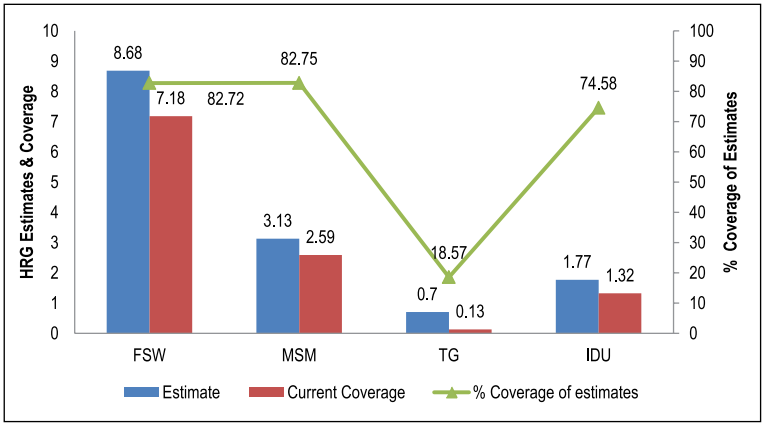
Figure 20: National HIV Prevalence for ANC attendees (2012 – 13) and among different risk groups (2010-11)



Source: Annual Report 2013-14, NACO, India

The key performance of TIs with respect to the coverage of core HRGs during 2013-2014 is depicted in Figure 21. This data based on CMIS reports received at DAC, shows that FSW coverage compared to the estimates, has already crossed 90%.

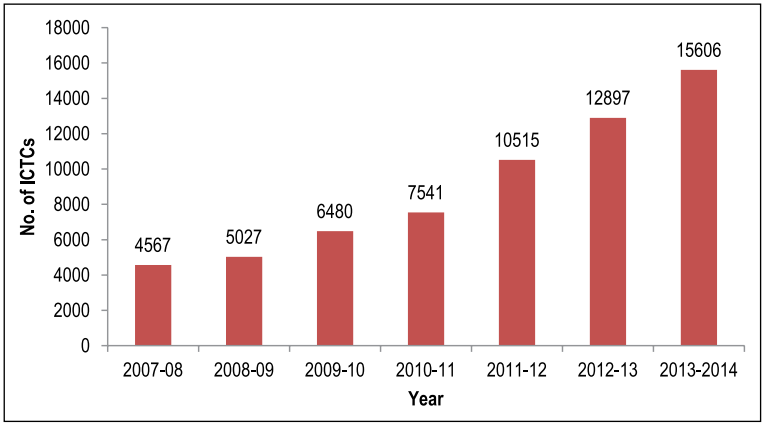
Figure 21: Coverage of Core HRG (FSW, MSM, IDU) during 2013-2014



Source: Annual Report 2013-14, NACO, India

Integrated Counseling and Testing Centre (ICTC): There are different types of HIV Counseling and testing services in India as described below. HIV Counseling and testing facilities have been rapidly scaled-up in India, as depicted in Figure 21.

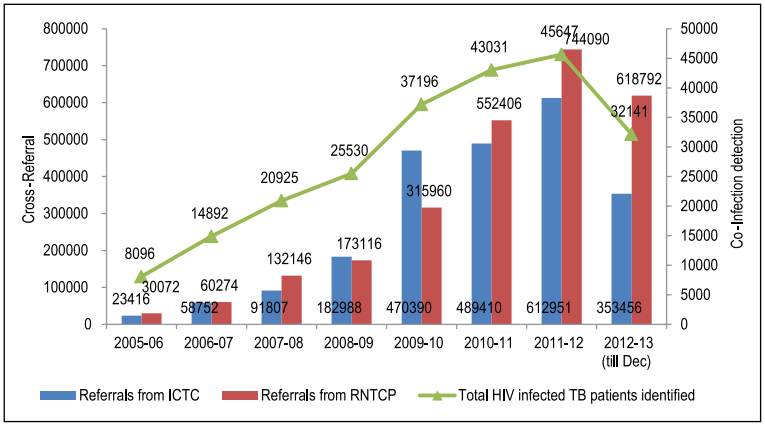
Figure 21: Scale up of ICTCs during the period 2007-08 to 2012-13



Source: Annual Report 2013-14, NACO, India

Figure 22 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.

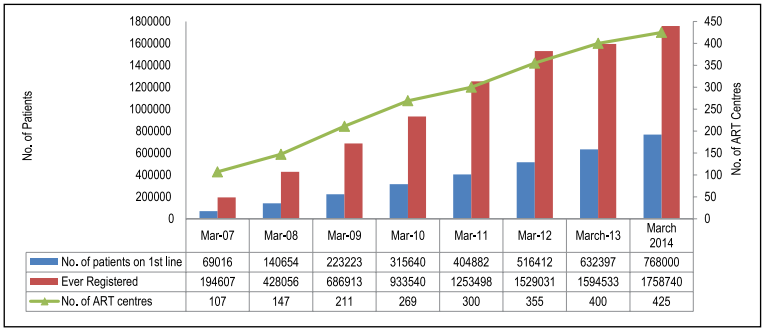
Figure 22: Trend of HIV/TB co-infections identified, 2005-2012



Source: Annual Report 2013-14, NACO, India

Figure 23 shows the scaling up of service provisioning under 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.

Figure 23: ART Scale-up for PLHIV in India, March 2007 – March 2014



	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	March-13	March 2014
No. of patients on 1st line	69016	140654	223223	315640	404882	516412	632397	768000
Ever Registered	194607	428056	686913	933540	1253498	1529031	1594533	1758740
No. of ART centres	107	147	211	269	300	355	400	425

Source: Annual Report 2013-14, NACO, India

Epidemic Overview, 2013	
Population(mid-year)	1247 million
Estimated Number of people living with HIV/AIDS	2.08 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	130000
Estimated number of deaths due to AIDS	130000
No. of patients on 1st line	768000
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	750000
Condom use at last sex	
FSW	83%
MSM	58%
PWID	63%
HIV Testing Coverage	
FSW	66%
MSM	68%
PWID	63%
Treatment	
Reported number of people on ART, 2013	747175
ART Coverage (%)	36

Source: Bhutan Progress Report – 2014, Global AIDS Response Progress Report & HIV and AIDS Data Hub for Asia Pacific

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).

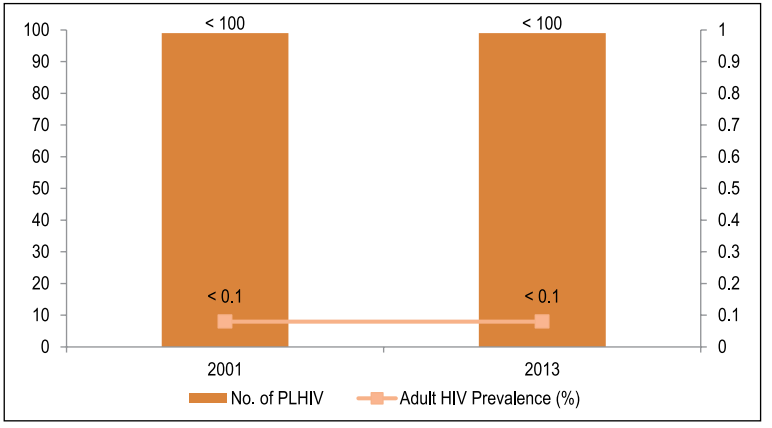
Maldives established the National AIDS Control Programme in 1987, four years before the first domestic HIV positive patient was reported. National AIDS Council, NAC, a multi-sectoral representative body was formed to provide direction to National AIDS Control Program (NAP). The Health Protection Agency (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 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. 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.

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

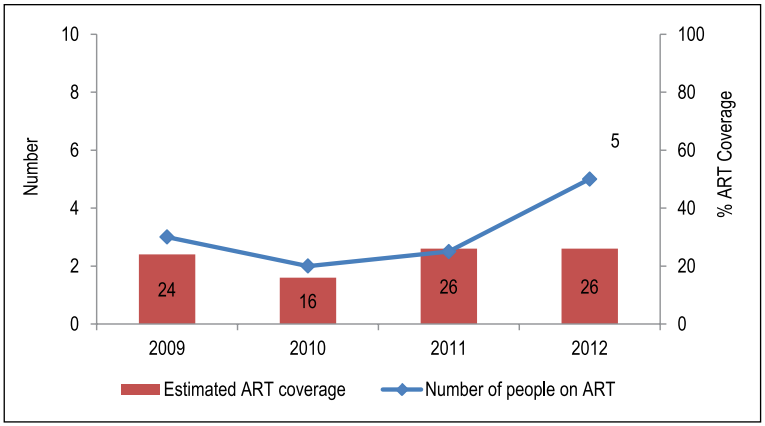
Figure 24: Estimated Adult HIV Prevalence & Number of PLHIV, Maldives, 2001-13



Source: UNAIDS report on the global AIDS epidemic 2013 & HIV and AIDS Data Hub for Asia Pacific

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 24).

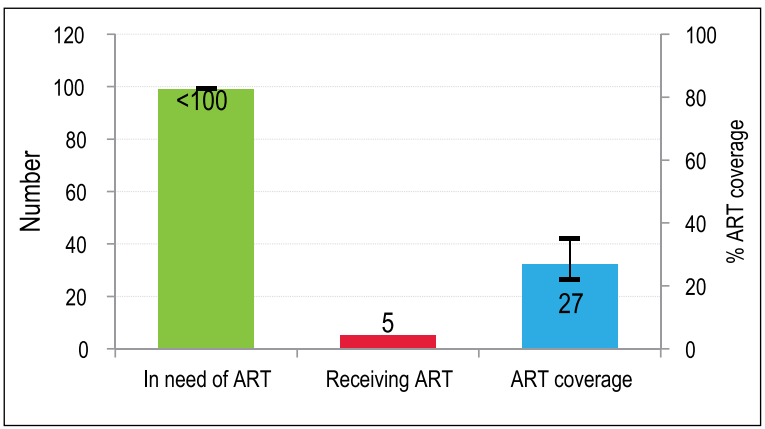
Figure 25: ART scale up, 2009-2012



Source: HIV and AIDS Data Hub for Asia Pacific

[Figure 25 & 26] shows the scaling up of number of people on ART from 3 in 2009 to 5 in 2012. The percentage ART coverage also increased from 24% in 2009 to 26% in 2012. However there are less than 100 cases who in need of ART.

Figure 26: Estimated number of adults receiving and needing ART, and coverage, 2012



Source: HIV and AIDS Data Hub for Asia Pacific

Epidemic Overview, 2013	
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
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	N/A
Condom use at last sex	
FSW	12%
MSM	34%
PWID	18%
HIV Testing Coverage	
FSW	14%
MSM	10%
PWID	17%
Treatment	
Reported number of people on ART, 2013	5
ART Coverage (%)	19

Source: HIV & AIDS SAARC Region- Update 2013 & HIV and AIDS Data Hub for Asia Pacific

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 million. The urban population is largely concentrated in the Kathmandu valley. Nepal has a market economy mainly based on farming and tourism.

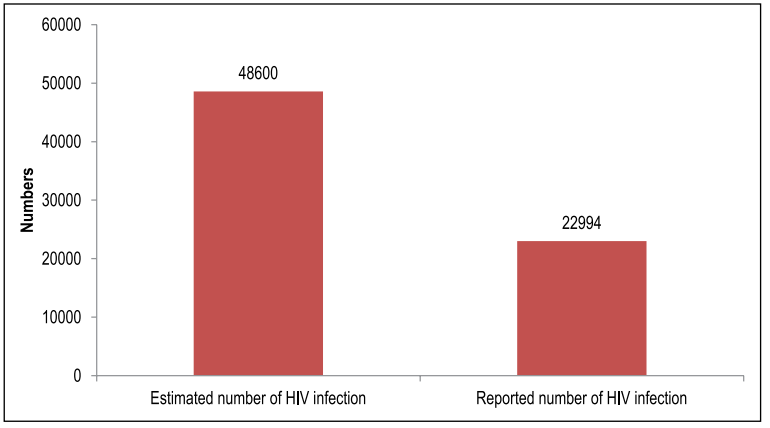
Overview of the HIV/AIDS epidemic

Nepal's HIV prevalence has not changed much over the last five years, it has remained within 0.3 - 0.2 percent. The estimated HIV prevalence among 15-49 years is 0.28 percent in 2013. With this level of HIV infection, there are approximately 48,600 people estimated to be living with HIV in Nepal. , Although HIV prevalence has not changed much, the country has achieved reduction in the number of new infections, from 8,039 new infections annually in 2000 to 1,443 in 2013. Apart from overall low HIV prevalence among adult population, the country's epidemic scenario looks much different among key populations where, in certain groups, HIV prevalence is much higher, notably among People who Inject Drugs (PWID), Men who have Sex with Men (MSM), Transgender People, Female Sex Workers (FSW) and Male Labour Migrants and their families. Besides HIV prevalence among key populations, their size remains a considerable challenge for achieving as well as maintaining optimal coverage.

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 27: Estimated numbers of people living with HIV and reported number of HIV infections, 2013



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. In 2010- 2012 July, 5540 HIV positive cases were detected. The gap between estimated and detected HIV cases (Figure 26) raises questions about the accessibility and uptake of testing and counseling services.

Table 06: HIV testing and counseling status, 2010 - 2013

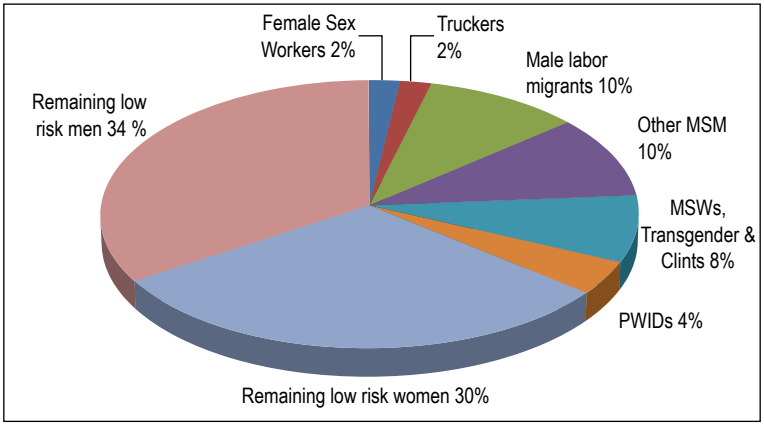
Counseling and Testing	2010	2011	2012	2013 (July)
Pre-test counseled	115,013	101,063	126, 511	89793
Tested for HIV	106,325	95,501	120,450	85,557
HIV +ve	2,015	2,060	2,433	1,443
Post-test counseled	104,666	94,190	118,570	84,544

Source: NCASC Fact Sheet, as of July 2013, Nepal

HIV testing and counseling status shows that clients post-test counseled is less than clients pre-test counseled. However counseling and testing has decrease in 2013 in comparison to 2010 and tested clients HIV positive is 1.7 % in 2013.

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 28).

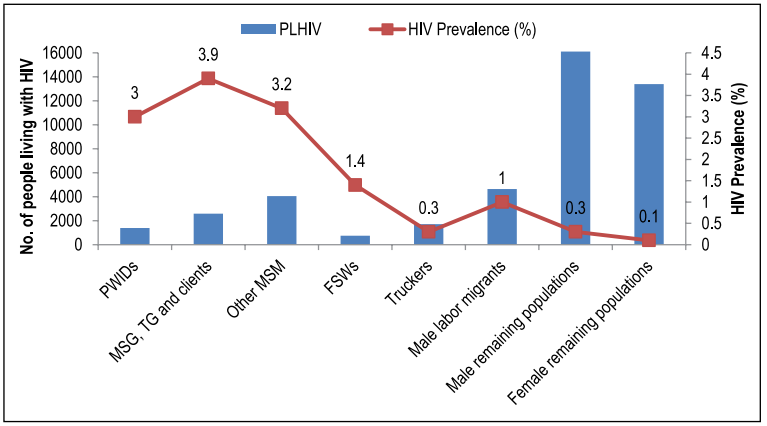
Figure 28: Estimated HIV Infections by Sub Population Groups, 2013



Source: NCASC Annual Report, 2010/12, Nepal

Estimated Number of people living with HIV/AIDS in 2013 is 48,600. HIV Prevalence is in decreasing order from PWIDs to female remaining population (Figure 29).

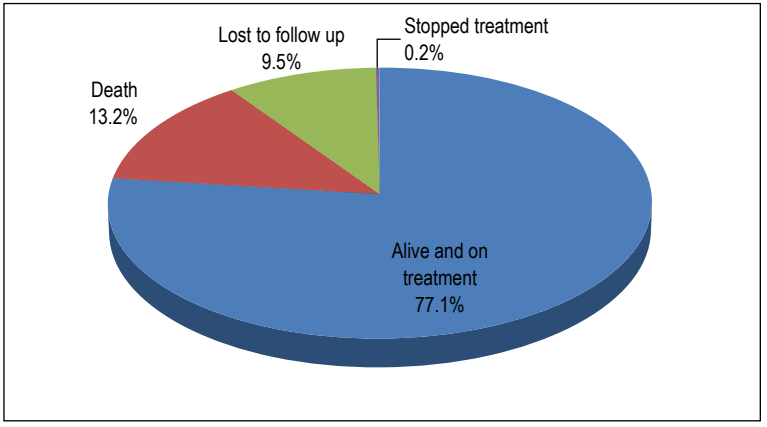
Figure 29: Estimated HIV Prevalence and number of people living with HIV by Key affected populations, 2012



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 30 shows outcomes of ART programme in Nepal in which 77.1% alive on treatment.

Figure 30: Outcomes of ART Programme in Nepal, As of July 2013



Source: NCASC Annual Report, 2010/12, Nepal

Epidemic Overview, 2013	
Population(mid-year)	28 million
Estimated Number of people living with HIV/AIDS	48600
HIV Prevalence	
Adult (15 - 49)	0.28%
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)	19 % to 36 %
Condom use at last sex	
FSW	83%
MSM	91%
PWID	47%
HIV Testing Coverage	
FSW	55%
MSM	42%
PWID	21%
Treatment	
Reported number of people on ART, 2013	8546
ART Coverage (%)	33

Source: NCASC Fact Sheet, as of July 2013, Nepal, & HIV and AIDS Data Hub for Asia Pacific

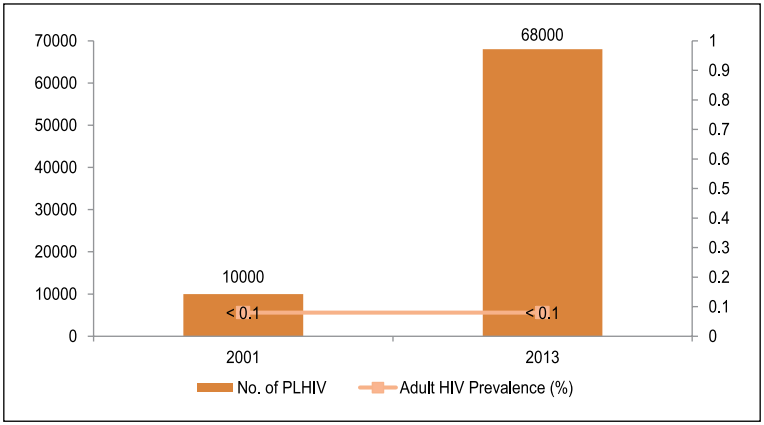
Pakistan

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 km2. The population of Pakistan was estimated at approximately 185 million in 2012-13 (as per Global AIDS Response Progress Report 2014) making it the sixth most populous nation in the world with an average annual growth rate of 2%. 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 68,000 people living with HIV by the end of 2013, with 14,000 estimated new HIV infection and 2200 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.

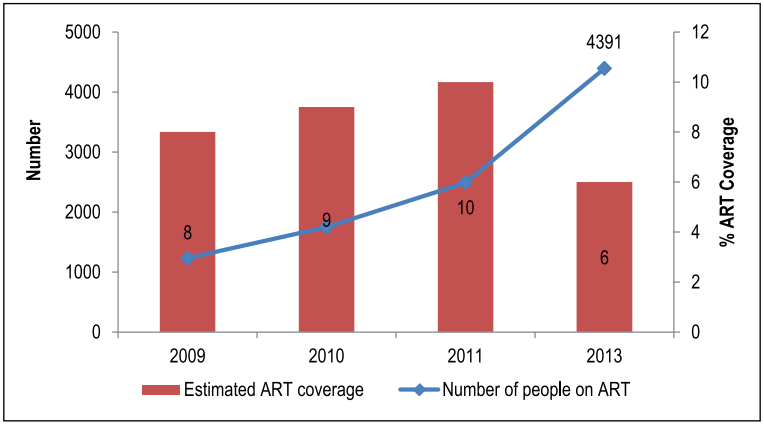
Figure 31: Estimated Adult HIV Prevalence & Number of PLHIV, Pakistan, 2001-13



Source: The Gap report, UNAIDS & HIV and AIDS Data Hub for Asia Pacific

The estimate adult HIV prevalence in 2013 is < 0.1 which is same as of 2001 (Figure 31). The total number of people living with HIV/AIDS (PLHIV) in Pakistan is estimated around at 68, 000 in 2013 which are heavy increase from 10,000 of 2001.

Figure 32: ART scale up, 2009-2013



Source: The Gap report, UNAIDS & HIV and AIDS Data Hub for Asia Pacific

In Pakistan 4391 are living on ART in 2013. Figure 32 shows the scaling up of number of people on ART. The percentage ART coverage has decrease from 8 in 2009 to 6 in 2013.

Despite various preventive efforts, infe ction 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, 2013	
Population(mid-year)	185 million
Estimated Number of people living with HIV/AIDS	68000
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%
Hijra SW	5.2%
Estimated newly infected	14000
Cummulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	2200
No. of patients on 1st line	-
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	19000 (5 % to 14 %)
Condom use at last sex	
FSW	41%
MSW	32%
Hijra	32%
PWID	23%
HIV Testing Coverage	
FSW	6%
MSM	5%
PWID	9%
Treatment	
Reported number of people on ART, 2013	4391
ART Coverage (%)	6

Source: The Gap report, UNAIDS & HIV and AIDS Data Hub for Asia Pacific

Sri-Lanka

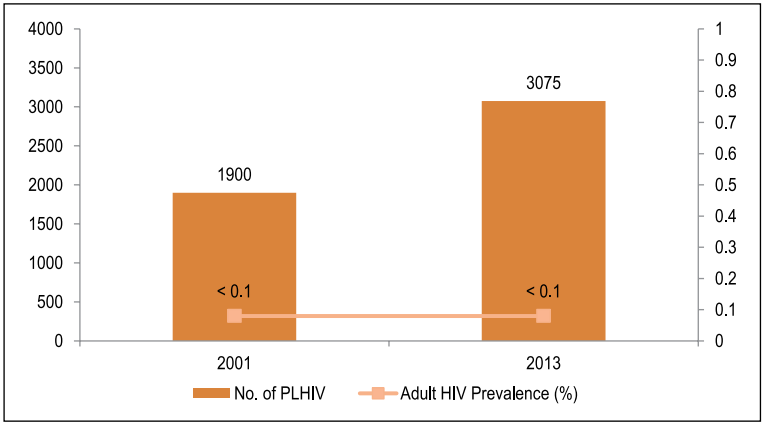
Sri-Lanka is an island country in the Indian Ocean, separated from the south- eastern coast of peninsular India. Its estimated population is 20 million in 2013. There are two ethnic groups which are Sinhalese and Tamils of which the Sinhalese are the predominant ethnic group, constituting about three quarters of the population.

Overview of the HIV/AIDS epidemic

The first Sri Lankan with HIV infection was reported in 1987.Since then as of the end of 2013, 1845 HIV positive persons were reported to the National STD/AIDS Control Programme. A cumulative number of 310 AIDS deaths and 71 Mother to Child transmitted cases have been reported. The male to female ratio of HIV cases is 1.5:1. During 2013, 586,762HIV screening tests were carried out in the country and 196were confirmed as HIV positive.

A detailed analysis of data reported during the last five years showed that 42% of the total reported HIV positive cases have been reported during the 2009-2013 period.

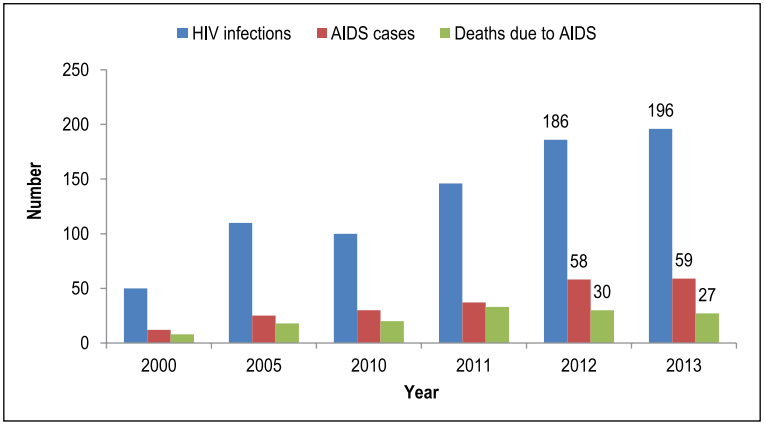
Figure 33: Estimated Adult HIV Prevalence & Number of PLHIV, Sri Lanka, 2001-13



Source: Annual Report, 2013, Sri Lanka & HIV and AIDS Data Hub for Asia Pacific

The estimated number of PLHIV in Sri-Lanka maintains a steady increasing trend from 1900 in 2001 to 3075 in 2013 (Figure 33).

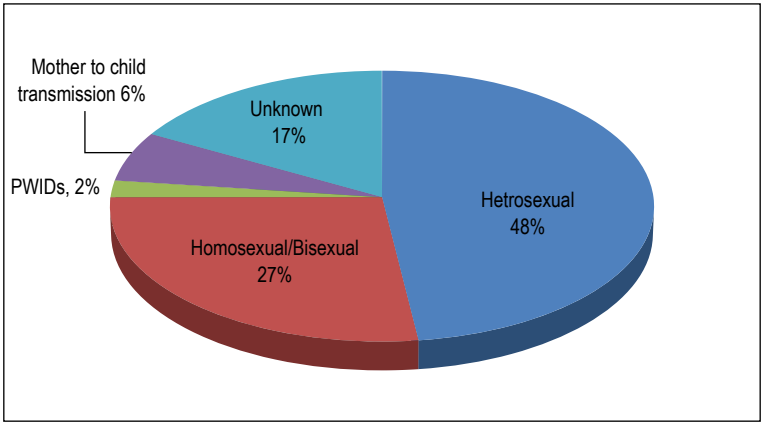
Figure 34: Annual reported number of HIV infections, AIDS cases and deaths, 2000-2013



Source: Annual Report, 2013, Sri Lanka & HIV and AIDS Data Hub for Asia Pacific

The annual reported number of HIV infections, AIDS cases and deaths due to AIDS is in increasing trend in 2013 compared to 2001(Figure 34).

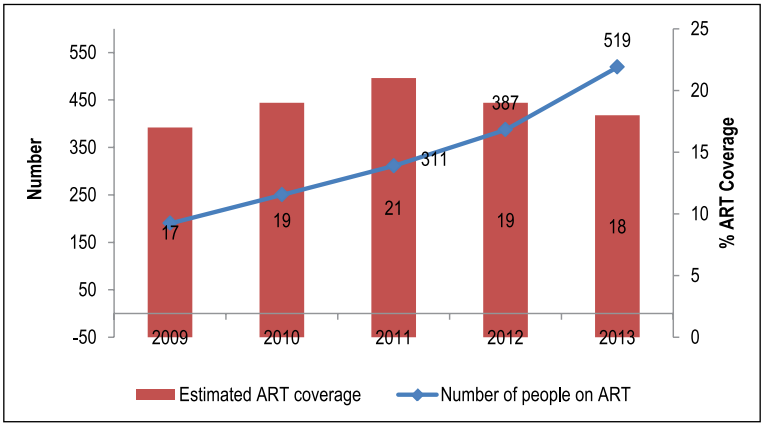
Figure 35: Cumulative HIV cases by mode of transmission, 2013



Source: Annual Report, 2013, Sri Lanka

In Sri-Lanka cumulative HIV cases by mode of transmission is high in heterosexual followed by homosexual and very less in PWID in 2013 (Figure 35) .

Figure 36: ART scale up, 2009-2013



Source: Source: Annual Report, 2013, Sri Lanka

In Sri-Lanka 519 are living on ART in 2013. Figure 36 shows the scaling up of number of people on ART. The percentage ART coverage also scales up slowly from 17 in 2009 to 18 in 2013.

Epidemic Overview, 2013	
Population(mid-year)	20 million
Estimated Number of people living with HIV/AIDS	3075
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
Cumulative number of reported HIV infections	-
Estimated number of deaths due to AIDS	<100
No. of patients on 1st line	406
HIV-positive pregnant women received prevention of parent-to-child transmission (PPTCT)	<1000 (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
Treatment	
Reported number of people on ART, 2013	492
ART Coverage (%)	18

Source: Annual Report, 2013, Sri Lanka

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 are 29 times 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 2013, 1.1 million (13%) of the 9.0 million people who developed TB worldwide were HIV-positive. The African Region accounted for 78% of the estimated number of HIV-positive incident TB cases. The number of people dying from HIV-associated TB has continued to fall globally, from a best estimate (and peak) of 540 000 in 2004 to 360 000 in 2013 (with approximately equal numbers of deaths among men and women).

Globally, 48% of notified TB patients had a documented HIV test result in 2013, 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. Coverage of co-trimoxazole preventive therapy (CPT) among HIV-positive TB patients remains high, and this increased slightly to 85% globally in 2013. Globally, 431 000 HIV-positive TB patients were enrolled on CPT in 2013, representing 85% of all notified HIV-positive TB patients, slightly higher than levels achieved in 2011 and 2012.

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.

WHO recommends that routine HIV testing should be offered to all patients with presumptive and diagnosed TB as well as to partners of known HIV-positive TB patients. In 2013, 2.9 million notified TB patients had a documented HIV test result, equivalent to 48% of notified TB cases. This represented an increase from 2.8 million and 46% respectively in 2012, and more than 15 times the coverage reported in 2004

ART is the intervention that can have the biggest impact on TB morbidity and mortality among HIV-positive TB patients. The number of notified HIV-positive TB patients on ART has grown from a very low level in 2004 to reach 364 000 in 2013.

Between 2012 and 2013, there was an encouraging increase in the global coverage of antiretroviral therapy (ART) for notified TB patients who were known to be co-infected with HIV, from 60% to 70%. However, considerably more progress is needed to reach the target of 100%. Moreover in 2013, the number of HIV-positive TB patients started on ART represented only 32% of the estimated number of HIV-positive people who developed TB in 2013.

In 2013, 64 countries reported a total of 5.5 million people enrolled in HIV care who were screened for TB, up from 4.1 million in 62 countries in 2012. Preventing TB deaths among people living with HIV requires intensified scale-up of TB prevention, diagnosis and treatment interventions and earlier initiation of ART among people living with HIV and those with HIV-associated TB. Further scale-up of collaborative TB/HIV activities could be facilitated by joint TB and HIV programming, which would help to overcome constraints, promote synergies and achieve efficiency gains, especially between TB and HIV programmes.

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 08: HIV testing and provision of CPT, ART and IPT in the SAARC Region, 2013

Country	TB patients with known HIV status		HIV-positive TB patients		% HIV-positive TB patients started on		HIV-positive people provided with IPT
	No.	%	No.	%	CPT	ART	
Afghanistan	8247	26	9	< 1	-	-	12
Bangladesh	2067	1	68	3	90	100	0
Bhutan	1115	100	1	< 1	0	100	-
India	887903	63	44027	5	95	88	-
Maldives	10	9	0	0	-	-	-
Nepal	3773	11	65	2	-	100	665
Pakistan	8306	3	36	< 1	-	-	-
Sri Lanka	4650*	49	37	< 1	100	100	9
Regional	**899992**	**-**	**44165**	**5**	**95**	**88**	**-**

*Source: Global TB Report WHO, 2014, * Country Report-2014, Sri-lanka*

In 2013, a total 8,999, 92 TB patients with known HIV status has tested in which 44,165 (5%) tested TB patients are HIV-positive among them 95% and 88 % 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 95% of HIV-positive TB patients started CPT and 88% started ART in India at the end of 2013. However Bangladesh, Bhutan and Nepal has 100 % HIV-positive TB patients started CPT and ART. Only in Afghanistan, Nepal and Sri-Lanka HIV-positive people provided with IPT and they are 12, 665 and 09 respectively.

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