SAARC EPIDEMIOLOGICAL RESPONSE ON HIV/AIDS

2017

SAARC Tuberculosis and HIV/AIDS Centre

CONTENTS

FOREWORD

The world has embarked on a mission to end the AIDS pandemic. Globally there is consensus that activities for HIV prevention and care services need to be accelerated to reach the targets of ending AIDS by 2030. Early enrollment in ART services contributes significantly to the ability for expanded ART access to make impact on averting AIDS related morbidity and mortality and reducing HIV transmission.

The political declaration on HIV and AIDS, the global community adopted new targets and made firm political commitments for 2020 and 2030. These targets aim to "fast track" the response, to accelerate scale up in the next five years.

The SAARC Member States have varied epidemiological patterns of HIV infection and AIDS. In reviewing the current epidemiology of HIV and AIDS within the SAARC region, the diversity needs to be fully addressed and defined. Despite of these diversities, Member States are committed to take necessary actions and contain HIV and AIDS epidemic.

In the year 2016, it is estimated that the number of people living with HIV globally was 36.7million [CI: 30.8 million-42.9 million] there were 2.1 million (CI 1.7 million-2.6 million) new HIV infections in 2016. In addition, there were 1.0 million [CI: 830 000 – 1.2 million] AIDS related deaths.

SAARC Region has an estimated 2.28 million People Living with HIV and India alone bears an estimated 2.1 million of that number in year 2016. HIV epidemic in the SAARC Region is a collection of different epidemics in the Member States with their own characteristics and dynamics.

The SAARC TB and HIV/AIDS Centre (STAC) coordinate the efforts of the National AIDS Control Programmes (NACPs). Since its inception in 1992, STAC has taken of the challenges of combating the threats of HIV/AIDS in SAARC region. The SAARC member states have made notable progress across South Asia in line with the SAARC Regional Strategy on HIV/AIDS and TB/HIV co-infection.

This is the 15th report on HIV epidemiology. This report "SAARC Epidemiological Response on HIV and AIDS – 2017" has incorporates the updated information and brief analysis on HIV/AIDS as of December 2016. It includes statistical information and brief analysis on HIV & AIDS and describes HIV/AIDS situation in global, regional and SAARC member states.

I believe that this document 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.

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ABBREVIATIONS

APLHIV	Association of People living with HIV
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Antiretroviral
BBS	Biological Behavioral Survey
CICT	Client- Initiated Counseling and Testing
CLHIV	Children Living with HIV/AIDS
CST	Care, Support &Treatment
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Reporting
HCT	HIV counseling and testing
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
MDR	Multi Drug Resistance
MSM	Men who have sex with men
NACP	National AIDS Prevention and Control Program
NSP	National Strategic Plan
NTPs	National Tuberculosis Control Programms
PICT	Provider-Initiated
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PPTCT	Prevention of Parent to Child Transmission
PWID	People who inject drugs
SAARC	South Asian Association for Regional Cooperation
SDGs	Sustainable Development Goals
STAC	SAARC Tuberculosis and HIV/AIDS Centre
STC	SAARC Tuberculosis Centre
STD	Sexually Transmitted Diseases
SW	Sex Worker
TB	Tuberculosis

TG	Transgender
TI	Targeted Intervention
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing
VDRL	Venereal Disease Research Laboratory Test
WHO	World Health Organization
XDRTB	Extensively Drug-Resistant TB

1. INTRODUCTION

1.1 Introduction of SAARC

SAARC is an organization of eight countries located in the South Asia and it stands for the South Asian Association for Regional Corporation (SAARC). This is an economic and geopolitical organization, established to promote socio-economic development, stability, welfare economics, and collective self-reliance within the Region. The first summit was held in Dhaka, Bangladesh on 7–8 December 1985 and was attended by the Government Representatives and Presidents from Bangladesh, Maldives, Pakistan and Sri Lanka, the Kings of Bhutan and Nepal, and the Prime Minister of India. The dignitaries signed the SAARC Charter on 8 December 1985, thereby establishing the regional association and to carry out different important activities required for the development of the Region. The summit also agreed to establish a SAARC secretariat in Kathmandu, Nepal and adopted an official SAARC emblem. Due to rapid expansion within the region, Afghanistan received full-member status and some countries are considered as observers. SAARC respects the principles of sovereign equality, territorial integrity, and national independence as it strives to attain sustainable economic growth.

1.2 Introduction of SAARC TB and HIV/AIDS Centre (STAC)

The Centre was established in 1992 as SAARC Tuberculosis Centre (STC) and started functioning from 1994. The Centre had been supporting the National Tuberculosis Control Programmes of the SAARC Member States. The Thirty–first session of Standing Committee of SAARC held in Dhaka on November 09th – 10th 2005, appreciating the efforts of the centre on TB/HIV co-infection and other works related to HIV/AIDS discipline and approved the renaming of the Centre as SAARC Tuberculosis and HIV/AIDS Centre (STAC) with additional mandate to support SAARC Member States for prevention of HIV/AIDS. Since then with its efforts and effective networking in the Member States the Centre is contributing significantly for control of both TB and HIV/AIDS.

Vision, Mission, Goal and Objective of STAC

The vision of the Centre is to be the leading institute to support and guide SAARC Member States to make the region free of TB and HIV/AIDS and the mission is to support the efforts of National TB and HIV/AIDS Control Programmes through evidence based policy guidance, coordination and technical support.

The goal of the Centre is to minimize the mortality and morbidity due to TB and HIV/AIDS in the Region and to minimize the transmission of both infections until TB and HIV/AIDS cease to be major public health problems in the SAARC Region and the objective of the Centre is to work for prevention and control of TB HIV/AIDS in the Region by coordinating the efforts of the National TB Programmes and National HIV/AIDS Programmes of the SAARC Member Countries.

Role of STAC

- To act as a Regional Co-ordination Centre for NTPs and NACPs in the Region.
- To promote and coordinate action for the prevention of TB/HIV co-infection in the Region.
- To collect, collate, analyze and disseminate all relevant information regarding the latest development and findings in the field of TB and HIV/AIDS in the Region and elsewhere.
- To establish a networking arrangement among the NTPs and NACPs of Member States and to conduct surveys, researches etc.
- To initiate, undertake and coordinate the Research and Training in Technical Bio-medical, operational and other aspects related to control of Tuberculosis and prevention of HIV/AIDS in the Region.
- To monitor epidemiological trends of TB, HIV/AIDS and MDR-TB in the Region.
- To assist Member States for harmonization of policies and strategies on TB, HIV/AIDS and TB/HIV co-infection.
- To assist National TB Reference Laboratories in the Region in quality assurance of sputum microscopy and standardization of culture and drug sensitivity testing and implementation of bio-safety measures.
- To carry-out other important works identified by the Programming Committees/Governing Board.

2. GLOBAL SITUATIONS OF HIV/AIDS

2.1 GLOBAL HIV STATISTICS

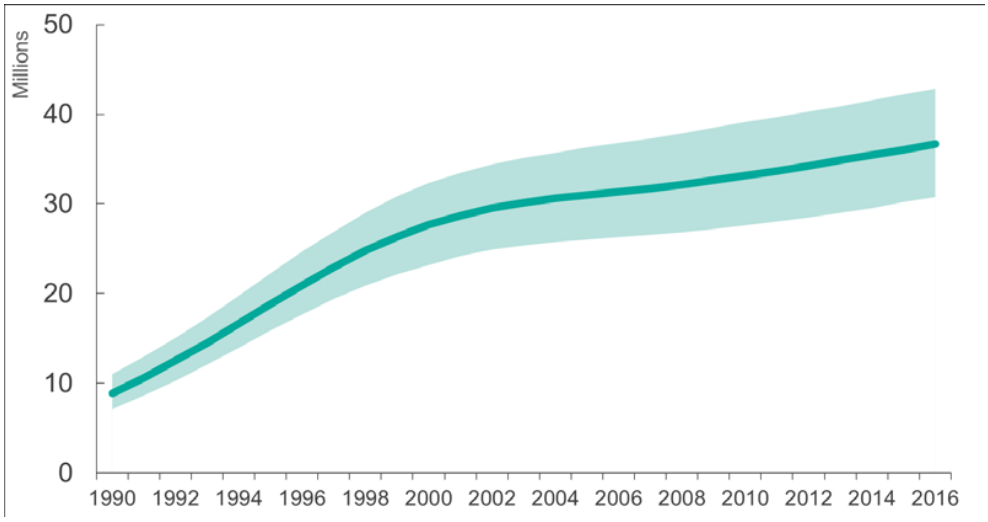
- 20.9 million People were accessing antiretroviral therapy in June 2017.
- 36.7 million [30.8 million–42.9 million] people globally were living with HIV in 2016.
- 1.8 million [1.6 million–2.1 million] people became newly infected with HIV in 2016.
- 1 million [830 000–1.2 million] people died from AIDS-related illnesses in 2016.
- 76.1 million [65.2 million–88.0 million] people have become infected with HIV since the start of the epidemic.
- 35.0 million [28.9 million–41.5 million] people have died from AIDS-related illnesses since the start of the epidemic.

People living with HIV

In 2016, there were 36.7 million [30.8 million–42.9 million] people living with HIV.

- 34.5 million [28.8 million–40.2 million] adults
- 17.8 million [15.4 million–20.3 million] women (15+ years)
- 2.1 million [1.7 million–2.6 million] children (<15 years)

Figure: 01 Adults and children estimated to be living with HIV (1990–2016)

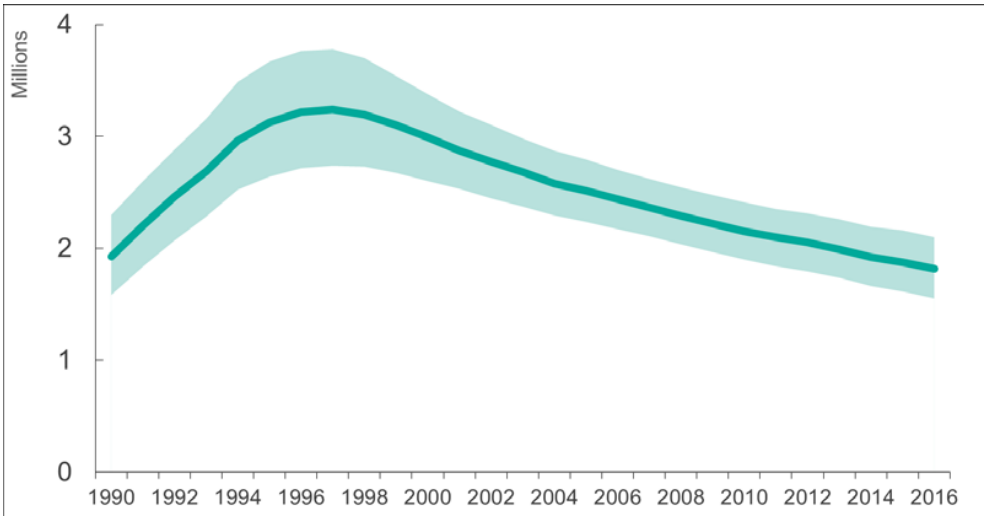


Source: UNAIDS DATA 2017

New HIV infections

- Worldwide, 1.8 million [1.6 million–2.1 million] people became newly infected with HIV in 2016.
- Since 2010, new HIV infections among adults declined by an estimated 11%, from 1.9 million [1.6 million–2.1million] to 1.7 million [1.4 million–1.9 million] in 2016.
- New HIV infections among children declined by 47% since 2010, from 300 000 [230 000–370 000] in 2010 to 160 000 [100 000–220 000] in 2016.

Figure 02: Adults and children newly infected with HIV (1990–2016)



Source: UNAIDS DATA 2017

About 5000 new HIV infections (adults and children) a day in 2016

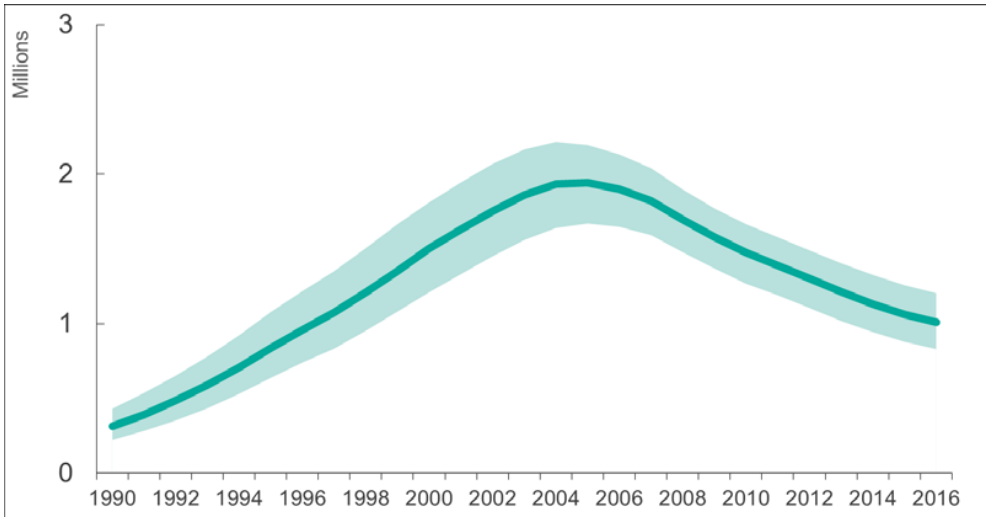
- About 64% are in sub-Saharan Africa
- About 400 are among children under 15 years of age
- About 4500 are among adults aged 15 years and older, of whom:
  - almost 43% are among women
  - about 37% are among young people (15–24)
  - about 22% are among young women (15–24)

AIDS-related deaths

AIDS-related deaths have fallen by 48% since the peak in 2005.

- In 2016, 1 million [830 000–1.2 million] people died from AIDS-related illnesses worldwide, compared to 1.9 million [1.7 million–2.2 million] in 2005 and 1.5 million [1.3 million–1.7 million] in 2010.

Figure 03: Adult & child deaths due to AIDS (1990–2016)



Source: UNAIDS DATA 2017

HIV/Tuberculosis

- ❖ Tuberculosis remains the leading cause of death among people living with HIV, accounting for around one in three AIDS-related deaths.
- ❖ In 2015, there were an estimated 10.4 million cases of tuberculosis disease globally, including 1.2 million [11%] among people living with HIV.
- ❖ Tuberculosis-related deaths among people living with HIV fell by 33% between 2005 and 2015.

    - However, almost 60% [57%] of tuberculosis cases among people living with HIV were not diagnosed or treated, resulting in 390 000 tuberculosis-related deaths among people living with HIV in 2015.

People living with HIV accessing antiretroviral therapy

- ❖ As of June 2017, 20.9 million [18.4 million–21.7 million] people living with HIV were accessing antiretroviral therapy, up from 17.1 million [15.1 million–17.8 million] in 2015 and 7.7 million [6.8 million–8.0 million] in 2010.
- ❖ In 2016, around 53% [39–65%] of all people living with HIV had access to treatment.
    - Some 54% [40–65%] of adults aged 15 years and older living with HIV had access to treatment, but just 43% [30–54%] of children aged 0–14 years had access.
- ❖ In 2016, around 76% [60–88%] of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their babies.

2.2 HIV prevention and Sustainable Development Goals

Efforts to scale up HIV prevention can build synergies with broader efforts to achieve the 2030 Agenda for Sustainable Development. Primary prevention of HIV contributes directly towards achieving six of the Sustainable Development Goals (SDGs), where ongoing HIV transmission currently holds back progress (Figure 04). For example, transformative AIDS responses can provide an important impetus to social protection schemes, using cash transfers to reduce HIV vulnerability and risk in ways that contribute to gender equality and the empowerment of all women and girls, support education and reduce poverty. Similarly, progress on other SDGs contributes to HIV prevention through policies that seek to leave no one behind. For example, improved opportunities for education, including comprehensive sexuality education, will empower young people and promote improved health outcomes. HIV-sensitive universal health coverage policies can play a vital role in ensuring access to key HIV prevention interventions.

Hence, HIV Prevention 2020 contributes to the Sustainable Development Goals. Efforts to achieve these goals will in turn support HIV prevention outcomes.

Figure 04: HIV prevention and the Sustainable Development Goals

Table 01:

Global Summary of HIV/AIDS, 2001 – 2016

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
2016*	36.7 million	1.8 million	0.8	1.0 million
2015	36.7 million	2.1 million	0.8	1.1 million
2014	36.9 million	2 million	0.8	1.2 million
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: SAARC Epidemiological Response on HIV/AIDS – 2016, * UNAIDS DATA 2017*

3. HIV/AIDS SIUATION 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 2.28 million HIV infected people and 0.07 million AIDS deaths in 2016. **Table 02** shows the estimated number of People Living with HIV (PLHIV) in eight Member States of the SAARC Region in the year 2016. 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: Estimated number of PLHIV, New HIV Infections, AIDS Deaths, Prevalence rate and incident rate in SAARC Region-2016

Country	*Population('000)***	*Estimated No. of PLHA*	*HIV Prevalence Rate (%)*	*Estimated New HIV infection in 2016(all ages)*	*HIV Incidence per 1000 population*	AIDS-related Deaths
Afghanistan	35000	7500	< 0.1	< 1000	0.03	<500
Bangladesh	163000	12000	< 0.1	1500	<0.01	1000
Bhutan	802	N/A	N/A	N/A	NA	NA
India	1324000	2.1 million	0.3	80000	NA	62000
Maldives	379	N/A	N/A	N/A	NA	NA
Nepal	29000	32000	0.2	<1000	0.03	1700
Pakistan	193000	130000	0.1	19000	0.1	5500
Sri- Lanka	21000	4000	< 0.1	< 1000	0.03	<200
Regional	**1.76 billion**	**2.28 million**		**0.1 million**		**0.07 million**

source: http://aidsinfo.unaids.org/data sheet 2017

*** Population taken from WHO Global Tuberculosis Report-2017*

The overall adult HIV prevalence in SAARC region remains below 1%. However, there are important variations existing between countries. Of the estimated number of 2.28 million PLHIV in SAARC region, 2.1 million were living in India in 2016 (Table 02).

Table 03: Progress towards 90-90-90 targets in SAARC Region 2016

Country	*Percent of people living with HIV who know their status*	*Percent of people who know their status who are on ART*	*Percent of people on ART who achieve viral suppression*
Afghanistan	29	26	86
Bangladesh	34	46	N/A
Bhutan	N/A	N/A	N/A
India	77	63	N/A
Maldives	N/A	N/A	N/A
Nepal	56	72	88
Pakistan	N/A	N/A	65
Sri- Lanka	47	56	N/A
Regional	**49**	**53**	**80**

Source: http://aidsinfo.unaids.org/data sheet 2017

Progress towards 90-90-90 targets, in the SAARC Region there were 49 Percent of people living with HIV who know their status, 53 Percent of people who know their status who are on ART and 80 Percent of people on ART who achieve viral suppression in the year 2016. However, country wise progress towards 90-90-90 targets has shown in table 03.

Table 04: Estimated size of population in key populations in SAARC Region-2016

Country	Sex Worker	Men who have sex with men	People who inject drugs	Transgender	Prisoners
Afghanistan	13000	11000	41000	NA	28000
Bangladesh	139961	101695	33066	10199	73433
Bhutan	NA	NA	NA	NA	NA
India	657829	238175	127532	25984	185182
Maldives	NA	NA	NA	NA	NA

Nepal	67300	60333	30868	21460	NA
Pakistan	229441	832213	113776	52646	77500
Sri- Lanka	14132	7551	423	NA	NA
Regional	**1121663**	**1250967**	**346665**	**110289**	**364115**

Source: http://aidsinfo.unaids.org/data sheet 2017

Country wise estimated size of populations in key populations has shown in table 04. India accounted for highest in size of populations among Sex Worker (SW), People who inject drugs and prisoners, however Pakistan accounted for highest in size of populations among Men who have sex with men (MSM) and Transgender.

Table 05: Elimination of Mother - to - Child Transmission in SAARC Region-2016

Country	Pregnant women needing ARV for PMTCT	Pregnant women who received ARV for PMTCT	ARV for PMTCT Coverage (%)
Afghanistan	<200	10	5
Bangladesh	<200	20	17
Bhutan	NA	NA	NA
India	35000*	14000	NA
Maldives	NA	NA	NA
Nepal	<500	180	64
Pakistan	2500	130	4
Sri- Lanka	NA	NA	NA
Regional	**37500**	**14340**	**38**

** Data of the year 2015*

Source: http://aidsinfo.unaids.org/data sheet 2017

Elimination of Mother to child transmission, in the SAARC Region there were 37500 pregnant women needing ARV for PMTCT, 14340 pregnant women who received ARV for PMTCT and 38 Percent ARV for PMTCT Coverage shown in table 05. About one million people receiving ART in year 2016 and 80200 deaths averted due to ART in 2015 in SAARC Region (Table 06)

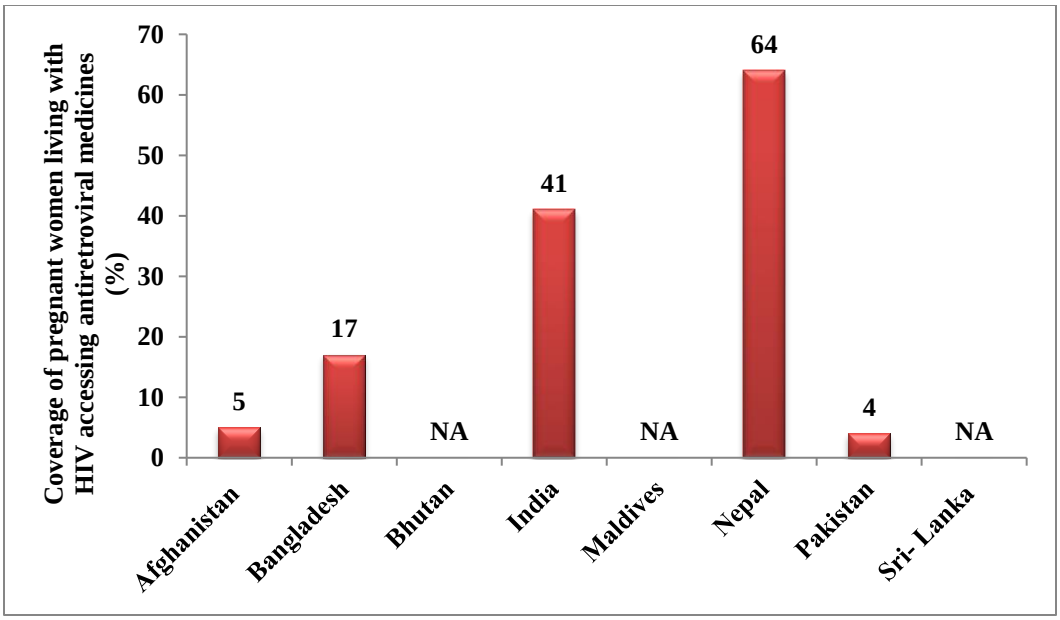
Table 06: Number of people living with HIV receiving ART and deaths averted due to ART in 2016

Country	No. of People receiving ART (2016)	Deaths averted due to ART (2015)
Afghanistan	560	<100
Bangladesh	1800	<200
Bhutan	260	NA
India	1036000	79000
Maldives	NA	NA
Nepal	13100	1200
Pakistan	8900	<1000
Sri- Lanka	1100	<200
Regional	**1061720**	**80200**

Source: http://aidsinfo.unaids.org/data sheet 2017

The figure 05 shows the Coverage of pregnant women living with HIV accessing antiretroviral medicines in the SAARC Region. In the year 2016, there was 64 % coverage covered by Nepal, which is the highest percentage among SAARC Member States.

Figure 05: Coverage of pregnant women living with HIV accessing antiretroviral medicines in the SAARC Region 2016



4. COUNTRY PROFILES

Afghanistan

Bangladesh

Bhutan

India

Maldives

Nepal

Pakistan

Sri-Lanka

AFGHANISTAN

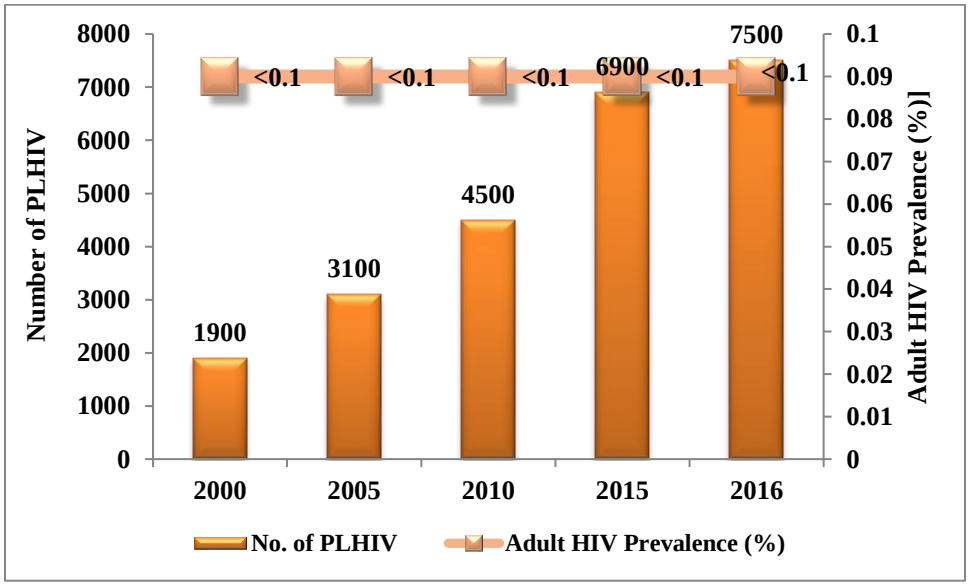
Islamic Republic of Afghanistan is one of the eight member countries of SAARC. It is a land-locked country, bordered by Pakistan in the south and east, Iran in the west, Turkmenistan, Uzbekistan and Tajikistan in the north, and China in the far northeast. The land area is 647,500 square kilometers and a population of 35 million (WHO Global Tuberculosis Report-2017). Afghanistan consists of 34 provinces and 398 districts.

Overview of the HIV/AIDS epidemic

The HIV epidemic in Afghanistan is low and on the verge of being concentrated; this means that HIV positives are mainly among key affected populations. The recent Integrated Biological Behavioral Surveillance Survey (IBBS) in 2012 shows an overall 4.4% of HIV prevalence among (People Who Inject Drugs (PWIDs). Prevalence of HIV among general population was 0.1% .

Figure 06 shows the trend of estimated adult HIV prevalence and number of PLHIV in Afghanistan from 2000 to 2016.A total 7500 estimated Number of People Living with HIV/AIDS (PLHIV) in the country in 2016. Less than 1000 estimated newly infected PLHIV and less than 500 an estimated number of deaths due to AIDS were in 2016.

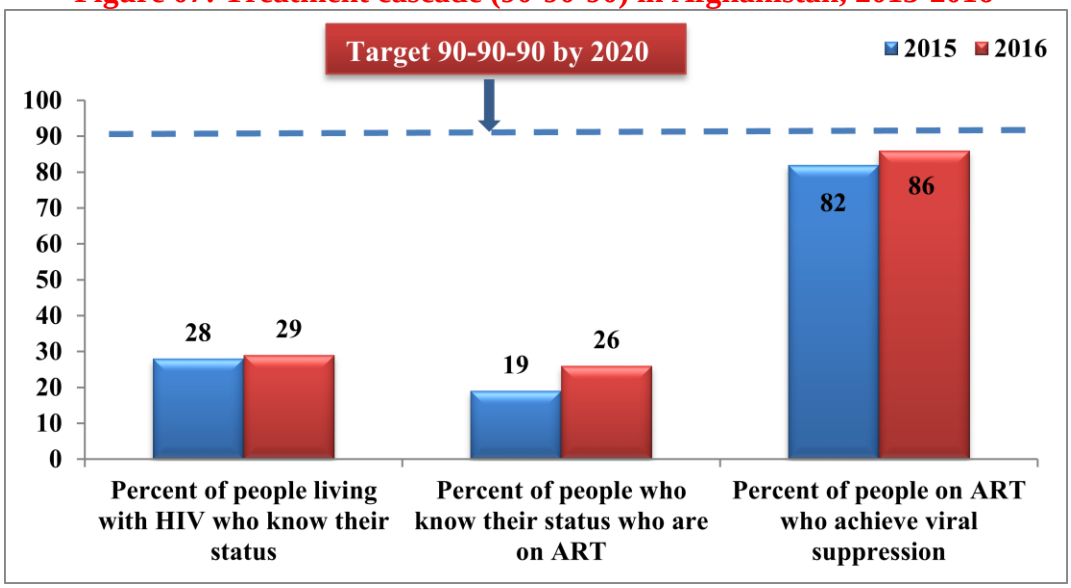
Figure 06: Estimated Adult HIV Prevalence & Number of PLHIV, Afghanistan, 2000-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 07 shows treatment cascade (90-90-90) in Afghanistan. In year 2016 there were 29 Percent of people living with HIV who know their status, 26 Percent of people who know their status who are on ART and 86 Percent of people on ART who achieve viral suppression in the year 2016. From the figure it seems, viral suppression may reach the target by 2020.

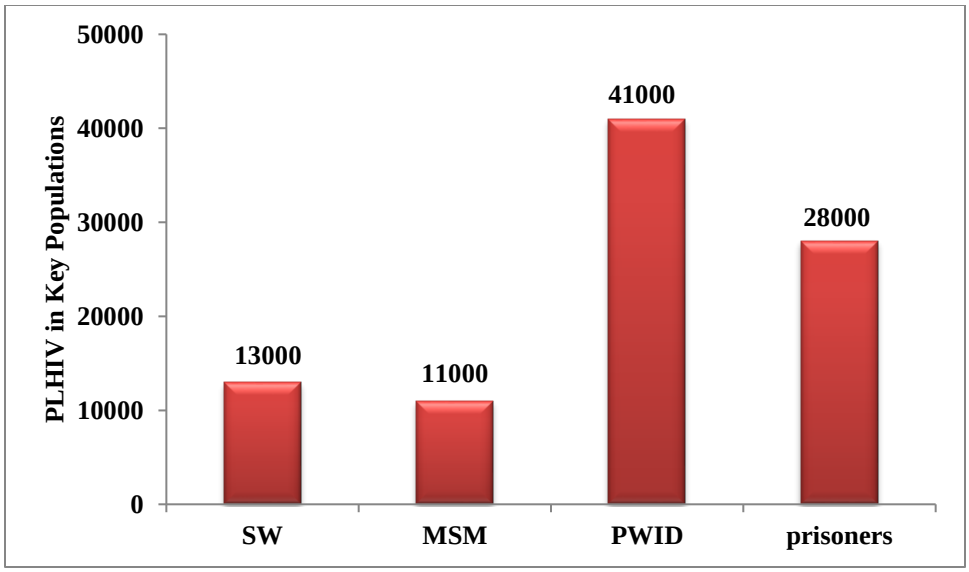
Figure 07: Treatment cascade (90-90-90) in Afghanistan, 2015-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 08 shows the number of estimated People living with HIV/AIDS (PLHIV) in key populations in Afghanistan. In 2016, there were 13000 Sex Worker (SW), 11000 Men who have sex with men (MSM), 41000 People who inject drugs (PWID) and 28000 prisoners.

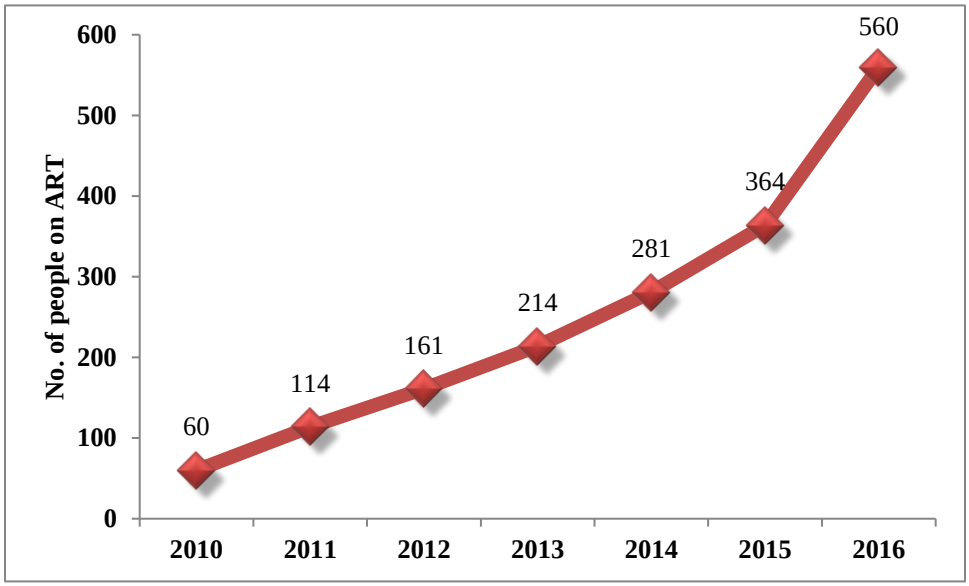
Figure 08: Number of estimated PLHIV in Key Populations in Afghanistan, 2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 09 shows, ART scale up of Afghanistan from 2010-2016, which has increased from 60 to 560.

Figure 09: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Priority Areas within NACP

- Increase coverage of prevention interventions for KAPs and their partners, vulnerable populations, as well as among general population.

- Increase coverage of comprehensive and integrated HIV treatment, care, and support for PLHIV and their families.
- Ensure availability and use of strategic information for decision-making.
- Create supportive and enabling environment for a sustained and effective national response to HIV and AIDS.
- Strengthening the governance and program management at national and provincial levels.

NACP Target Groups

- High Risk Group
    - People who Inject Drugs (PWIDs)
    - Female with High Risk Behavior (WHRB)
    - Male with High Risk Behavior (MHRB)
    - Prisoners
- Vulnerable Group
    - Long distance drivers
    - IDP, Returnees and Refugee
    - Uniformed Service Personnel
    - Migrant Workers
    - Youth and Street Children
    - Spouse of most at risk population
- General Population

Risk Factors

- Drug use, cultivation, trafficking
- Open border
- Poverty
- Insecurity
- Low literacy rate
- Low knowledge of HIV/AIDS
- Population movement

Challenges

- limitation of budget (WB)

- Stigma and discrimination
- Access to hidden population
- Inadequate Political commitments
- Limited geographical coverage if high risk population
- Lack of communication and coordination

AFGHANISTION

Populations(mid-year)			35 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	<500 (<500-<1000)	<1000 (<500-1400)	<1000 (<500-3000)
HIV Incidence per 1000 populations	0.02 (0.01-0.04)	0.02 (0.01-0.05)	0.03 (0.01-0.1)
AIDS related deaths	<200 (<100-<500)	<500 (<200-<500)	<500 (<200-<1000)
People living with HIV	3100 (1900-5300)	4500 (2700-8900)	7500 (3900-19000)
90-90-90			**2016**
People living with HIV who know their HIV Status		2100	29% (17%-79%)
People living with HIV who are on Treatment		<1000	7% (4%-19%)
Adults living with HIV who are on treatment		520	7% (4%-19%)
People living with HIV who are virally suppressed		<500	6 % (3%-16%)
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		<100 (<100-<100)	<100 (<100-<200)
Children living with HIV who are on treatment		1% (1%-2%)	17 % (10%-37%)
Coverage of pregnant women living with HIV accessing antiretroviral medicines		2 % (1%-5%)	5% (3%-12%)
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			<500 (<500-<1000)
Proportion of people living with HIV with active TB in HIV care			5.1%
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			12.4 %
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			-
Males			-
Females			-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			-
Men aged 15-49 who are circumcised			99.9%
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			60.2%
POLICIES AND REGULATIONS			**2016**

Community delivery of treatment	No
Laws requiring parental consent for adolescents to access sexual and reproductive health services	No
TRIPS flexibilities incorporated in national legislation	No
Laws or policies restricting entry, stay and residence of people living with HIV	No
Criminalization of transmission of, nondisclosure of, or exposure to HIV	No
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	13000
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to sex workers enrolled in prevention programmes (2016)	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	41000
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Clean needle use at last injection	-
Needles and syringes distributed per person who injects (2016)	-
Coverage of HIV prevention programmes	-
Coverage of opioid substitution therapy (2016)	2.03%
Naloxone available (2016)	No
Safe injection rooms available (2016)	No
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	11000
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to men who have sex with men in prevention programmes (2016)	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	-
HIV prevalence	-

Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PRISONERS	
Estimated size of population	28000
HIV prevalence	-
Antiretroviral therapy coverage	40%
HIV prevention programmes in prisons (2016)	
Condoms distributed	67925
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

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 163 million (WHO Global Tuberculosis Report -2017), 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

National AIDS Policy and National AIDs committee was formed in 1985 even before the detection of the 1st HIV case in the country in 1989.The 1st comprehensive HIV prevention program was started in the country in the mid 90 by NGOs. Government initiated prevention program in 2004 under health sector program. The Global Fund has been supporting in HIV/ AIDS program since 2004. In Bangladesh -61 pediatric cases has diagnosed, among 61 cases one case from blood transfusion and remaining 60 cases are vertical transmission.

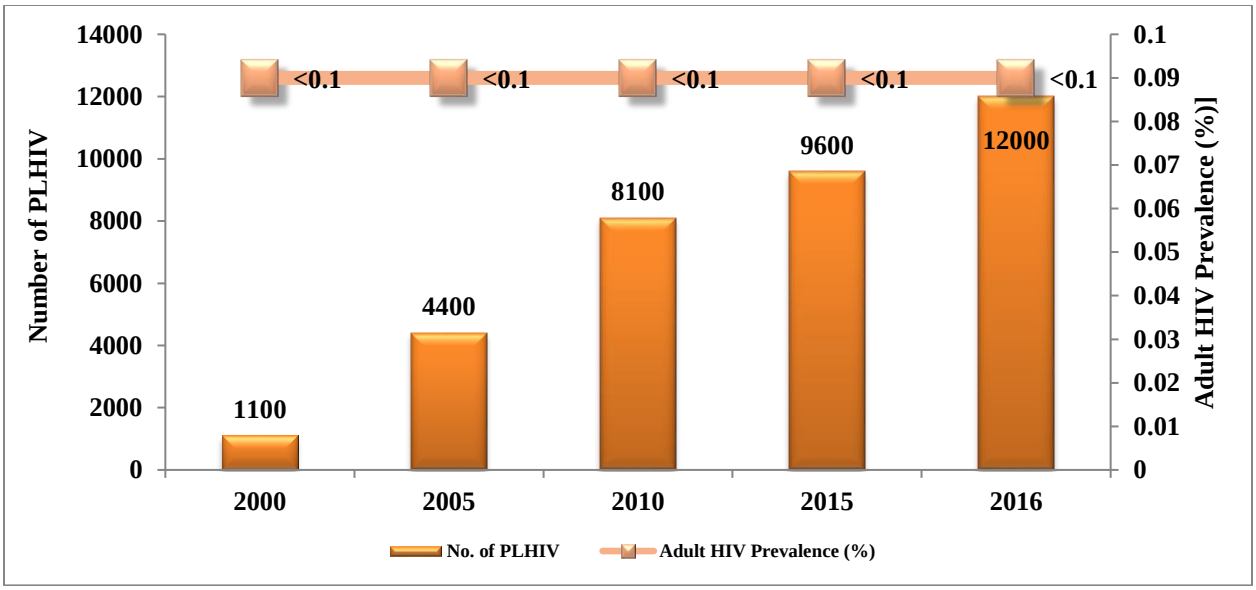
Reported Cases-2016

New HIV positive and Death Cases

Indicator	New Cases in 2016	Cumulative Cases as of 2016
HIV positive	578	4,721
Death	141	799
Over 32% of reported cases of HIV positive are migrant populations.		

In 2016 the Number of New HIV infected is 1500 and the Number of HIV/AIDS related Death was 1000. Bangladesh still a low prevalent country in the region with prevalence of less than 0.1% among the general population and less than 1% among Most at risk population except transgender. Figure 10 shows the trend of estimated PLHIV from 2000 to 2016.

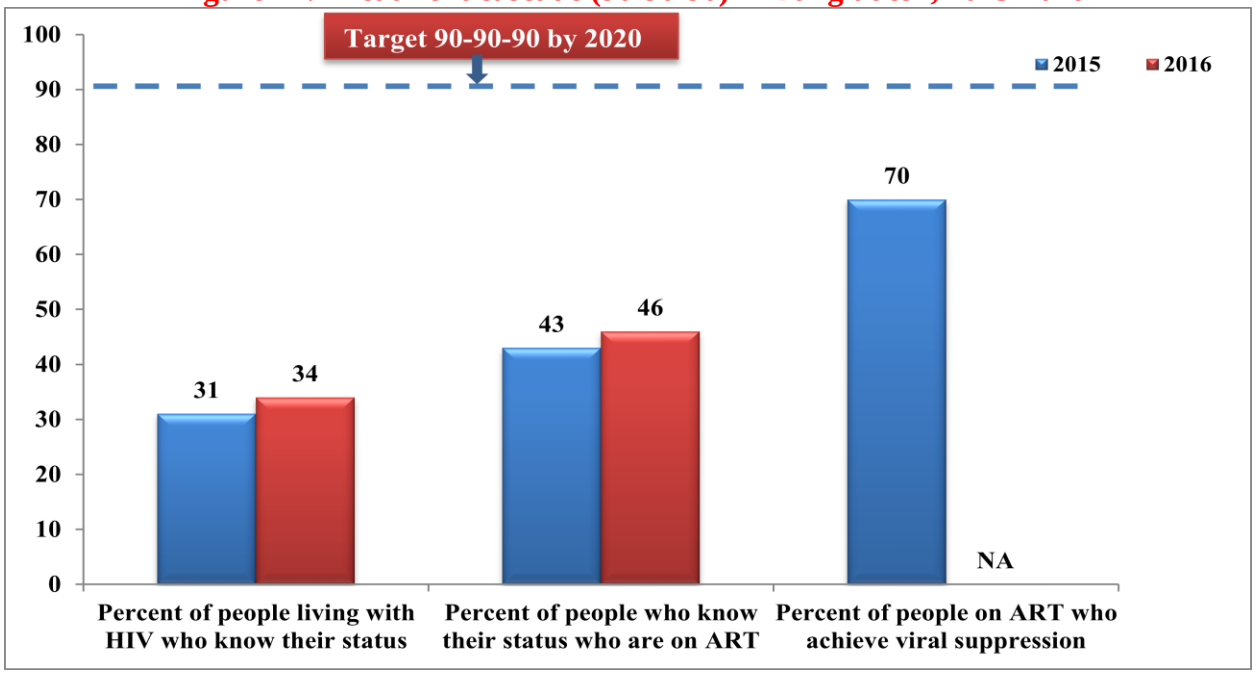
Figure 10: Estimated Adult HIV Prevalence & Number of PLHIV, 2000-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 11 shows treatment cascade (90-90-90) in Bangladesh. In year 2016 there were 34 Percent of people living with HIV who know their status and 46 Percent of people who know their status who are on ART. 70 Percent of people were on ART who achieve viral suppression in the year 2015. From the figure it seems, viral suppression may reach the target by 2020.

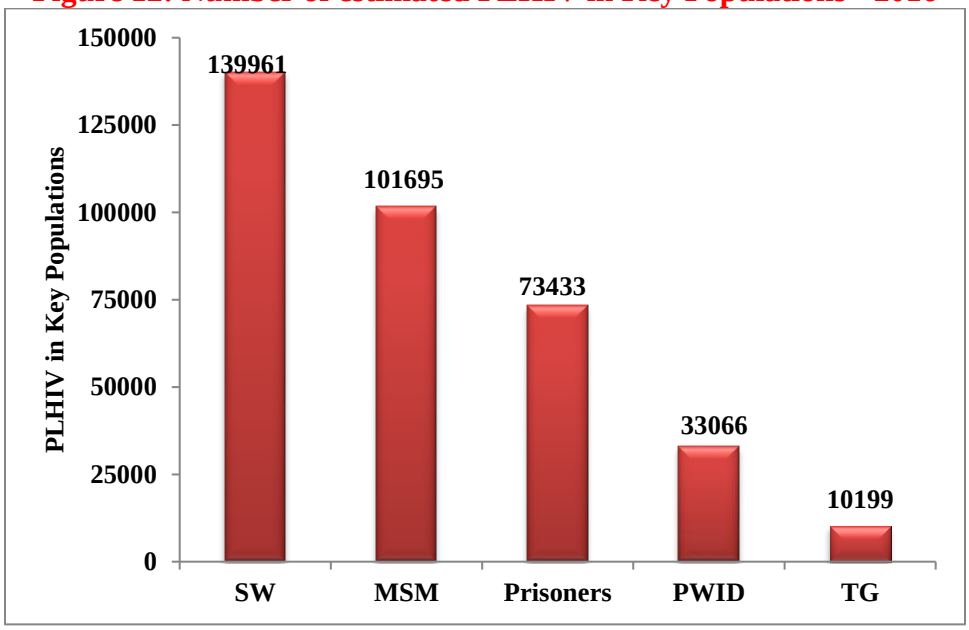
Figure 11: Treatment cascade (90-90-90) in Bangladesh, 2015-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

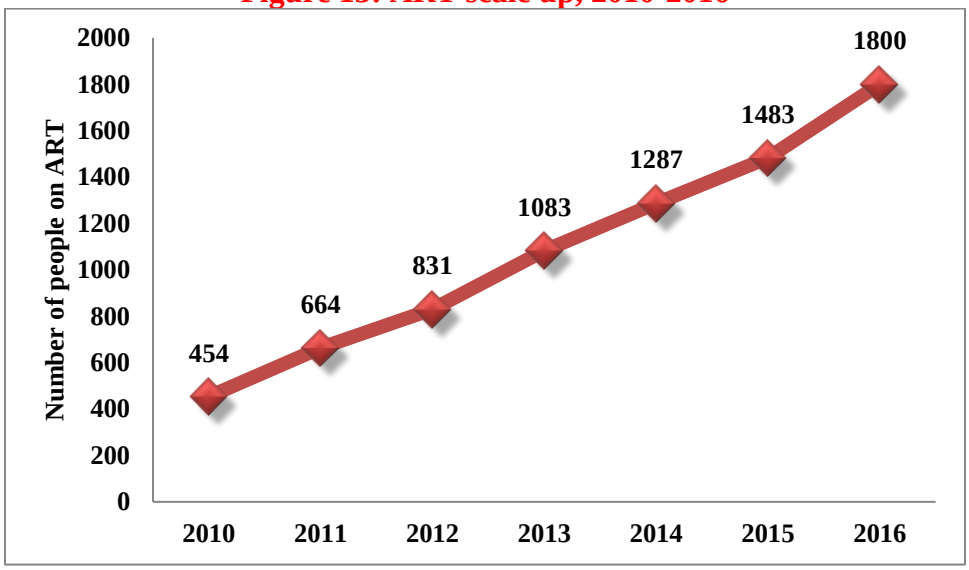
The number of estimated PLHIV in Key population were 139961 in SW, 101695 in MSM, 33066 in PWID, 13433 in Prisoners and 10199 in transgender (Figure 12).

Figure 12: Number of estimated PLHIV in Key Populations - 2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 13: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 13 shows the scaling up of number of people on ART from 454 in 2010 to 1800 in 2016.

National Response for HIV/AIDS

- ASP, DGHS - the nodal body for national response to HIV and AIDS and performs the stewardship role and implementing prevention and care support program

- Save the Children and icddr,b is providing HIV prevention services for Key Population across the country under Global Fund (donor) support
- Key Population as per Strategic Plan
    - Female Sex Worker (brothel, hotel, street, residence)
    - People who Inject Drug (PWID)
    - Men sex with Men (MSM)/ Transgender / Hijra
- Vulnerable Population
    - Internal and external migrants
    - Drug user including heroin smoker
    - Adolescent and young people

AIDS/ STD Programme (ASP)

- ASP - the nodal body for national response to HIV and AIDS and performs the stewardship role and implementing the program under the guidance of Directorate General of Health Services (DGHS), its established in 1997.
- National AIDS Policy and National AIDs committee was formed in 1985 even before the detection of the 1st HIV case in the country in 1989
- Major role of ASP;
    1. Strategic Direction
    2. Management of Coordination
    3. Prevention program
    4. Treatment , Care & support for PLHIV
    5. Monitoring & Evaluation of programs

Risk Factors

- High rate of needle sharing among PWID

- Low condom use among key populations (15% consistent condom use- Size Est. Survey - 2015)
- External and Internal migration
- High HIV prevalence in neighboring countries with porous border
- Limited correct knowledge on HIV and AIDS among young people
- High prevalence of STIs among Key Populations

Strength of the Country

- Political Commitment
- GO-NGO Collaboration
- People's Participation
- Donor Support
- Media Support

BANGLADESH

Populations(mid-year)			163 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	1600 (1400-1800)	1400 (1300-1500)	1500 (1200-1600)
HIV Incidence per 1000 populations	0.01 (0.01-0.01)	<0.1 (<0.01-0.01)	<0.01 (<0.01-0.01)
AIDS related deaths	<500 (<500-<500)	<1000 (<1000-<1000)	1000 (<1000-1100)
People living with HIV	6100 (5400-6800)	9700 (8500-11000)	12000 (10000-14000)
90-90-90			**2016**
People living with HIV who know their HIV Status		3900	34 % (28%-38%)
People living with HIV who are on Treatment		1800	16 % (13%-18%)
Adults living with HIV who are on treatment		1700	15% (13%-17%)
People living with HIV who are virally suppressed		-	-
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		<100 (<100-<100)	<100 (<100-<100)
Children living with HIV who are on treatment		13 % (11%-15%)	39% (33%-34%)
Coverage of pregnant women living with HIV accessing antiretroviral medicines		15% (13%-18%)	17 % (15%-21%)
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			<1000 (<500-<1000)
Proportion of people living with HIV with active TB in HIV care			11.4%
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			-
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			-
Males			-
Females			-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			-
Men aged 15-49 who are circumcised			Not applicable
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			-

POLICIES AND REGULATIONS	2016
Community delivery of treatment	No
Laws requiring parental consent for adolescents to access sexual and reproductive health services	Yes, <18 years
TRIPS flexibilities incorporated in national legislation	Yes
Laws or policies restricting entry, stay and residence of people living with HIV	No
Criminalization of transmission of, nondisclosure of, or exposure to HIV	No
Recommended CD4 level for treatment initiation	<500 cells/mm^3
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	139961
HIV prevalence	0.2 %
Know HIV status	31.2%
Antiretroviral therapy coverage	-
Condom use	66.7%
Condoms distributed to sex workers enrolled in prevention programmes (2016)	-
Coverage of HIV prevention programmes	15.2%
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	33066
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	34.9%
Clean needle use at last injection	83.9%
Needles and syringes distributed per person who injects (2016)	157
Coverage of HIV prevention programmes	27.8%
Coverage of opioid substitution therapy (2016)	2.4%
Naloxone available (2016)	No
Safe injection rooms available (2016)	No
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	101695
HIV prevalence	0.2%
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	45.8%
Condoms distributed to men who have sex with men in prevention programmes (2016)	-
Coverage of HIV prevention programmes	4.4 %
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	10199

HIV prevalence	1.4%
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	41.1%
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PRISONERS	
Estimated size of population	73433
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

BHUTAN

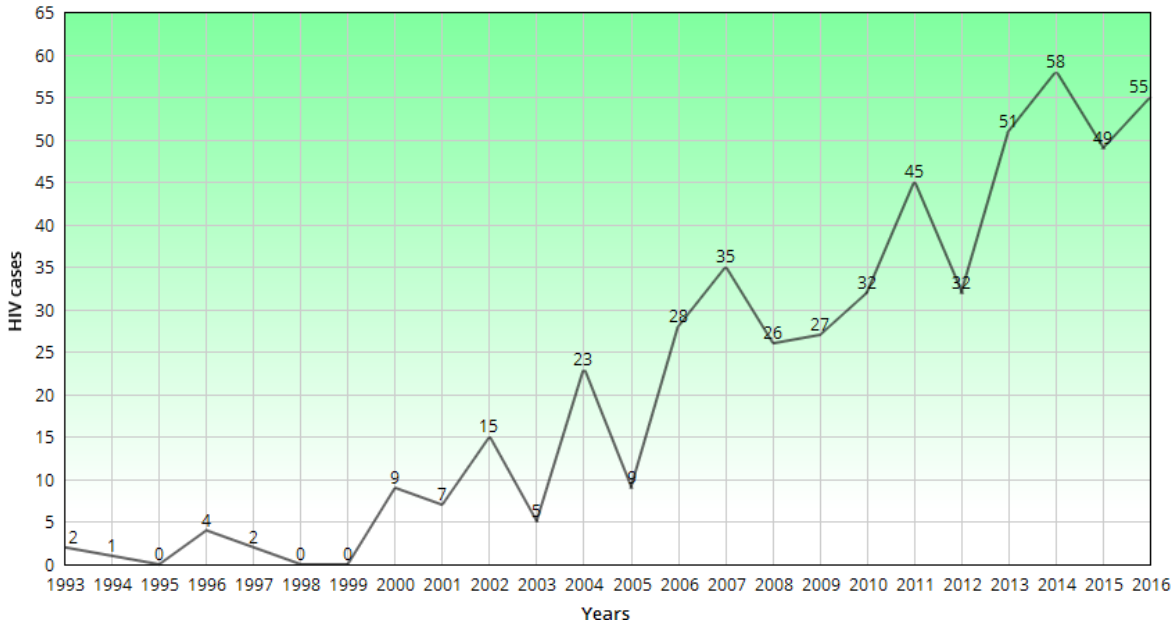
Bhutan is a land locked country situated in the Himalayas, it has border with China and India. Bhutan has an area of 38,394 sq km and the altitude varying from 180 m to 7,550 m above sea level. The total population of Bhutan is 802000. The country is divided into 20 districts for administrative purposes.

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

The first case of HIV was detected in 1993, and the number of cases increased from the year 2000 onwards, with more than 80% of the total cases reported within the last 10 years.

Figure: 14 Trends of HIV cases among General Populations in Bhutan from 1993-2016

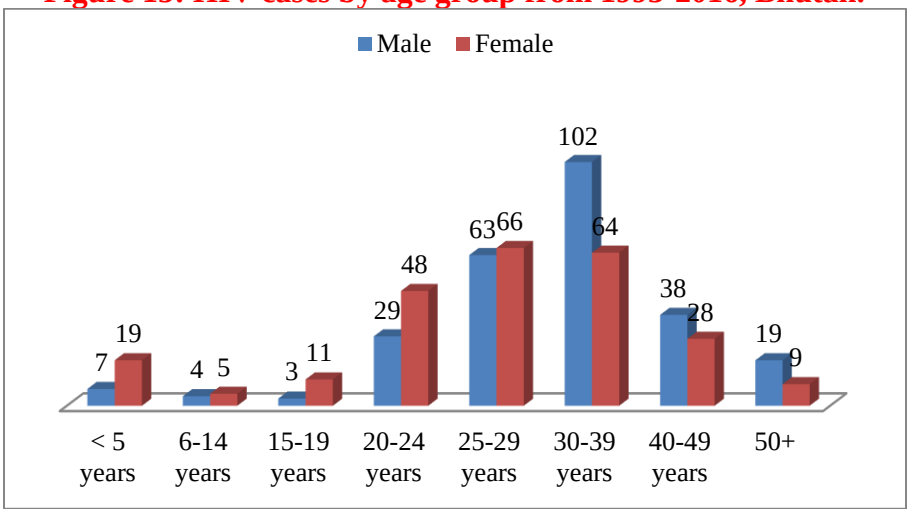


Source: NACP-Bhutan report 2016

The case detection has improved with increasing uptake of HIV counseling and testing (HCT) services. Since 2006 no less than 25 cases have been detected every year and in the last three years the average yearly detection was 53 cases. As it was well understood that Bhutan is one of the few countries in South Asia that continue to experience a low adult (15-49years) HIV prevalence of below 0.2 percent (0.1-0.6%). Although, the UNAIDS estimate approximately

about 1,100 HIV cases in Bhutan in year 2016, the total case detected since the first detection in 1993 stands at 515 thus creating a case detection gap of 53%. Of the total reported cases approximately 91% of the total HIV cases were reported between 2004 and 2016 attributable to the intensified HTC services and aggressive awareness programs mostly funded by the World Bank and the Global Fund.

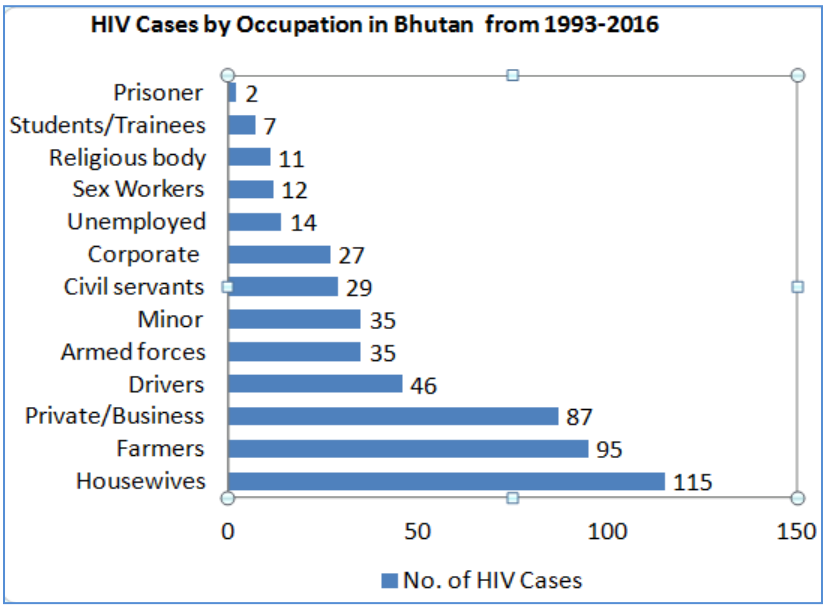
Figure 15: HIV cases by age group from 1993-2016, Bhutan.

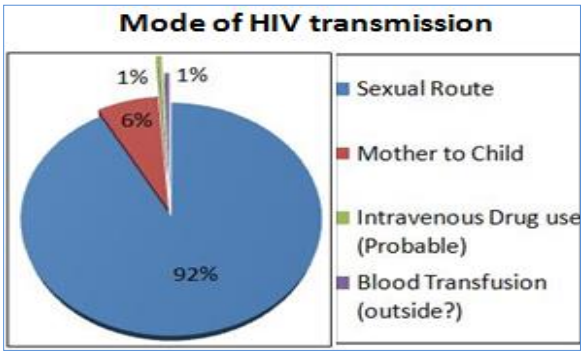


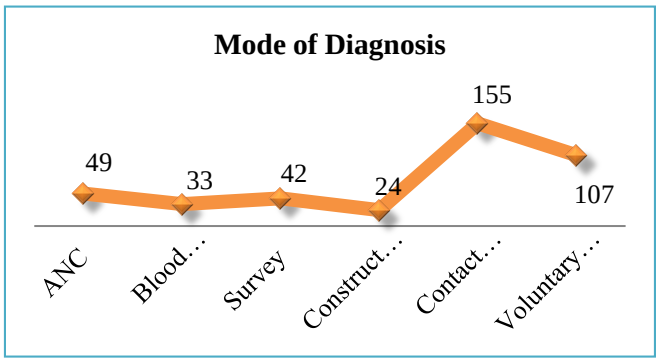
Source: NACP-Bhutan report 2016

The reported cases are predominantly (85%) among the productive age group of 20-49 years and (17%) among the youth 15–24 years in Bhutan. Of the total population, 56 % is below the age of 24 years therefore young age sexuality and HIV infection is a concern for Bhutan. Unlike in many of the countries where female are disproportionally affected by HIV but in Bhutan over the two decades there hasn't been any significant difference in terms of gender with equal proportion of male and female detected with HIV. However, the recent new HIV infection showed that among the males older males are more infected while among the females younger females are more infected. This shows that the likelihood of older men being sexually active with younger females is high however owing to inadequate data we cannot rule out the prevalence of intergenerational sex in Bhutan despite the high risk associated to such sexual practices.

Figure 16: Bhutan HIV, AIDS Epidemiological Background







Above graph clearly shows that all sections of Bhutanese population such as (prisoners, students, religious body etc) were infected which indicating the diffuse nature of HIV epidemic in Bhutan. The diffuse epidemiological pattern in Bhutan is one of the challenges that we are confronted with because in such epidemic we don't have defined risk population to focus our interventions rather the interventions remains vague. This is accounts to more resources and intensive planning approach to reach all the population.

About 92% of the reported cases have acquired the HIV infection through the heterosexual followed by MTCT (6%) and rest through blood transfusion and IDUs. The several behavioral studies among the Bhutanese population also showed high multiples sexual practices and low condom use including the emergence of transactional sex in the booming entertainment centers in urban areas. In terms of case finding, majorities (155) of the reported cases were detected through contact tracing and VCT followed by ANC and onsite screenings.

Figure 17: Treatment cascade 2015-2016

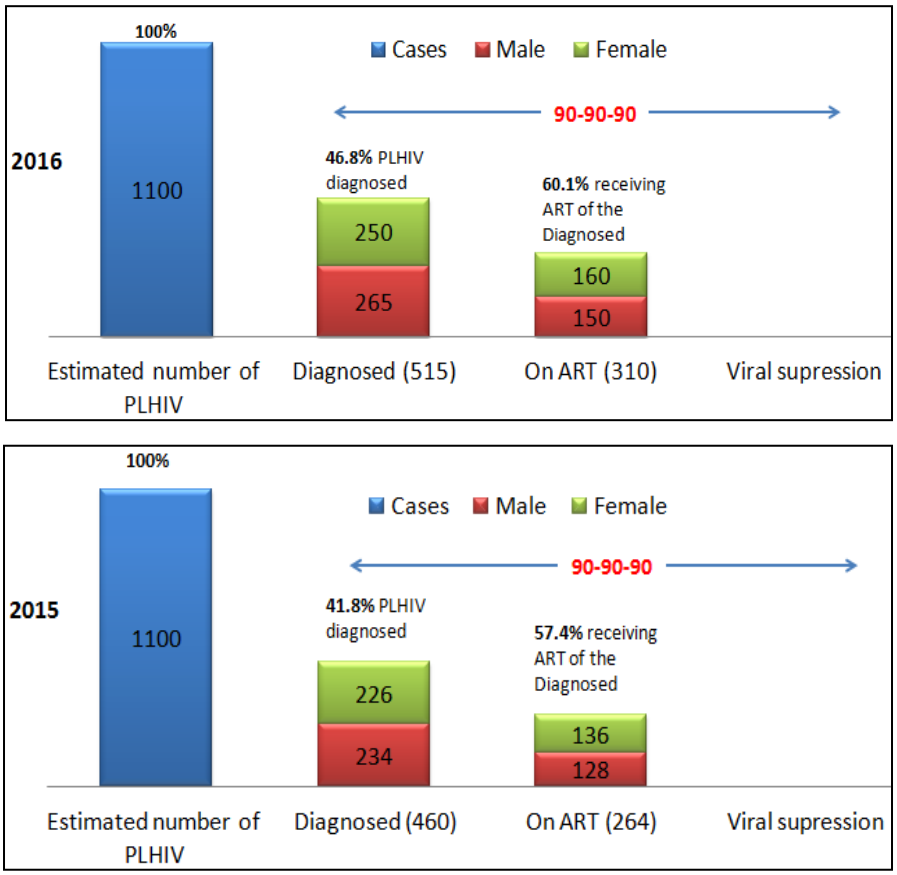
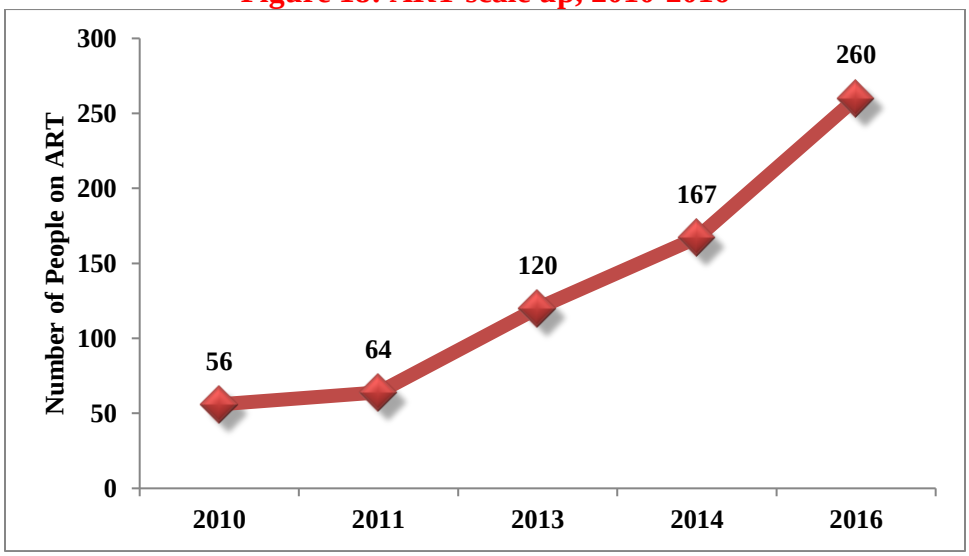


Figure 18: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 18 shows, the trend of ART scale up from 2010-2016.Till date there are 260 people on ART.

Major Risk Factors

- Age and Sex
- Individual lifestyle
- Living and working condition
- Socio-economic status
- Socio - cultural practices

Major achievements

- IBBS study conducted for 6 key populations.
- Formative Assessment on Stigma and Discrimination Impacting universal Access to HIV and Health Services for MSM & TG.
- Mapping and Size Estimation of MSM and Transgender (TG).
- HTC services by instituted in all there tiers of health system.
- HIV treatment guideline revised and health care providers trained.
- Adoption of Treat All Policy
- 3rd NSP III developed in line with Fast Track response to end HIV/AIDS by 2030
- High level advocacy to GPs and MSM/TG.
- Baseline Viral load for 120 PLHIV conducted

Innovations

1. **Bringing HIV Testing to the People**
   a) **HTC**-A gateway for HIV prevention, care and treatment. Providing HIV testing services to all the people who need to know their status is the top most priority of the national program. As a result, to maximize our coverage the mobile testing van has been instituted to enhance the greater accessibility of HTC services by taking the services to the people instead of they coming to us in a established health centers. The mobile testing is aim at reaching the most at risk population (MARPS) including the migrant workers. It is also meant to use during the high level advocacy programs in the districts including the World AIDS Day and some active surveillance.
   b) **Rapid HIV Test Kits**: The new rapid point of care test device is being introduced since 2013 as part of the early case diagnosis within a shorter period of time. With the

introduction of this test kits the health centers can generate a rapid test result within 10-15mins.

2. Care and Treatment

a) Portable CD4 count machines: 1. Absolute CD4 count in less than 20 minutes. 2. Requires no external controls or calibration, 3. Portable, small and lightweight, weighing just 2.5kg. Therefore, Alere Pima™ test gives you the tools, at the point-of-care, to enhance patient management, allowing you to make important treatment decisions and provide antiretroviral therapy, if needed. Since it is portable and can be run by charged battery it empowers you to take healthcare to the patient rather than making the patient come to you. Such machines are placed in strategic location in Major Health center of Bhutan for easy accessibility.

b) GeneXpert Machine: Previously we rely on CD4 count for overall monitoring of the PLHIV who are on the treatment cascade. However, with the introduction of the geneXpert machine patient monitoring will be much more effective as compared to just relying on the CD4 count.

c) Fixed Dose Combination pills:

d) Pill Box:

3. Innovation-Condom Promotion

We will be installing a condom vending machines in a strategic locations for effective distribution and easy accessibility. The condom vending machines will be installed under the mechanism of Public Private Partnership for its sustainability.

BHUTAN

Populations(mid-year)			<1 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	-	-	-
HIV Incidence per 1000 populations	-	-	-
AIDS related deaths	-	-	-
People living with HIV	-	-	-
90-90-90			**2016**
People living with HIV who know their HIV Status		-	-
People living with HIV who are on Treatment		<500	-
Adults living with HIV who are on treatment		260	-
People living with HIV who are virally suppressed		-	-
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		-	-
Children living with HIV who are on treatment		-	-
Coverage of pregnant women living with HIV accessing antiretroviral medicines		-	-
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			<200 (<100-<200)
Proportion of people living with HIV with active TB in HIV care			-
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			23.2%
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			-
Males			-
Females			-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			-
Men aged 15-49 who are circumcised			Not applicable
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			-
POLICIES AND REGULATIONS			**2016**
Community delivery of treatment			-
Laws requiring parental consent for adolescents to access sexual and reproductive health services			-
TRIPS flexibilities incorporated in national legislation			-
Laws or policies restricting entry, stay and residence of people living with HIV			-

Criminalization of transmission of, nondisclosure of, or exposure to HIV	-
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to sex workers enrolled in prevention programmes (2016)	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Clean needle use at last injection	-
Needles and syringes distributed per person who injects (2016)	-
Coverage of HIV prevention programmes	-
Coverage of opioid substitution therapy (2016)	-
Naloxone available (2016)	-
Safe injection rooms available (2016)	-
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to men who have sex with men in prevention programmes (2016)	-
Coverage of HIV prevention programmes	
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-

PRISONERS

Estimated size of population	-
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

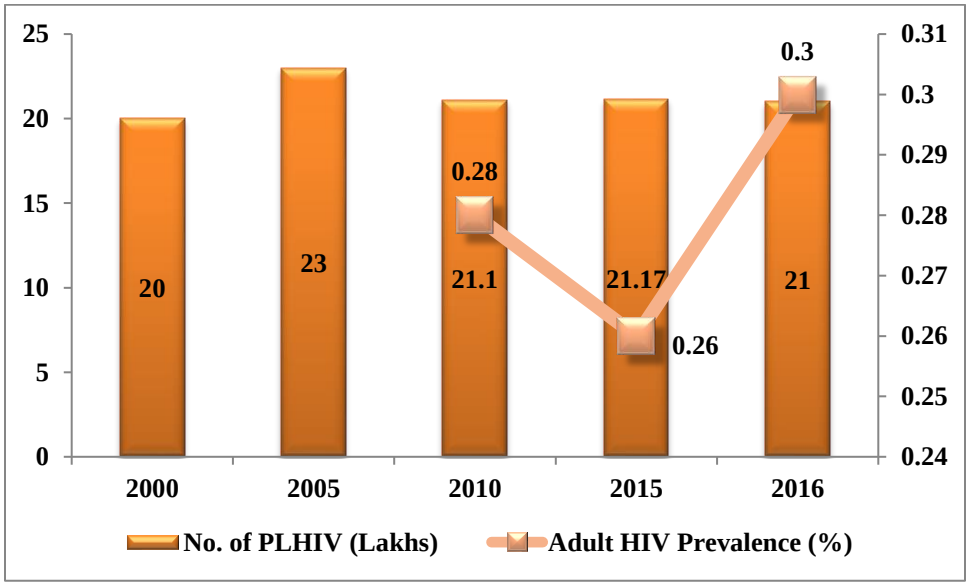
INDIA

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 1324 million (WHO Global Tuberculosis Report-2017). 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

National adult (15–49 years) HIV prevalence in India is estimated at 0.3% in 2016. The adult HIV prevalence at national level has continued its steady decline from an estimated peak of 0.38% in 2001-03 through 0.34% in 2007 and 0.28% in 2012 to 0.26% in 2015.

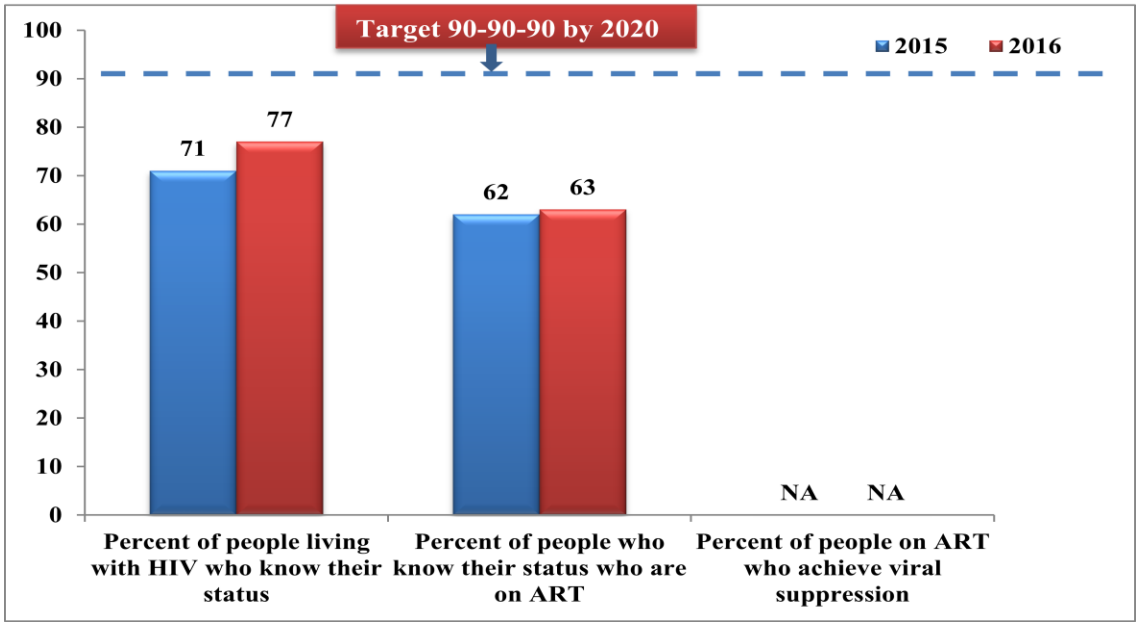
Figure 19: Estimated Adult HIV Prevalence & Number of PLHIV in India 2000-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

The total number of People Living with HIV (PLHIV) in India is estimated at 21 lakhs (17 lakhs–26 lakhs) in 2016 compared with 22.26 lakhs (18.00 lakhs-27.85 lakhs) in 2007(Figure 19)

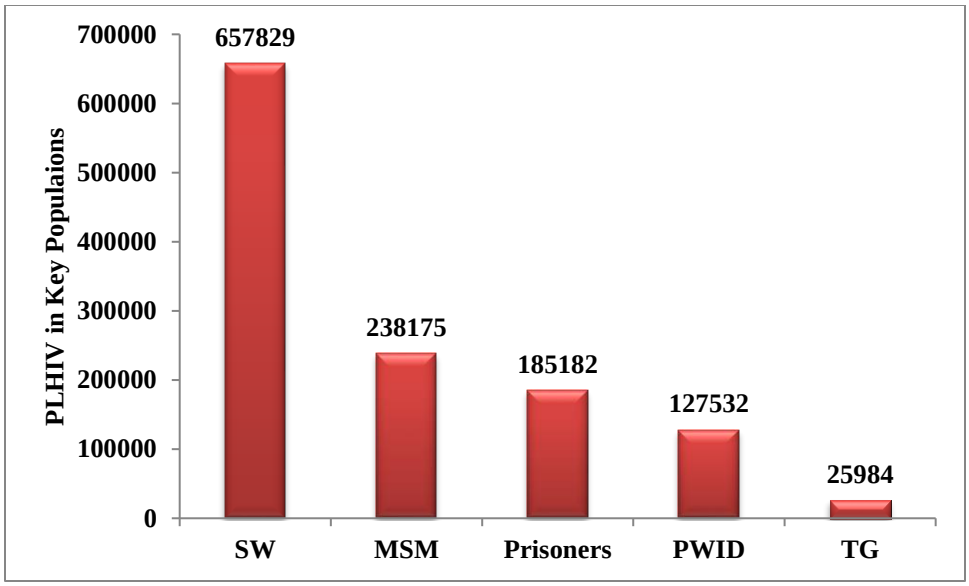
Figure 20: Treatment cascade (90-90-90) in India, 2015-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 20 shows treatment cascade (90-90-90) in India. In year 2016 there were 77 Percent of people living with HIV who know their status and 63 Percent of people who know their status who are on ART. From the figure it seems, Percent of people living with HIV who know their status may reach the target by 2020.

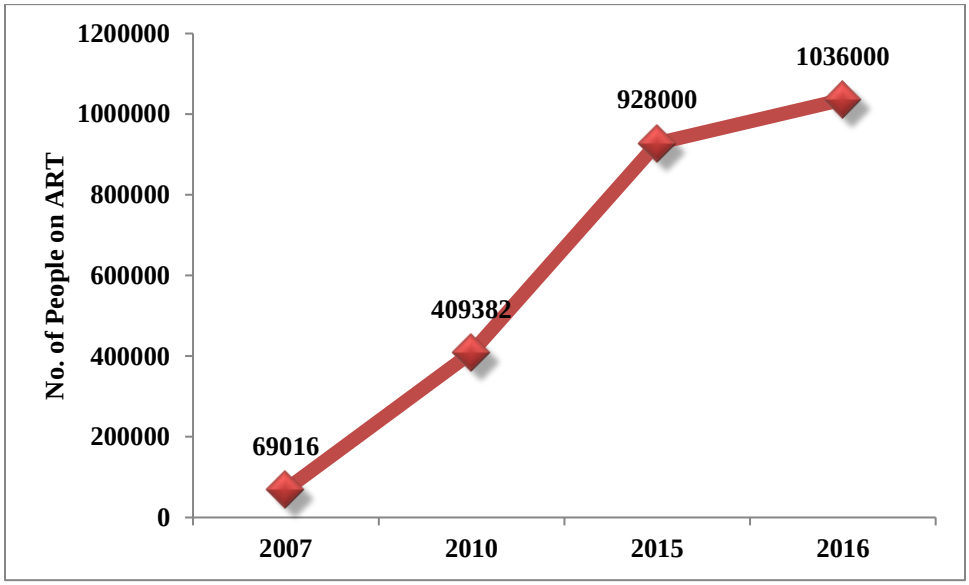
Figure 21: Number of estimated PLHIV in Key Populations - 2016



Source: http://aidsinfo.unaids.org/data sheet 2017

The number of estimated PLHIV in Key population were 657829 in SW, 238175 in MSM, 127532 in PWID, 185182 in Prisoners and 25984 in transgender (Figure 21).

Figure 22: ART scale up, 2007-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 22 shows, the trend of ART scale up from 2007-2016.Till date there are 1036000 people on ART.

New initiatives

New initiatives under Targeted Interventions

1. The Mid Term Assessment (MTA) of NACP
2. "Sustaining the HIV Prevention Impact among KEY Populations" in the State of Andhra Pradesh, Telangana, Karnataka, Maharashtra and Tamil Nadu
3. Implementation of Project Nirantar PEPFAR CDC-supported program under the Local Capacity Initiative (LCD) implemented by India HIV/AIDS Alliance in State of Chhattisgarh, Odisha and Madhya Pradesh
4. Methadone Based Opioid Substitution Treatment Lunched at Regional Institute of Medical Science (RIMS), Imphal, Manipur
5. HIV Interventions in 12 Central Prisons of Punjab, Chandigarh, Manipur and Mizoram
6. Project Sunrise at Imphal, Manipur
7. Enchaining partnerships between Law enforcement agencies & Civil Society Organization in the context of Drug use and HIV
8. Employer Led Model

New Initiative under STI /RIT programme

1. Elimination of parent to child transmission of syphilis (EPTCT)
2. Mid Term Appraisal of STI Programme

New Initiatives under Blood Transfusion Services

1. NBTC Microsite on National Health Portal
2. Baseline Assessment of Licensed Blood Banks
3. Review of DGHS Technical Manual on Transfusion Medicine
4. National Review Meeting
5. Scheme for Modernization
6. Model Blood Banks
7. Blood component Separation Units (BCSU)
8. Major Blood Banks (MBB) and District Level Blood Banks (DLBB)
9. Blood Transportation Vans
10. Metro Blood Banks
11. Plasma Fractionation Centre

New Initiatives under IEC

1. Mobile App.
2. Postal Stamp-Special Campaign
3. Second Phase of Helpline 1097
4. India International Trade-Fair-Digital India
5. Update of Website

INDIA

Populations(mid-year)			1324 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	150 000 (130 000-180 000)	100 000 (82 000-130 000)	80 000 (62 000-100 000)
HIV Incidence per 1000 populations	-	-	-
AIDS related deaths	150 000 (110 000-270 000)	120 000 (86 000- 200 0000)	62 000 (43 000-91 000)
People living with HIV	2 300 000 (1 900 000-2 800 000)	2 200 000 (1 800 000 - 2 700 000)	2 100 000 (1 700 000-2 600 000)
90-90-90		**2016**	
People living with HIV who know their HIV Status		1 600 000	77 % (63%->95%)
People living with HIV who are on Treatment		1 000 000	49 % (40%-61%)
Adults living with HIV who are on treatment		992 000	50% (41%-63%)
People living with HIV who are virally suppressed		-	-
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		17 000 (14 000-22 000)	9100 (7200-12 000)
Children living with HIV who are on treatment		18 % (15%-21%)	33% (29%-38%)
Coverage of pregnant women living with HIV accessing antiretroviral medicines		0% (0%-0%)	41 % (33%-54%)
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			110 000 (58 000- 190 000)
Proportion of people living with HIV with active TB in HIV care			12.1%
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			25.7%
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			
Males			37.8%
Females			15.4%
Women aged 15-49 who have their demand for family planning satisfied with modern methods			-
Men aged 15-49 who are circumcised			13%
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-

STIGMA AND DISCRIMINATION	
People who report they would not buy vegetables from a shopkeeper living with HIV	-
POLICIES AND REGULATIONS	**2016**
Community delivery of treatment	No
Laws requiring parental consent for adolescents to access sexual and reproductive health services	Yes, <18 years
TRIPS flexibilities incorporated in national legislation	No data Available
Laws or policies restricting entry, stay and residence of people living with HIV	No
Criminalization of transmission of, nondisclosure of, or exposure to HIV	No
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	657 829
HIV prevalence	2.2 %
Know HIV status	69.9%
Antiretroviral therapy coverage	-
Condom use	90.8%
Condoms distributed to sex workers enrolled in prevention programmes (2016)	259
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	127 532
HIV prevalence	9.9%
Know HIV status	72%
Antiretroviral therapy coverage	-
Condom use	77.4%
Clean needle use at last injection	86.4%
Needles and syringes distributed per person who injects (2016)	284
Coverage of HIV prevention programmes	-
Coverage of opioid substitution therapy (2016)	20.8%
Naloxone available (2016)	Yes
Safe injection rooms available (2016)	No
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	238 175
HIV prevalence	4.3%
Know HIV status	69.2%
Antiretroviral therapy coverage	-
Condom use	83.9%
Condoms distributed to men who have sex with men in prevention programmes (2016)	200

Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	25 984
HIV prevalence	7.2 %
Know HIV status	59.7%
Antiretroviral therapy coverage	-
Condom use	79.7%
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PRISONERS	
Estimated size of population	185 182
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

MALDIVES

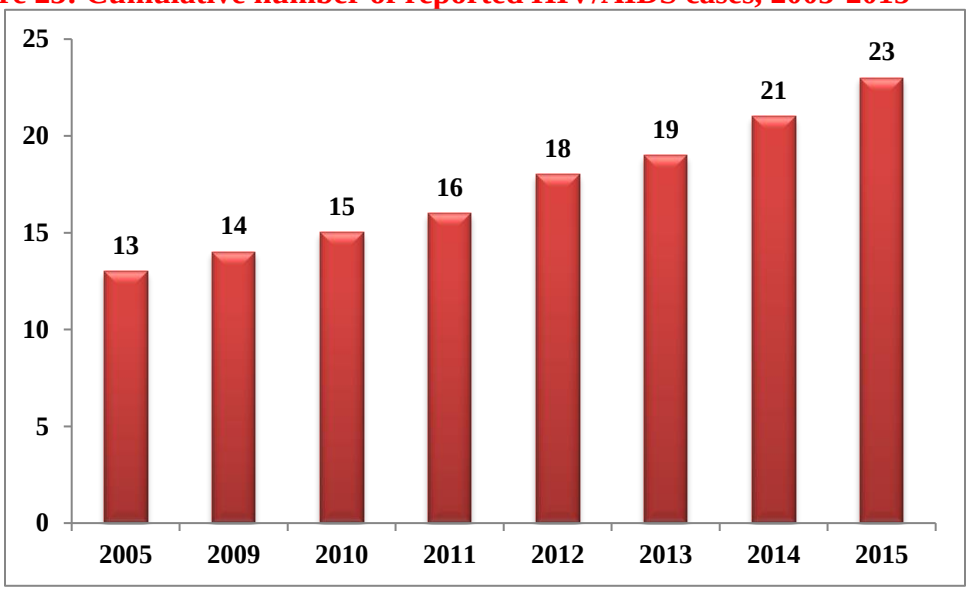
Republic of Maldives is a country formed by a number of natural atolls plus a few islands and isolated reefs which form a pattern from North to South. Maldives is situated in the Indian Ocean, close to India and Sri Lanka. It is located southwest of the Indian subcontinent stretching 860 km north to 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 379000 in year 2016. 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

Epidemiological data continues to show the HIV/AIDS epidemic in the Maldives may be characterized as low prevalence but high vulnerability, risk and epidemic potential. As of 2015, 23 HIV positive cases had been reported among Maldivians, among which 12 have died. In contrast, by 2015, 356 HIV positive cases were found among expatriates during pre-employment screening, and thus were not granted work permits. 9 Maldivians (and 1 expatriate until his contract concluded in 2014) continue to receive antiretroviral treatment provided by the Maldivian government.

Figure 23: Cumulative number of reported HIV/AIDS cases, 2005-2015



Source: http://aidsinfo.unaids.org/data sheet 2017

Majority of these were identified through case reporting, and most infections were reportedly acquired though heterosexual transmission, and one case of transmission via blood transfusion in 2013. There have not been any reported transmission through intravenous drug use, nor through mother-to-child transmission. However, HIV infection was found among men who have sex with men (MSM) in 2011, and among injecting drug users in 2012. The year 2012 also saw the first reported case of pediatric HIV/AIDS.

With the second Bio-Behavioral Survey still in the preparatory stage, the BBS 2008 remains the most recent large-scale prevalence study on the AIDS epidemic in the Maldives. As such, the figures presented in previous country progress reports remain in effect, and the more notable points are provided below:

The results of BBS 2008 revealed potential routes for HIV transmission in the country. Sizeable numbers of risk groups (FSW, Male clients of FSW, MSM, IDU and youth) were found in Male', Addu and Laamu. The Risk Behavior Mapping Survey (2010) done in 12 islands across Maldives extrapolated the data to calculate the national estimates of 1139 FSWs, 1199 MSMs and 793 IDUs with high percentages of the key populations concentrated in Male' alone (FSW 37%, MSM 48% and IDU 53%).

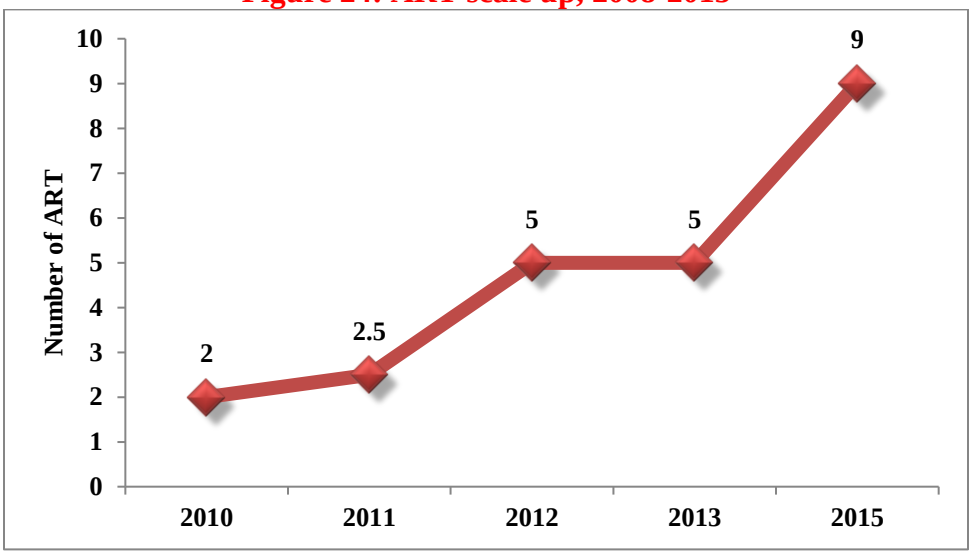
Although HIV prevalence is still below 1%, sexually transmitted infections (STIs), particularly, syphilis, an ulcerative STI, was detected among the resort workers with a prevalence of 1.2%. Likewise, Hepatitis B was also detected among the resort workers, MSM, seafarers, construction workers and IDU.

Although high levels of knowledge about HIV/AIDS and using condoms was noted in the DHS 2009, but due to perceived linkages of HIV to immoral behaviors and low self perceived risk, condom use is low across all most-at-risk populations. The targeted outcome by 2016 is to increase in the outlets providing condoms and lubricants by 50%

The national testing guidelines stipulates that, pregnant women should be offered an HIV test, allowing them to opt out; also, pre- and post-test counseling should be provided and written informed consent should be obtained prior to testing. However, contrary to these guidelines, all pregnant women are still screened for HIV along with VDRL and hepatitis B, and pre- and post-test counseling is not available. The NSP targets for 2016 include 100% of women attending ANC clinics are tested for HIV as per the national guidelines that allow 'opt-out'. Efforts to achieve this are underway with the establishment of the new Guidelines for PMTCT of HIV as part of reproductive and maternal health services. Under this guideline, 3704 women were tested in 2014, and as of this reporting cycle in 2016, 6828 women were screened at ANC visits and none tested positive.

In 2014, nearly 25,000 HIV tests were carried out- a slight drop from 2013, which saw 35,754 tests being done. In order to increase the uptake of HIV testing services, the NSP states that the policy of HIV testing will be moved from solely voluntary counseling and testing (VCT) to provider-initiated and client- initiated counseling and testing (PICT and CICT). However, in 2016, only 803 people underwent self-referred testing for HIV and none tested positive.

Figure 24: ART scale up, 2008-2015



Source: http://aidsinfo.unaids.org/data sheet 2017

Antiretroviral services are being delivered from one center, Indira Gandhi Memorial Hospital in Male'. People testing positive for HIV are immediately enrolled in the national treatment programme, and a treating physician assigned to every client, who will look after the client, ensuring regular checkups, dispensing the ARV drugs and follow-up. The National Programme facilitates psychosocial support, and if required legal support as well. Patients on treatment, who are living away from the ART center, are asked to identify a family member who will collect the drugs from the ART center and deliver the drugs to the client. This practice has been ongoing and functional ever since the ARV programme was established, and reported in previous reporting cycles. The NSP 2014-2018 notes a commitment to focus on taboo, denial and stigma of risk behaviors and people living with HIV in the next wave of advocacy, information and education activities. Figure 24 shows the ART scale up from 2008 to 2015.

Best practices

Two achievements are notable as best practices. First is the engagement of two NGOs in providing VCT services, which ensures availability of such services independent of the health sector. Secondly, the Guidelines for the Prevention of Mother to Child Transmission (PMTCT) of HIV integrate PMTCT into the mainstream health system via Reproductive Health Services.

Establishing these guidelines and training health personnel has contributed to the Maldives being on the road to achieving elimination of Mother-to-Child syphilis and HIV transmission.

Major challenges and remedial actions:

As with preceding years, one main challenge that persists is the limited number of civil society partners available to support the state-run National AIDS Programme. This limits opportunities to tap into communities and networks to implement target interventions for KAPs.

The second main challenge is the widening funding gap. The transitions from Lower-Income Country to an Upper Middle-Income Country as well as from MDGs to SDGs combine with continued low prevalence to make it challenging for Maldives to be eligible to access funding mechanisms such as the Global Fund. This scenario is also linked with challenges in justifying state funding and priorities. Potential ways of alleviating this resource gap include regional partnership for cross-border issues as well as country participation in consultations to lobby for differentiate consideration- that is, to be considered for funding assistance based on more than country income status and low prevalence.

The NSP 2014-2018 notes the following weaknesses and challenges in particular:

- HIV in Maldives is mostly likely to be concentrated among populations at high risk of infection and is different from other countries that may reflect predominantly generalized heterosexual epidemic.
- Though there is some good information available about IDU, largely anecdotal evidence is available regarding sex work and MSM.
- Little ethnographic or socio-cultural background insights are available regarding contexts in which high risk behavior takes place.
- There is limited anthropological research in assessing how high-risk behaviors work, in which contexts, who are the gatekeepers and significant others when these behaviors occur. Thus the programming –including communication strategy -remains uninformed.
- Monitoring and evaluation of responses to the epidemic needs strengthening, specially, targeted interventions, strategic information systems to measure progress these are yet to be in place.

- Protocols for ensuring efficient flow of information from periphery to center and then back to periphery needs strengthening.
- Statistical modeling to better understand trends in HIV prevalence in Key Populations at risk is yet to be carried out; this can be a follow-up activity of IBBS 2016, and it is essential that more data is available to conduct modeling and this underscores the importance of strengthening surveillance systems as well as the collection of routine data.

MALDIVES

Populations(mid-year)			<1 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	-	-	-
HIV Incidence per 1000 populations	-	-	-
AIDS related deaths	-	-	-
People living with HIV	-	-	-
90-90-90			**2016**
People living with HIV who know their HIV Status		-	-
People living with HIV who are on Treatment		<100	>95%
Adults living with HIV who are on treatment		-	-
People living with HIV who are virally suppressed		-	-
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		-	-
Children living with HIV who are on treatment		-	-
Coverage of pregnant women living with HIV accessing antiretroviral medicines		-	-
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			<100 (<100-<100)
Proportion of people living with HIV with active TB in HIV care			-
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			35.5%
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			-
Males			-
Females			-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			-
Men aged 15-49 who are circumcised			Not applicable
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			-
POLICIES AND REGULATIONS			**2016**
Community delivery of treatment			-
Laws requiring parental consent for adolescents to access sexual and reproductive health services			-
TRIPS flexibilities incorporated in national legislation			-
Laws or policies restricting entry, stay and residence of people living with HIV			-

Criminalization of transmission of, nondisclosure of, or exposure to HIV	-
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to sex workers enrolled in prevention programmes (2016)	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Clean needle use at last injection	-
Needles and syringes distributed per person who injects (2016)	-
Coverage of HIV prevention programmes	-
Coverage of opioid substitution therapy (2016)	-
Naloxone available (2016)	-
Safe injection rooms available (2016)	-
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to men who have sex with men in prevention programmes (2016)	-
Coverage of HIV prevention programmes	
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	-
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-

PRISONERS

Estimated size of population	-
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

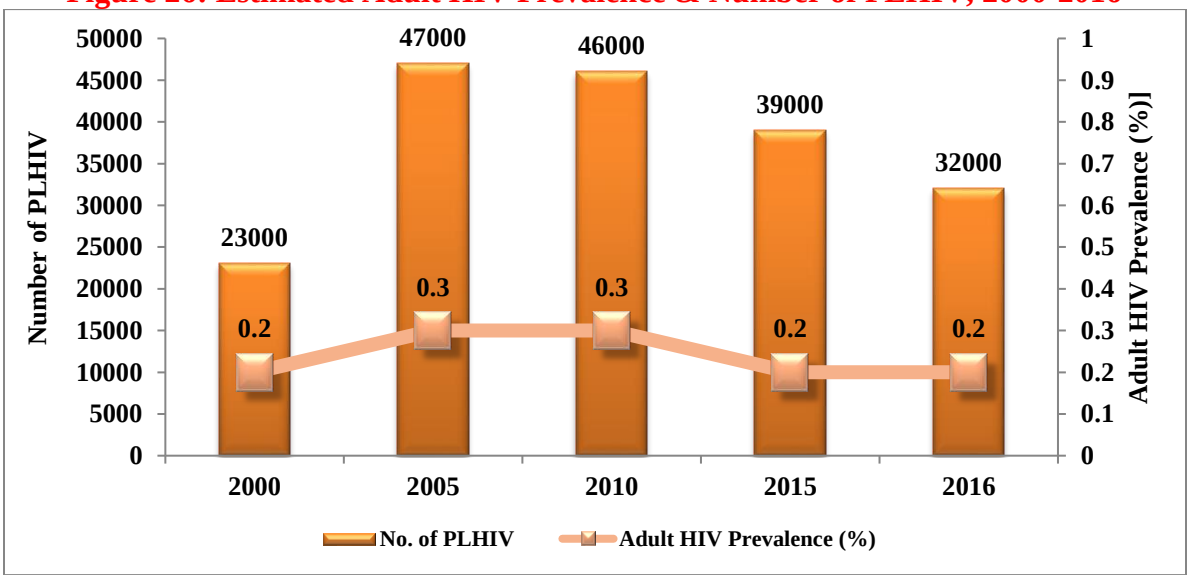
NEPAL

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. Nepal is divided into 7 states and 77 districts. It has an area of 147,181 square kilometers and a population of approximately 29 million (WHO Global Tuberculosis Report-2017). The urban population is largely concentrated in the Kathmandu valley.

Overview of the HIV/AIDS epidemic:

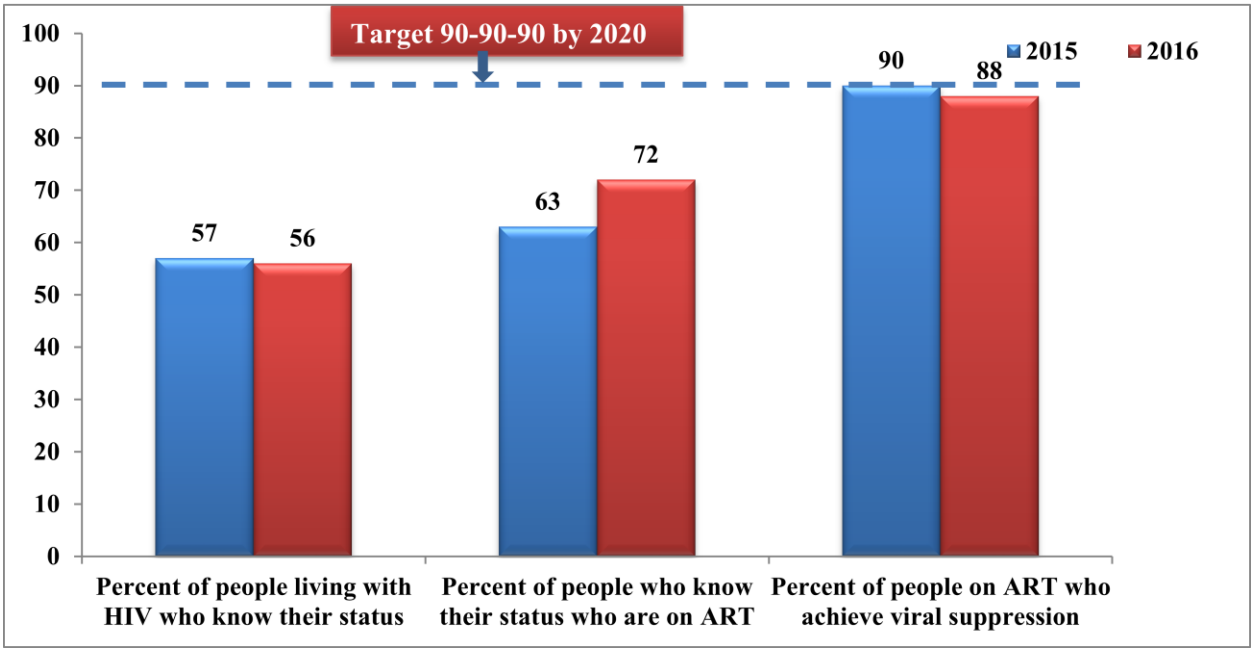
The first HIV infection has detected in 1988 in Nepal. Since then HIV epidemic has evolve from low to concentrated among key affected populations (people who inject drugs, female sex worker, clients of female sex worker, Men who have sex with men, Male labor migrants). However heterosexual transmission is dominant. Nepal's HIV prevalence has not changed much over the last five years, it has remained within 0.3 - 0.2 percent. It is estimated that there are around 32,000 people living with HIV in 2016, decreasing from 39000 in 2015 (Figure 26). An estimated number of 1700 deaths were due to AIDS in 2016 declining from 2300 deaths in 2015. The number of estimated deaths is projected to decline to 1,266 in 2020, due to an expected increase in the numbers of people on Antiretroviral Therapy (ART). The estimated number of new cases in 2016 is less than 1000 as compared to 1300 in 2015.

Figure 26: Estimated Adult HIV Prevalence & Number of PLHIV, 2000-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

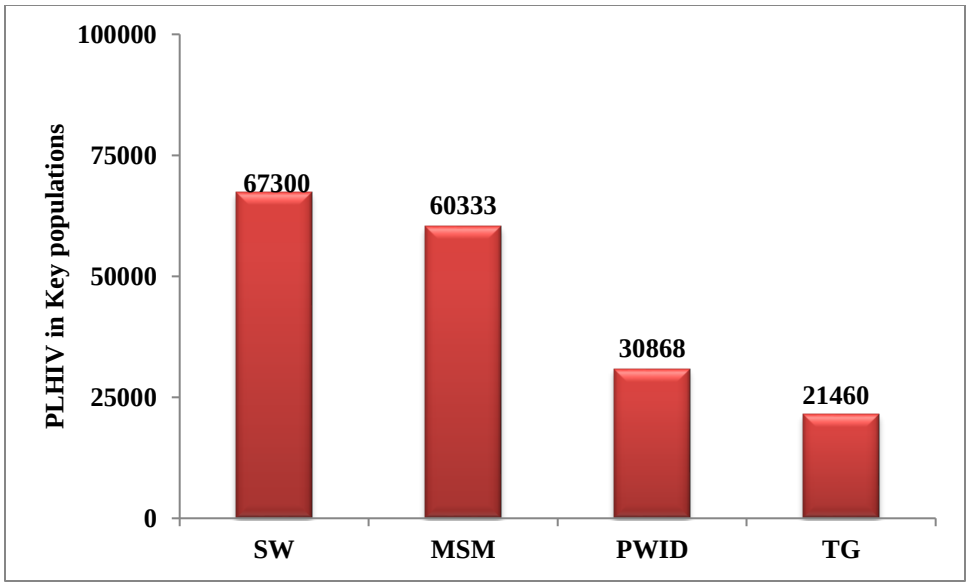
Figure 27: Treatment cascade (90-90-90) in Nepal, 2015-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 27 shows treatment cascade (90-90-90) in Nepal. In year 2016 there were 56 Percent of people living with HIV who know their status, 72 Percent of people who know their status who are on ART and 88 percent of people on ART who achieve viral suppression. From the figure it seems, Percent of people on ART who achieve viral suppression has achieved its target in 2015.

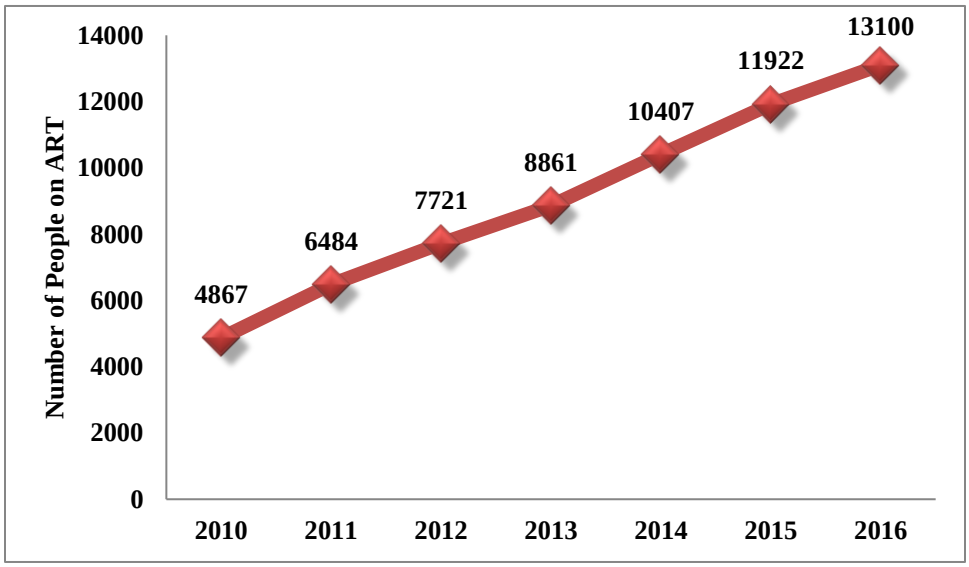
Figure 28: Number of estimated PLHIV in Key Populations -2016



Source: http://aidsinfo.unaids.org/data sheet 2017

The HIV epidemic in Nepal remains concentrated among the key affected population notably; sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), transgender people (TG) as well as their spouses. Figure 28 shows the number of estimated PLHIV in key populations (SW, MSM, PWID, TG) in Nepal 2016.

Figure 29: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 29 shows the scaling up of number of people on ART from 4867 in 2010 to 13100 in 2016.

National Programme and Achievements

- Quality improvement and Capacity Enhancement of Viral Load Testing
- Legal Literacy Toolkit
- Expansion of Early Infant Diagnosis (EID) Service Sites
- Piloting of Unique Identification Code for tracking patients

Best Practices

- Scaling up Monitoring of HIV DR related Early Warning Indicators
- Saath-Saath Project Festival Campaign 2014 - Urging the Migrant Workers and their Spouses to get Tested for HIV and STI
- Using Geographical Information System (GIS) in HIV Programme in Nepal: A Saath-Saath Project Experience
- Clinical Placement for Mid-level Healthcare staff of Antiretroviral Therapy (ART) centers for better clinical management of HIV
- Online Programme Management Information System (OPMIS) for the Global Fund HIV Programme of Save the Children
- Cash transfer support for children living with HIV
- Community-based Prevention of Mother to Child transmission of HIV services in Nepal

Challenges in HIV Program to achieve 90/90/90 Target

- Low programme Coverage (only 60 % of key population are reached through programme)
- Only 60 % of diagnosed PLHIV receive ART
- 70 % cases had late initiation of ART with <200 CD4 count/mm3.
- 48 % pregnant women tested for HIV and limited EID services
- TB/HIV co infection is not manage properly
- Lost to Follow Up clients is high (9%) ; no proper tracking mechanism, most of them are migrants and they may again go to India for work

NEPAL

Populations(mid-year)			29 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	4200 (3800-4700)	2200 (2000-2400)	<1000 (<1000-1000)
HIV Incidence per 1000 populations	0.17 (0.15-0.19)	0.08 (0.08-0.09)	0.03 (0.03-0.04)
AIDS related deaths	2300 (1900-2800)	2500 (2100-2800)	1700 (1400-2100)
People living with HIV	40 000 (36 000-44 000)	38 000 (33 000-44 000)	32 000 (28 000-38 000)
90-90-90		**2016**	
People living with HIV who know their HIV Status		18 000	56 % (49 %-66%)
People living with HIV who are on Treatment		13 000	40 % (35%-47%)
Adults living with HIV who are on treatment		12 100	39% (33%-45%)
People living with HIV who are virally suppressed		12 000	36 % (32%-42%)
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		<200 (<200-<200)	<100 (<100-<100)
Children living with HIV who are on treatment		21 % (18%-24%)	83% (72%->95%)
Coverage of pregnant women living with HIV accessing antiretroviral medicines		16% (13%-19%)	64 % (54%-76%)
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			1900 (1500-2400)
Proportion of people living with HIV with active TB in HIV care			27.3%
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			27.8%
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			
Males			-
Females			-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			56.2%
Men aged 15-49 who are circumcised			Not applicable
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			28.3%

POLICIES AND REGULATIONS	2016
Community delivery of treatment	No
Laws requiring parental consent for adolescents to access sexual and reproductive health services	Yes, <16 years
TRIPS flexibilities incorporated in national legislation	Yes
Laws or policies restricting entry, stay and residence of people living with HIV	No
Criminalization of transmission of, nondisclosure of, or exposure to HIV	No
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	67 300
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Condoms distributed to sex workers enrolled in prevention programmes (2016)	109
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	30 868
HIV prevalence	6.4%
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	52.5%
Clean needle use at last injection	96%
Needles and syringes distributed per person who injects (2016)	-
Coverage of HIV prevention programmes	-
Coverage of opioid substitution therapy (2016)	-
Naloxone available (2016)	No
Safe injection rooms available (2016)	No
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	260 333
HIV prevalence	2.4%
Know HIV status	73.2%
Antiretroviral therapy coverage	-
Condom use	86%
Condoms distributed to men who have sex with men in prevention programmes (2016)	43
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	21 460

HIV prevalence	6 %
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	88.4%
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PRISONERS	
Estimated size of population	-
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

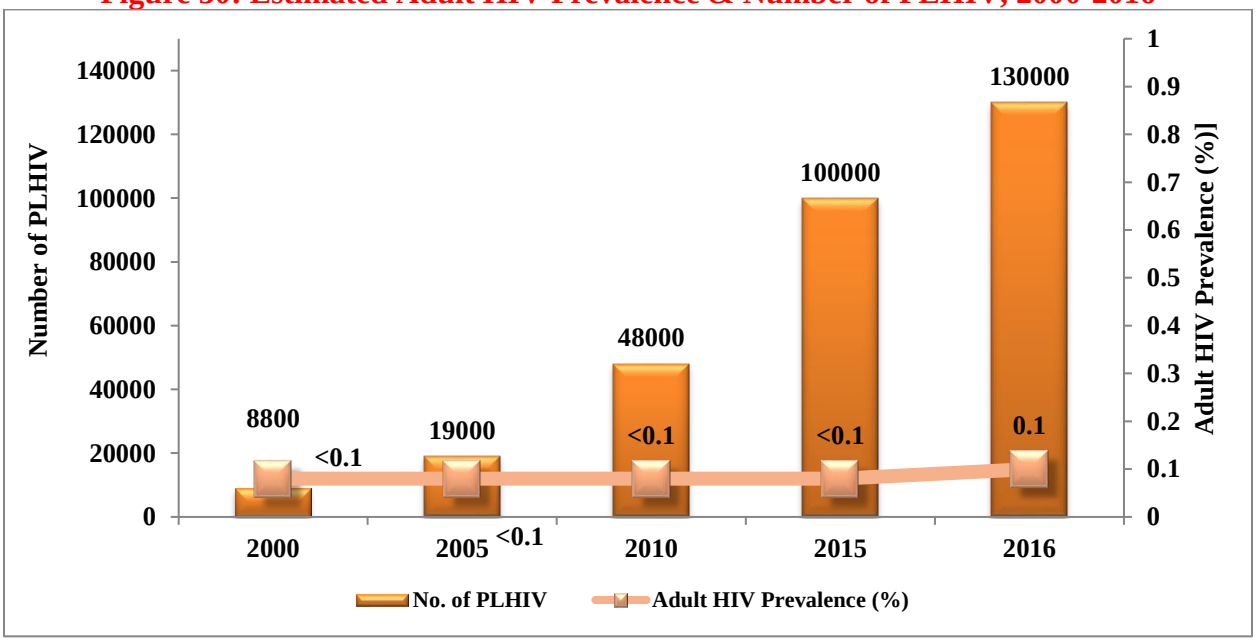
Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

Islamic Republic of Pakistan is the second largest country in the South Asia. It is bordered by India to the east, China in the far northeast, Afghanistan to the west and north, Iran to the southwest and Arabian Sea in the south. The land area of the country is 796,095 square kilometers. Population of Pakistan was approximately 193 million (WHO Global Tuberculosis Report-2017) at the end of 2016.

Overview of the HIV/AIDS epidemic

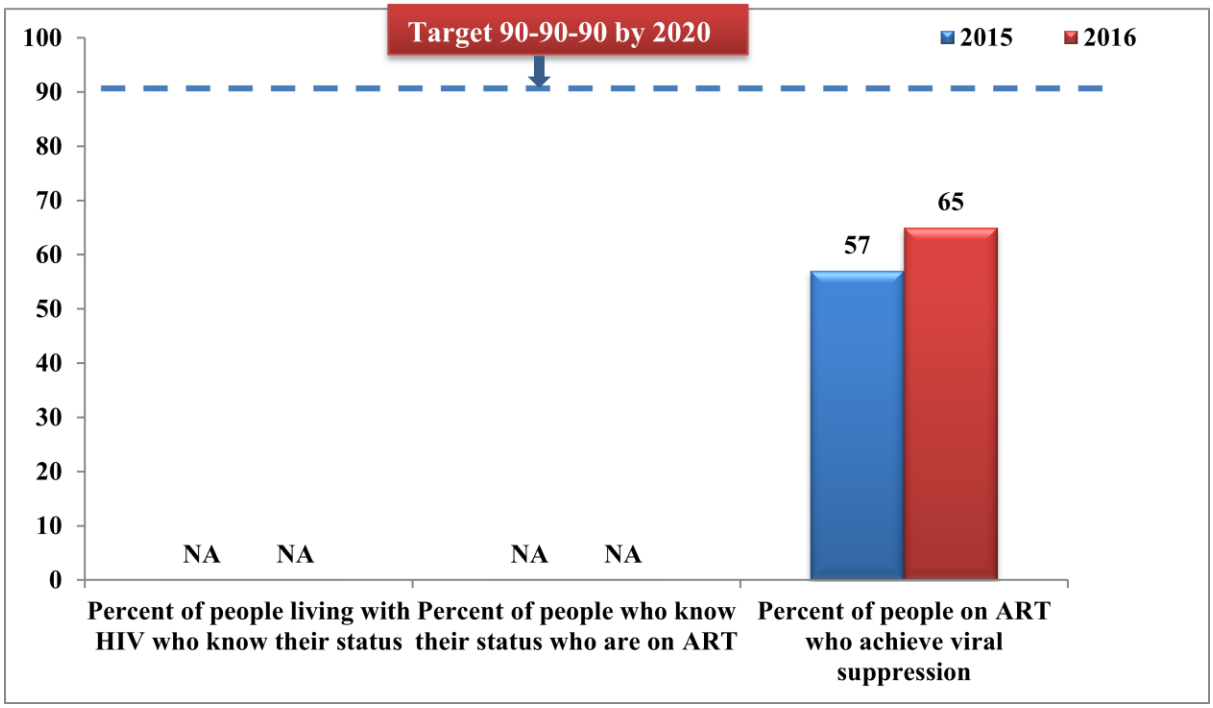
Pakistan's Federal Ministry of Health initiated a National AIDS Prevention and Control Program (NACP) in 1987. Pakistan had an estimated 130 000 people living with HIV by the end of 2016, with 19,000 estimated new HIV infection and 5500 deaths due to AIDS. Adult HIV Prevalence was less than 0.1 in year 2016 (Figure 30).

Figure 30: Estimated Adult HIV Prevalence & Number of PLHIV, 2000-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

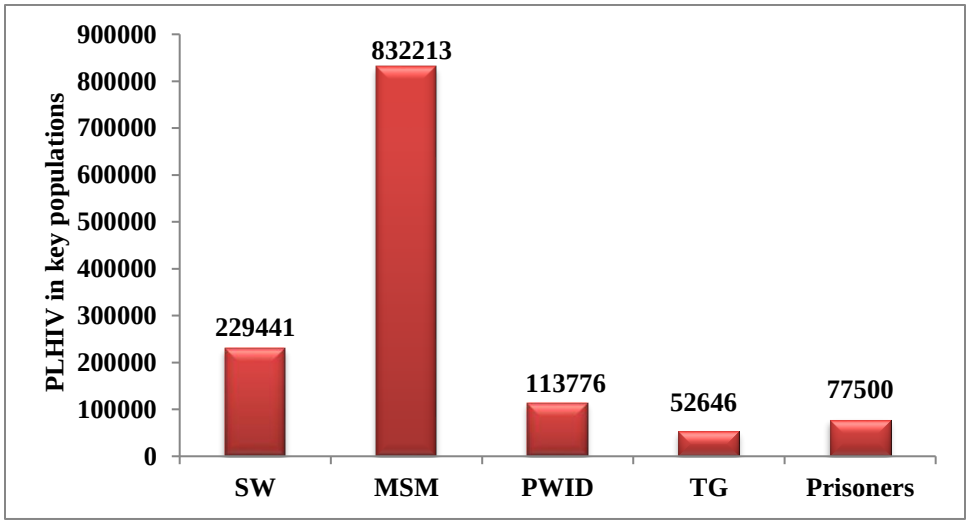
Figure 31: Treatment cascade (90-90-90) in Pakistan 2015-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 31 shows treatment cascade (90-90-90) in Pakistan. In year 2016 there were 65 percent of people on ART who achieve viral suppression.

Figure 32: Number of estimated PLHIV in Key Populations-2016

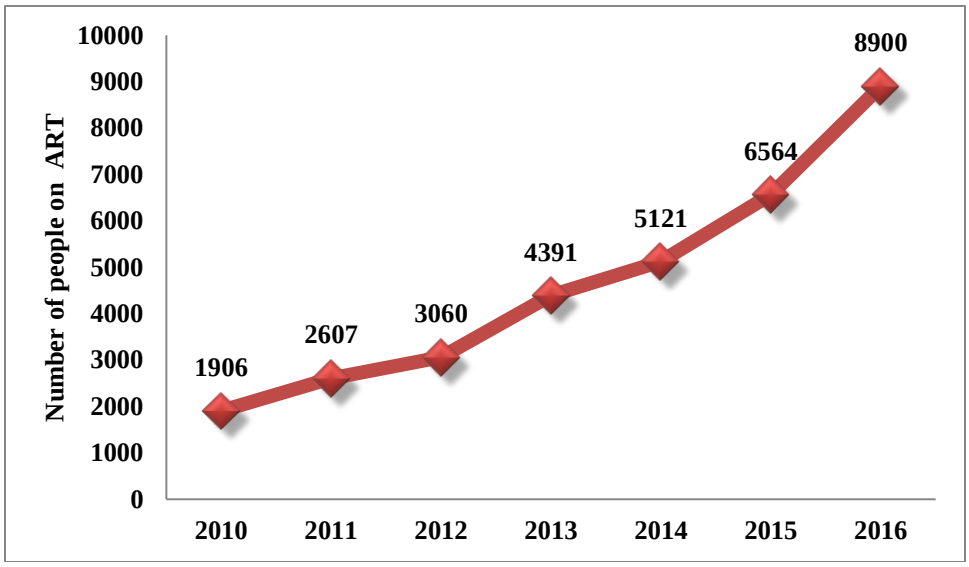


Source: http://aidsinfo.unaids.org/data sheet 2017

Pakistan is concentrated HIV epidemic among Key Affected Population. The size of PLHIV in MSM was highest (832213) among key affected population in year 2016 (Figure 32). Other than the Key Affected Population, evidence also exists of either HIV-related risk factors or infection

among certain vulnerable population, such as the spouses of key affected population, imprisoned population, at-risk adolescents and in certain occupational settings. Figure 33 shows the scaling up of number of people on ART from 1906 in 2010 to 8900 in 2016.

Figure 33: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Best practice

- Expansion of CD4 and Viral load facilities in Punjab:
- HIV viral load testing facility was also made available to nearly all HIV treatment centers in the country
- The community based monitoring is being provided through:

  a. The provincial Coordinators, who visit all the treatment centers and the CHBC sites in their respective provinces in every quarter (each site is visited every months).

  b. Assessment tools are used to perform the monitoring by the Provincial Coordinators.

  c. Feedback from both the services providers and the clients is received which helps to identify the gaps and suggest measures to address these gaps.

  d. In each province one FGD with clients is held in every quarter on various service delivery points on rotational bases.

e. Provincial Coordinators are also tasked to make contacts and establish links between the private sector and public sectors; visits of influential are also part of this aspect which is mainly conducted by the Federal Secretariat.

f. In addition the APLHIV is acting as a holding point for complaints, suggestions and feedbacks.

g. The APLHIV is also committed to provide leadership in engaging community participation at National level.

- The APLHIV is also providing the services of Toll Free Helpline at National level.

Major Challenges

1. Poverty:
2. Low level of education
3. Gender inequalities:
4. Devolution:
5. Non availability of OST
6. Funding Gap:

PAKISTAN

Populations(mid-year)			193 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	9400 (8500-10 000)	14 000 (12 000-15 000)	19 000 (17 000- 21 000)
HIV Incidence per 1000 populations	0.06 (0.06-0.07)	0.08 (0.07-0.09)	0.10 (0.09-0.11)
AIDS related deaths	<100 (<100-<100)	1300 (<1000-1800)	5500 (4500-6600)
People living with HIV	12 000 (11 000-13 000)	66 000 (59 000-73 000)	130 000 (120 000-150 000)
90-90-90			**2016**
People living with HIV who know their HIV Status		-	-
People living with HIV who are on Treatment		8900	7 % (6%-8%)
Adults living with HIV who are on treatment		8600	7% (6%-7%)
People living with HIV who are virally suppressed		5800	4% (3%-5%)
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		<1000 (<500-<1000)	<1000 (<1000-1100)
Children living with HIV who are on treatment		5 % (4%-6%)	10% (9%-12%)
Coverage of pregnant women living with HIV accessing antiretroviral medicines		1% (1%-2%)	4 % (4%-5%)
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			8800 (5400-13 000)
Proportion of people living with HIV with active TB in HIV care			-
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			4.3%
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			
	Males		-
	Females		-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			46%
Men aged 15-49 who are circumcised			Not applicable
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			49%
POLICIES AND REGULATIONS			**2016**

Community delivery of treatment	No
Laws requiring parental consent for adolescents to access sexual and reproductive health services	No
TRIPS flexibilities incorporated in national legislation	No
Laws or policies restricting entry, stay and residence of people living with HIV	No
Criminalization of transmission of, nondisclosure of, or exposure to HIV	No
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	229 441
HIV prevalence	3.8 %
Know HIV status	30.6%
Antiretroviral therapy coverage	4.1%
Condom use	35.1%
Condoms distributed to sex workers enrolled in prevention programmes (2016)	-
Coverage of HIV prevention programmes	0.7%
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	113 776
HIV prevalence	21%
Know HIV status	39.3%
Antiretroviral therapy coverage	5.9%
Condom use	15.3%
Clean needle use at last injection	72.5%
Needles and syringes distributed per person who injects (2016)	51
Coverage of HIV prevention programmes	1.6%
Coverage of opioid substitution therapy (2016)	-
Naloxone available (2016)	No
Safe injection rooms available (2016)	No
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	832 213
HIV prevalence	3.7%
Know HIV status	22.3%
Antiretroviral therapy coverage	1%
Condom use	22.4%
Condoms distributed to men who have sex with men in prevention programmes (2016)	234
Coverage of HIV prevention programmes	1.2%
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	52 646
HIV prevalence	5.5 %

Know HIV status	29%
Antiretroviral therapy coverage	2.3%
Condom use	24.4%
Coverage of HIV prevention programmes	1.1%
Avoidance of services due to stigma and discrimination	-
PRISONERS	
Estimated size of population	77 500
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org/data sheet 2017

SRI-LANKA

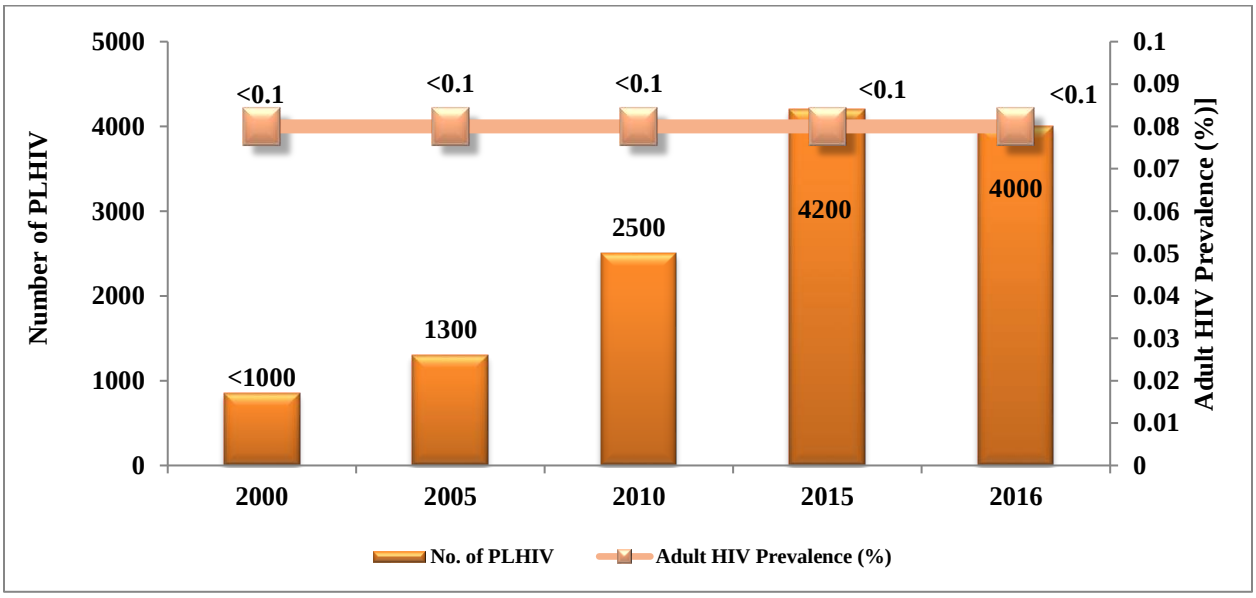
Sri-Lanka is an island country in the Indian Ocean, separated from the south- eastern coast of peninsular India. Its estimated population is 21 million in 2015 (WHO Global Tuberculosis Report-2016).

Overview of the HIV/AIDS epidemic

During 2016, a total of 249 HIV cases were newly reported in Sri Lanka. This is the highest number reported in a year since the identification of the first HIV infected Sri Lankan in 1987 and this amounts to about 21 persons newly reported with HIV for a month. However, the reported numbers represent only a fraction of HIV infected people in the country as many infected persons may perhaps not be aware of their HIV status and in addition, stigma and discrimination towards HIV hinders seeking HIV testing services.

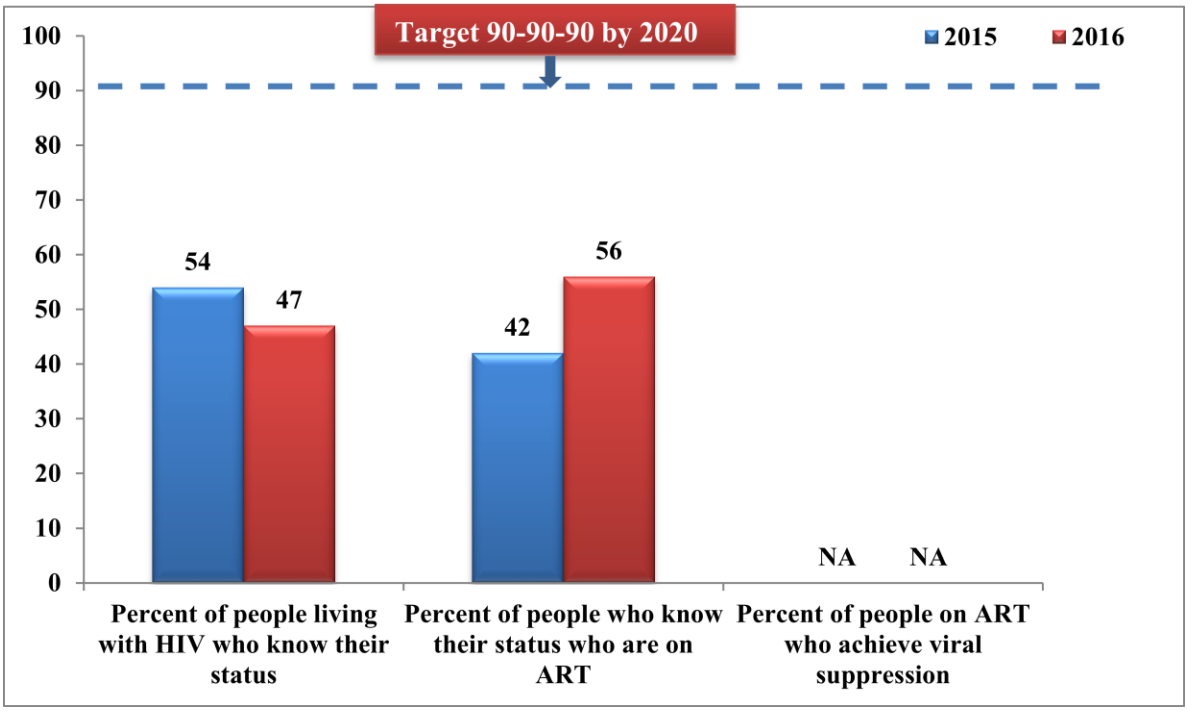
Sri-Lanka had an estimated 4000 people living with HIV by the end of 2016, with less than 1000 estimated new HIV infection and less than 200 deaths due to AIDS. Adult HIV Prevalence remain same (<0.1) since 2000 to 2016. (Figure 34)

Figure 34: Estimated Adult HIV Prevalence & Number of PLHIV, 2000-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

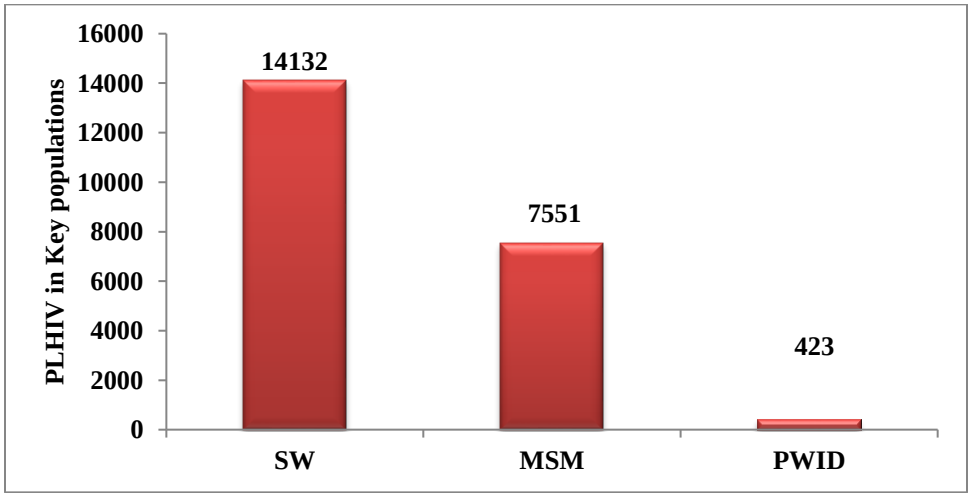
Figure 35: Treatment cascade (90-90-90) in Sri Lanka 2015-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 35 shows treatment cascade (90-90-90) in Sri Lanka. In year 2016 there were 47 Percent of people living with HIV who know their status and 56 Percent of people who know their status who are on ART.

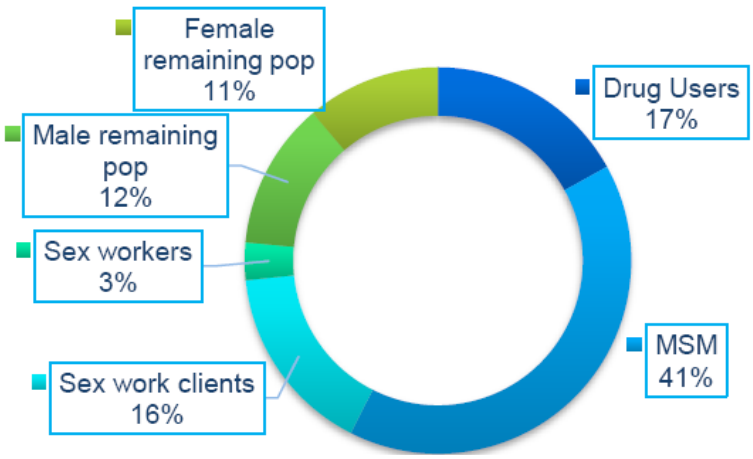
Figure 36: Number of estimated PLHIV in Key Populations- 2016



Source: http://aidsinfo.unaids.org/data sheet 2017

The HIV epidemic in SriLanka remains concentrated among the key affected population notably; sex workers (SW), men who have sex with men (MSM) and people who inject drugs (PWID). Figure 36 shows the number of estimated PLHIV in key populations (SW, MSM, PWID) in Sri Lanka 2016.

Figure 37: Estimated new HIV infections by risk group during 2016

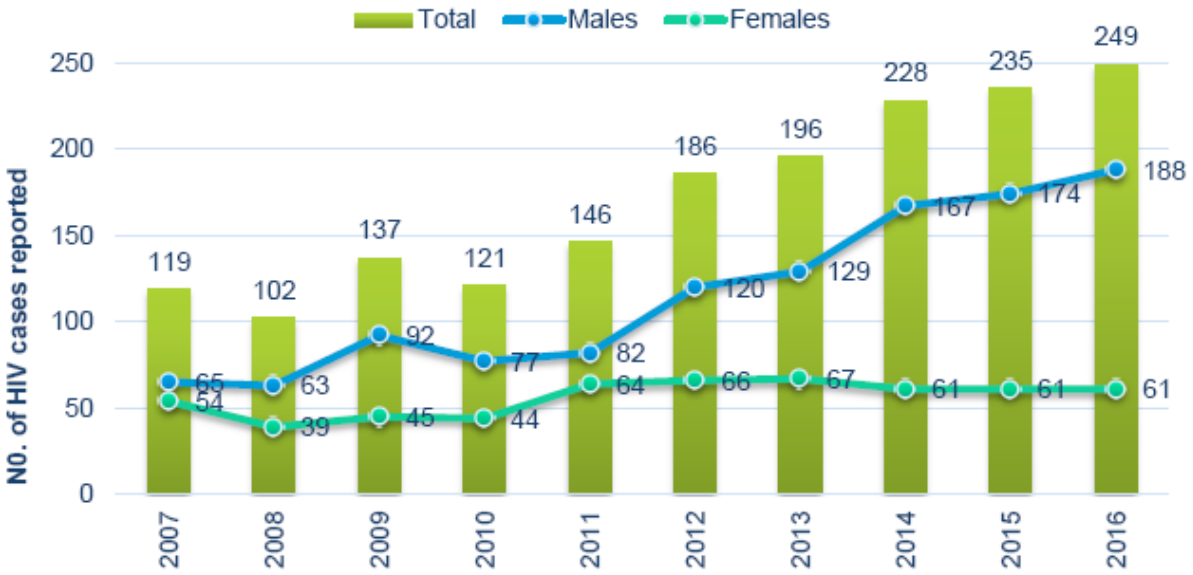


Source: *National STD/AIDS Control programme Sri Lanka, Annual Report 2016*

The Figure 37 shows the estimated number of new HIV infections by risk groups. MSM have contributed to the largest portions of PLHIV (41%) followed by drug users and sex work clients (17% and 16% respectively). Together male and female remaining populations have contributed 23% of all estimated new HIV infections during 2016.

Figure 38 shows the trend of reported HIV cases by sex during last 10 years. Although the percent increase in number of HIV cases reported is nearly 110% over last 10 years, this increase is mainly due to increase among males. The percentage increase among males is 190% whereas number of females has increased only by 13% during this period. In addition to increase in new HIV infections, increase in testing facilities and better reporting have contributed to this trend.

Figure 38: Trends of reported HIV cases by sex 2007-2016



Source: *National STD/AIDS Control programme Sri Lanka, Annual Report 2016*

Since 2011, the proportion of males with HIV is gradually increasing (Figure 38). The male to female ratio of cumulative reported cases as of end 2016 was 1.8:1. However, during 2016 the male to female ratio increased to 3.1:1.

Figure 39: Cumulatively reported HIV cases by Age and Sex by end of 2016

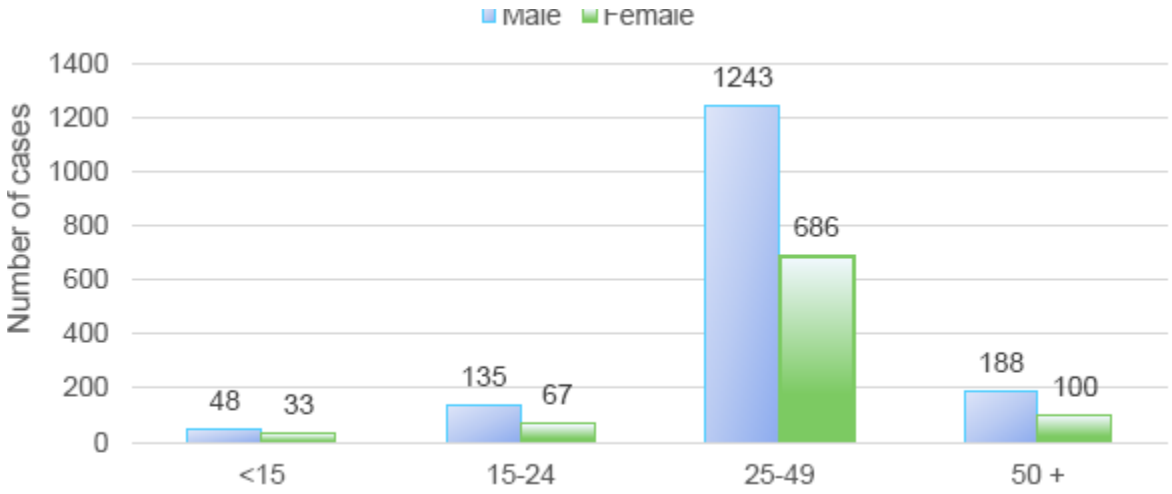


Figure 39 shows age and sex distribution of cumulative reported HIV cases since 1987 (N=2500, age and sex not reported in 57 cases).

Figure 40: Trend of age categories of reported HIV cases, 2007-2016

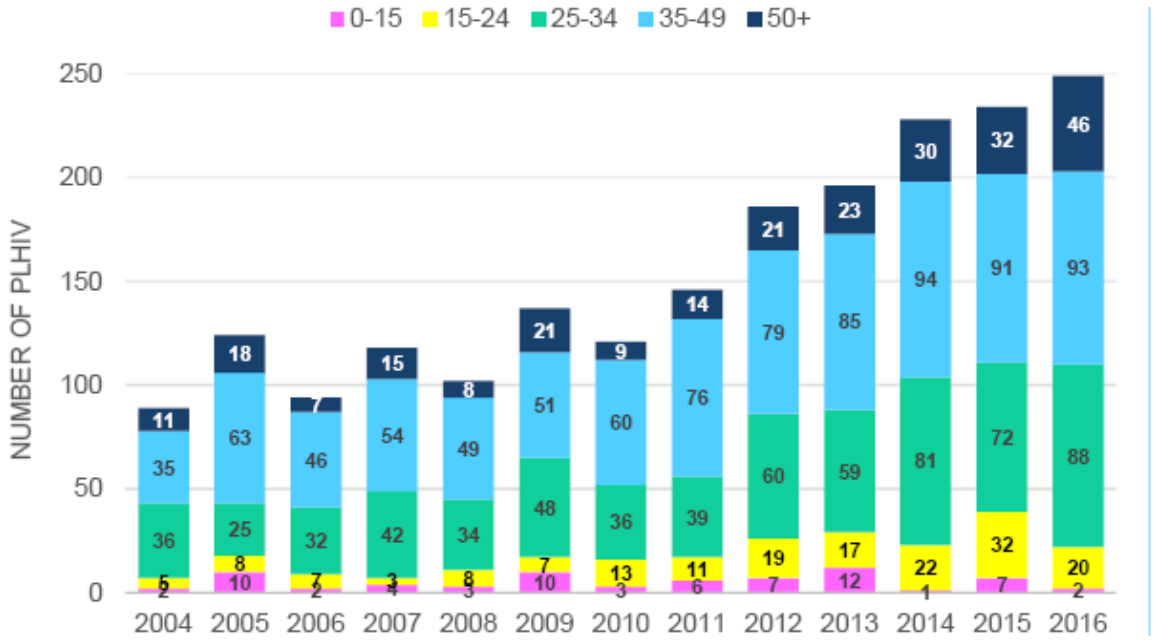
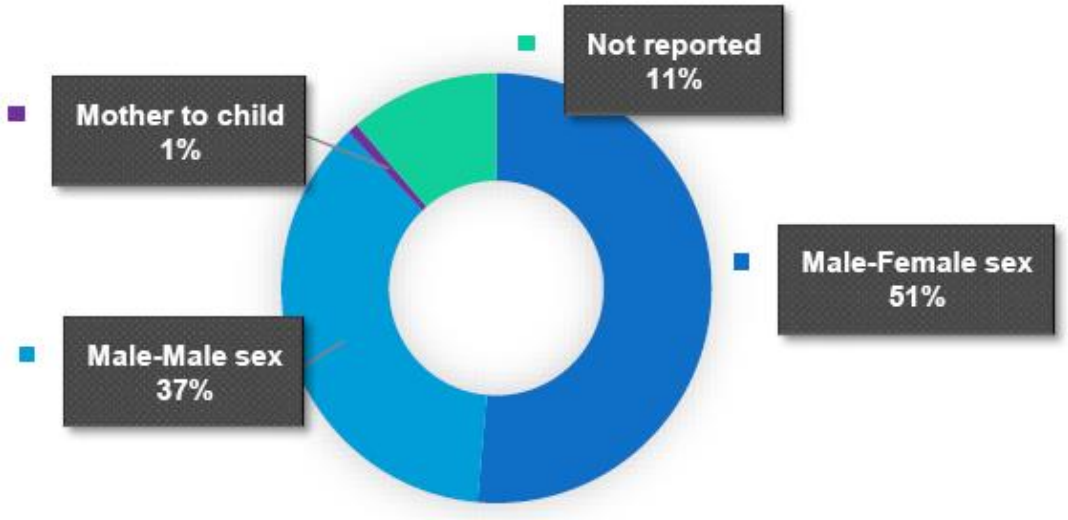
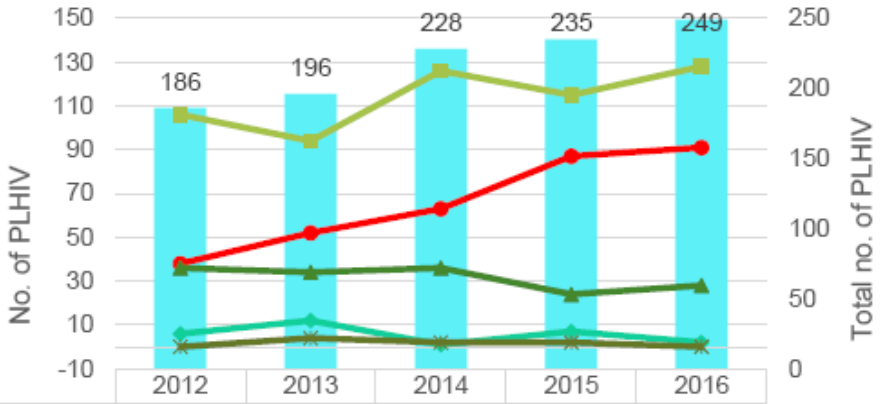


Figure 41: Probable modes of transmission of HIV cases reported in 2016 (N=249)



Sexual transmission accounted for 88% of all cases reported during 2016. However, in 11% of cases adequate data was not available to ascertain the probable mode of transmission.

Figure 42: Probable modes of HIV transmission of reported HIV cases 2012-2016



	2012	2013	2014	2015	2016
Total	186	196	228	235	249
Male to Female sex	106	94	126	115	128
Male to Male sex	38	52	63	87	91
Mother-to-child	6	12	1	7	2
IDU	0	4	2	2	0
No Data	36	34	36	24	28

According to figure 42 and 43, the proportion of male to male HIV transmission is gradually increasing. Nearly 50% of all males reported with HIV gave a history of male to male sexual contacts. Most of these men are married, thus causing added implications on spousal transmission and mother to child transmission of HIV.

Figure 43: Percentage of male to male transmission among reported male HIV cases

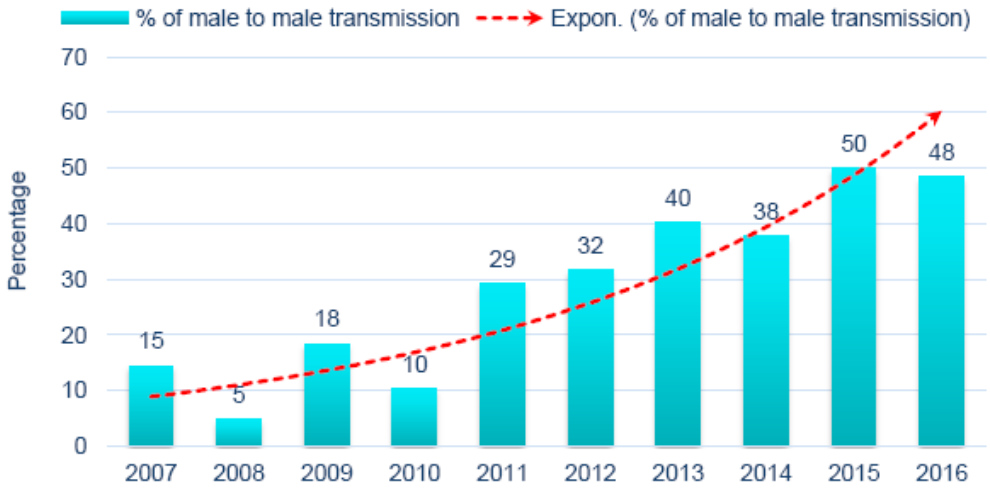
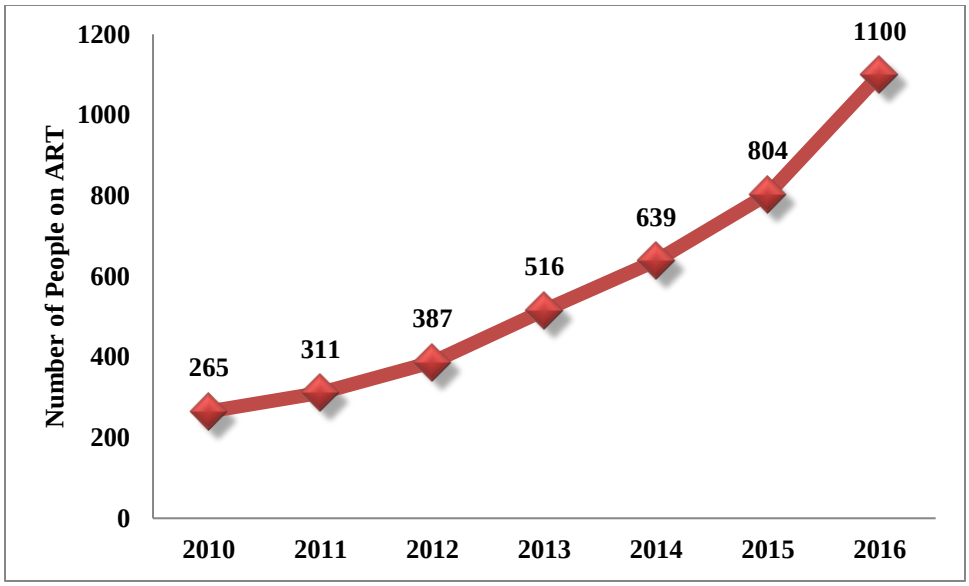


Figure 44: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2017

Figure 44 shows the trend of ART Scale up from 265 in 2010 to 1100 in 2016.

PEP (post-exposure prophylaxis) for HIV:

PEP (post-exposure prophylaxis) for HIV is prescribed to reduce the risk if somebody has been exposed to HIV. Accidental exposure to HIV can occur in the healthcare setting due to:

1. Accidental needle prick injury
2. Cut injuries during surgeries
3. Splashing of infected material onto mucous membranes such as eyes, mouth etc.
4. Exposure to infected material through non-intact skin

Preventing exposure to blood and body fluids is the most important strategy for preventing occupationally acquired HIV infection. If an occupational exposure has occurred, appropriate post exposure management is an important element of workplace safety. Post exposure prophylaxis refers to medications given to prevent HIV infection after exposure to potential infectious materials like blood, CSF, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, semen and vaginal secretions.

Before prescribing post exposure prophylaxis, the severity should be assessed by an expert medical officer. Then detailed counselling should be done and if PEP is indicated and the health care worker is willing, PEP must be started as soon as possible from the exposure, preferably

within 72 hours. It should be continue for 28 days if there are no side effects to antiretroviral drugs.

PEP services during 2016

Post exposure prophylaxis was given by 27 STD clinics and it was available at 37 hospitals in the country during 2016.

A total of 3136 healthcare workers came following potential exposure to HIV and of them 56 (1.78%) were started on PEP throughout the country. Only 18 people completed the total 28 days of treatment. Majority came to the Colombo and Anuradhapura STD clinic and the numbers were 537 and 496 respectively. In addition to occupational exposures, 2 people were started on post exposure prophylaxis following sexual exposure at Colombo and Ratnapura STD clinics. Both completed their 28 days.

When considering the antiretroviral treatment, most clinics used TDF+FTC+EFV regimen for PEP (46%). In addition following combinations had been given.

- TDF+FTC+EFV 26 health care workers
- TDF+FTC+LPV/r 23 health care workers
- AZT+3TC+LPV/r 03 health care workers
- AZT+3TC 02 healthcare workers
- TDF+FTC+ATZ/r 01 health care worker
- AZT+3TC+EFV 01 health care worker

Situation of STIs during 2016

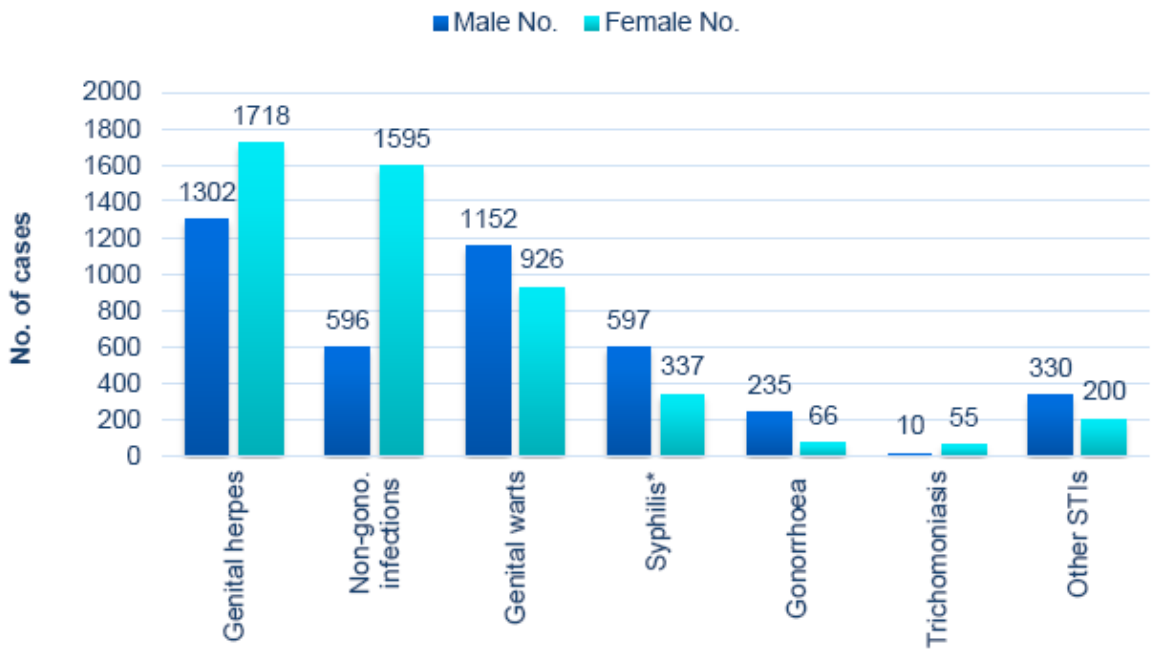
Monitoring and evaluation of STD services are carried out by the Strategic Information Management unit of the National STD/AIDS Control Programme. In low level HIV epidemics, STIs act as a sensitive marker of high risk sexual activity. Therefore, monitoring STI rates can help to identify vulnerability to HIV and also help to evaluate the success of prevention programmes. In addition, STI services are critical entry points for HIV prevention in low–level epidemics. Early diagnosis and treatment of STI will decrease related morbidity and reduce the likelihood of HIV transmission.

National STD/AIDS Control Programme provides comprehensive care for sexually transmitted infections (STIs) other than HIV. The most common sexually transmitted infections (STIs) are genital herpes, genital warts, non-gonococcal infections, syphilis, gonorrhoea, chlamydial infection and trichomoniasis. People who have infected with STIs are encouraged to seek services

from STD clinics distributed throughout the island. All service delivery points are equipped with specially trained staff who provide curative and preventive services.

A total of 21,973 new patients had received services from the National STD/AIDS Control Programme during 2016 while a total of 65,820 clinic visits were made by all STD attendees. Among them 9,129 STI diagnoses were made as summarized in the table above. Genital herpes has been reported as the commonest STI presentation. The Central clinic Colombo is the clinic with the highest service utilization serving the highly populated capital of the country. These patients are managed according to the standard guidelines on STD management, which include appropriate treatment, contact tracing, regular follow up and defaulter tracing. Out of the 31 STD clinics, 21 clinics have the capacity to provide antiretroviral treatment services for people living with HIV (PLHIV) at the end of 2016.

Figure 45: STI diagnoses reported from STD clinics by sex during 2016



Laboratory services

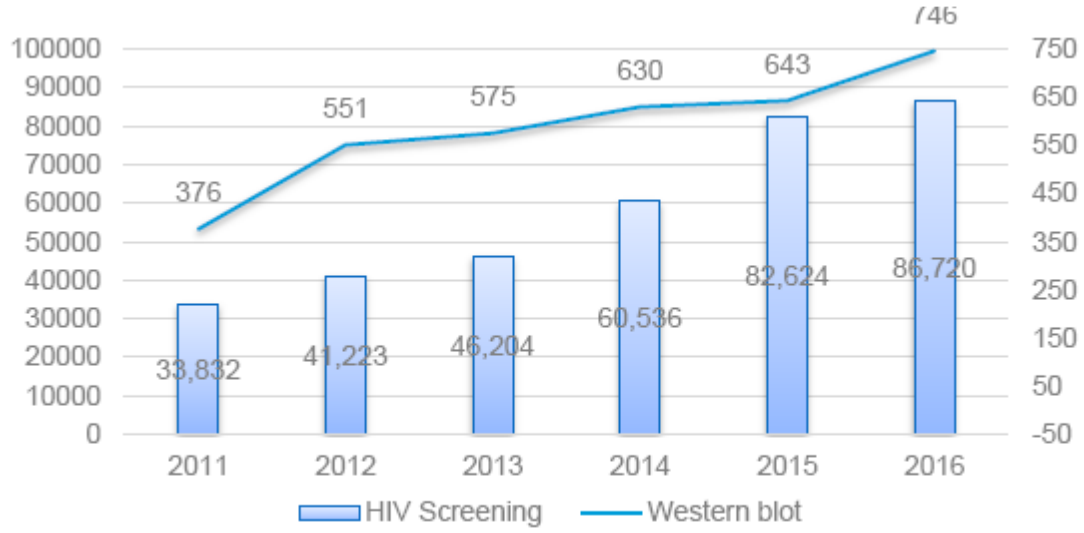
The laboratory services for HIV and STIs are provided by the National reference laboratory (NRL) of NSACP and the peripheral laboratories of the STD clinics. NRL provides technical guidance for diagnostic laboratory services of the country and plays the role of a reference centre. The range of laboratory services extends from the detection of sexually transmitted infections and HIV to evaluation and monitoring of the clinical management of these conditions. In addition,

biochemical and haematological tests are also provided for the HIV patients while PAP smear services are offered to eligible patients. Introduction of new tests related to STI and HIV is always considered in the programme while improving the quality of the existing tests. All the peripheral laboratories are planned to be equipped with ELISA technique for HIV screening. This was addressed in 2016 with the distribution of 10 ELISA machines to the peripheral clinics. In reference laboratory, new testing with real time PCR technology for Chlamydia, Gonorrhoea and HSV was introduced in year 2016. In addition, to facilitate HIV management at peripheral level, two CD4 machines were provided to Kandy and Galle STD clinics while two automated real time PCR machines for viral load testing were introduced to Galle and Anuradhapura.

The workload of the laboratory system has tremendously increased since 2013. This is mainly due to the implementation of EMTCT programme throughout the country in stepwise manner. The laboratory is expected to work towards the accreditation with the intention of maintaining its standards especially for EMTCT validation procedure. Some of the existing work setups are adversely affecting the path of accreditation process.

The graph below illustrates the number of CD4 and viral load tests carried out by the NLR from 2014 – 2016.

Figure 46: HIV testing at NRL, 2011-2016



World AIDS Day 2016

Each year the World AIDS Day (WAD) is commemorated on the 1st of December to remember those who were passed away due to AIDS as well as to re-invigorate determination and dedication for the battle against HIV/AIDS. The theme for this year is 'Hands up for HIV prevention'.

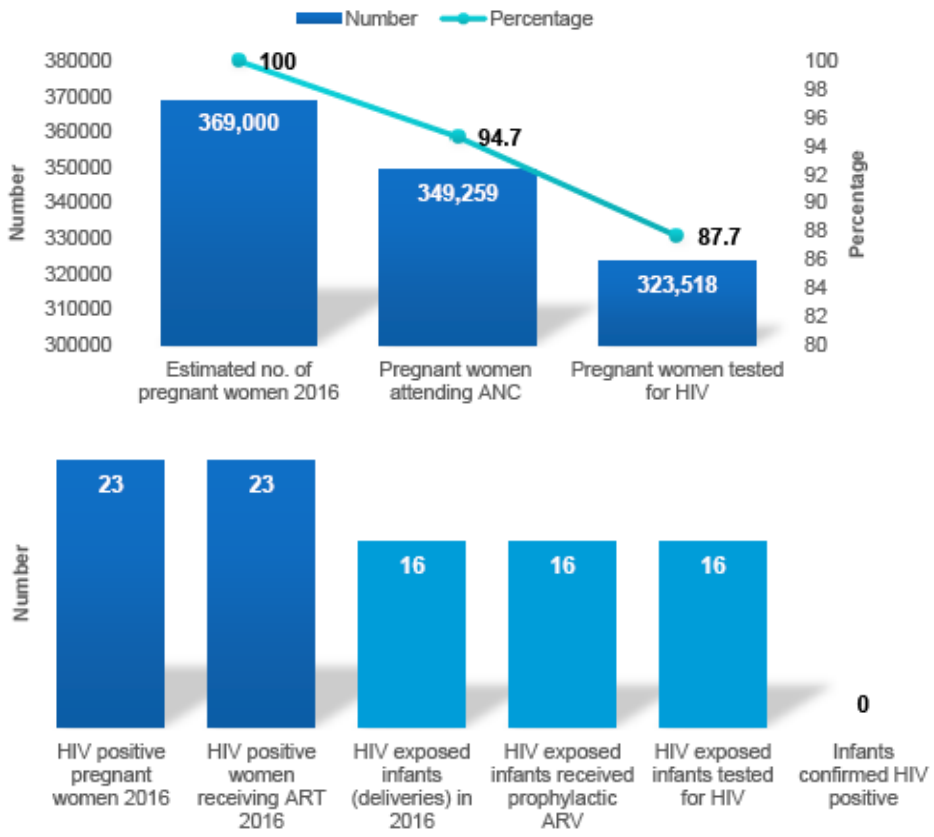
The National STD/AIDS Control Programme in collaboration with its partner organizations conducted an elaborated programme throughout the country to mark the WAD 2016.

National level activities

- ❖ World AIDS Day Walk
- ❖ Cycle parades
- ❖ Community based HIV rapid testing
- ❖ Raising public awareness through mass and social media

Cascade analysis in EMTCT

Figure 47: Cascade graphs for elimination of mother-to-child transmission of HIV



Above graph shows the cascade analysis of PMTCT services for HIV. Of the pregnant women attending government ANC clinics (349,259), 92.6 % (323,518) were tested for HIV by the

government system (STD clinics). A total of 23 pregnant women were given care in 2016 and of these 16 women delivered during the year. Services have been given to all 16 HIV exposed infants and none of newborns were infected with HIV.

HIV testing services in 2016

HIV testing services are critical in national response to HIV epidemic in the country. Over the years the number of HIV tests carried out in the country has increased. However, total number of HIV tests done may be underreported in the private sector as there is no formal mechanism established to report all the HIV tests. However, all confirmed positive HIV results are reported to NSACP as confirmatory test (Western Blot) testing is available only at the national reference laboratory of NSACP. Diversification of testing and service delivery methods were attempted during 2016. A total of 1,129,246 HIV tests had been done in 2016. There is an increase of over one hundred thousand (100,000) HIV tests compared to that of 2015. As expected, antenatal samples and testing through STD clinics have shown an increase. Blood donor screening also had added a significantly higher number of HIV tests compared to 2015 and a slight increase of testing among TB patients also observed in the given year. Total number of HIV positive persons detected during the year was 249.

HIV testing services through outreaching by STD clinics

Below given is the table which shows the out-reach HIV testing services provided by STD clinics in the country.

HIV screening through outreach activities by all STD clinics -2016

Type of outreach activities	Number tested
Prison blood survey	12,776
Female sex workers	1,408
Men who sex with men	379
Drug user survey	975
Colombo municipal council	288
World AIDS day 2016-Colombo	1,401
Others	33,270
Total	50,497

Providing HIV testing services through outreaching is an accepted good practice in many parts of the world. In Sri Lanka, there is an increase of outreach activities to provide STI/HIV/AIDS related services and HIV testing services are also increasingly being provided through outreaching. While the total number of HIV tests provided through outreaching in 2015 was

35,385 that in 2016 was 50,497. In 2017, a significant improvement is expected in the given area of services.

Escorting of Key population to STD clinics

Peer-led targeted intervention programme provides a sexual health services package to Key population groups. Promoting care seeking behavior among service recipients is one component of the package. Within that component, the peer-leaders (peer-educators) are supposed to escort certain number persons of relevant Key population groups. These escorts usually are offered HIV tests when they attend STD clinics.

HIV testing among Key populations (Escorts by peer-educators)

Type of Key population	Number of HIV tests
Female Sex workers	1413
Men who have sex with men	1085
Beach Boys	492
Total	2990

NSACP and its partners are planning to start community level HIV testing in 2017 for female sex workers, men having sex with men and drug users. In this service model, communities will provide services to fellow members of the communities. The services will be run by communities. An increased service uptake is expected by above population groups in coming years. A guideline for National HIV Testing was launched on 1st December 2016.

Multi-sectoral collaboration

This programme area has its focus mainly on the activities conducted aiming the vulnerable groups which has been identified in the National HIV Strategic plan 2013-2017. It oversees, coordinates and provides technical support for advocacy, capacity building, awareness and internalization of STI and HIV prevention activities of the multi-sectoral institutions.

- Capacity building at district level public health leaders
- Prison sector ("Light for life" HIV prevention programme)
- Armed forces - HIV prevention programmes
- Police Sector – HIV prevention programmes
- Media seminars
- Youth sector- HIV prevention programmes

- Education sector programmes
- Migrant Sector Programmes
- Tourism sector programmes
- Distribution of communication and teaching material

IEC and Advocacy programmes

Communication on STI and HIV is important to raise awareness as well as to achieve behavior change among public including the Key populations. These activities are implemented by NSACP and district STD clinics. Some of them are part of planned programmes and others on request from different organizations.

Many modes are used to reach different groups in the community including lectures, discussions, exhibitions, media conferences and newspaper supplements. Newspaper supplements were published to mark world AIDS day 2016 in Sinhalese, Tamil and English in 'Dinamina', 'Thinakaran' and 'Daily News' respectively to increase the coverage. The capacity building and training activities carried out by NSACP are not included in the below table and they are given in a different chapter.

Awareness activities carried out by NSACP in 2016

Type of activity and target group	Number of programmes	Number of attendees
School children	2	1200
Factory workers	1	150
Public-Exhibitions	12	149,450
Public-Lectures	3	650
Media conferences	2	200
others	106	4855
Newspaper supplements	3	NA
Total	**129**	**156,505**

Communication Strategy

A national communication strategy on control and prevention of STI/HIV/AIDS is being drafted currently. A steering committee within the IEC, Advocacy and Condom promotion sub-committee of NAC is leading this process. Under this activity following activities were carried out during 2016.

- desk reviews on available research of media usage in Sri Lanka,
- in-depth interviews with selected high level stakeholders and

- ❖ focused group discussions on communication of preventive and clinical services
- ❖ initiation of drafting the communication strategy

It is expected to finalize the national communication strategy on control and prevention of STI/HIV/AIDS during first half of 2017.

Challenges

- ▶ Identify the MARPs
- ▶ Link to the service
- ▶ Stigma and Discrimination
- ▶ Legal barriers for MARPS
- ▶ Strengthen the capacity of the community organization

SRI LANKA

Populations(mid-year)			21 millions
THE HIV EPIDEMIC	**2005**	**2010**	**2016**
New HIV infections	<200 (<200-<500)	<500 (<200-<1000)	<1000 (<500-1100)
HIV Incidence per 1000 populations	<0.01 (<0.01-0.02)	0.02 (<0.01-0.03)	0.03 (0.01-0.05)
AIDS related deaths	<100 (<100-<100)	<100 (<100-<200)	<200 (<100-<200)
People living with HIV	<1000(<1000-1900)	1800 (1300-3200)	4000 (2700-6000)
90-90-90			**2016**
People living with HIV who know their HIV Status		1900	47% (31%-68%)
People living with HIV who are on Treatment		1100	27 % (18%-39%)
Adults living with HIV who are on treatment		1000	26% (17%-39%)
People living with HIV who are virally suppressed		-	-
CHILDREN AND PREGNANT WOMEN		**2010**	**2016**
New HIV infections—children		-	-
Children living with HIV who are on treatment		-	-
Coverage of pregnant women living with HIV accessing antiretroviral medicines		-	-
HIV COMORBIDITIES			
Estimated number of incident TB cases among people living with HIV (2015)			<100 (<100-<100)
Proportion of people living with HIV with active TB in HIV care			5.8%
Cervical cancer screening of women living with HIV			-
HIV PREVENTION			
Knowledge of HIV prevention among young people (15-24)			-
Condom use at last higher-risk sex (with a non-marital, non cohabiting partner)			
Males			-
Females			-
Women aged 15-49 who have their demand for family planning satisfied with modern methods			-
Men aged 15-49 who are circumcised			Not applicable
Male circumcisions performed according to national standards (2016)			Not applicable
People on PrEP (2016)			-
STIGMA AND DISCRIMINATION			
People who report they would not buy vegetables from a shopkeeper living with HIV			-
POLICIES AND REGULATIONS			**2016**

Community delivery of treatment	No
Laws requiring parental consent for adolescents to access sexual and reproductive health services	No
TRIPS flexibilities incorporated in national legislation	No data available
Laws or policies restricting entry, stay and residence of people living with HIV	-
Criminalization of transmission of, nondisclosure of, or exposure to HIV	-
Recommended CD4 level for treatment initiation	Treat all
KEY POPULATIONS	
SEX WORKERS	
Estimated size of population	14132
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	93.1%
Condoms distributed to sex workers enrolled in prevention programmes (2016)	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PEOPLE WHO INJECT DRUGS	
Estimated size of population	423
HIV prevalence	-
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	25.9%
Clean needle use at last injection	46.3%
Needles and syringes distributed per person who injects (2016)	-
Coverage of HIV prevention programmes	-
Coverage of opioid substitution therapy (2016)	-
Naloxone available (2016)	No
Safe injection rooms available (2016)	No
Avoidance of services due to stigma and discrimination	-
GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN	
Estimated size of population	7551
HIV prevalence	1.5%
Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	47.1%
Condoms distributed to men who have sex with men in prevention programmes (2016)	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
TRANSGENDER PEOPLE	
Estimated size of population	-
HIV prevalence	-

Know HIV status	-
Antiretroviral therapy coverage	-
Condom use	-
Coverage of HIV prevention programmes	-
Avoidance of services due to stigma and discrimination	-
PRISONERS	
Estimated size of population	-
HIV prevalence	-
Antiretroviral therapy coverage	-
HIV prevention programmes in prisons (2016)	-
Condoms distributed	-
Clean needles distributed	-
Prisoners on opioid substitution therapy	-

Unless indicated otherwise, data are from the most recent survey available between 2011 and 2015.
Source: http://aidsinfo.unaids.org, http://aidsinfo.unaids.org/data sheet 2017

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. Starting in the 1980s, the HIV epidemic led to a major upsurge in TB cases and TB mortality in many countries.

In 2016, there were an estimated 1.3 million TB deaths among HIV-negative people (down from 1.7 million in 2000) and an additional 374 000 deaths among HIV-positive People.

Globally in 2016, 57% of notified TB patients had a documented HIV test result, up from 55% in 2015. The treatment success rate for HIV-associated TB (2015 cohort) was 78% and for extensively drug-resistant TB (XDRTB) (2014 cohort) it was 30%.

Improvements in the coverage and quality of data for this indicator are necessary to track the impact of HIV care, especially antiretroviral therapy (ART), on the burden of TB in people living with HIV.

Preventing TB deaths among HIV-positive people requires intensified scale-up of TB prevention, diagnosis and treatment interventions, including earlier initiation of ART among people living with HIV and those with HIV-associated TB. Increased efforts in joint TB and HIV programming could facilitate further scale-up and consolidation of collaborative TB/HIV activities.

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: Estimates of TB/HIV care in new and relapse TB patients, 2016

Country	Patients with known HIV status who are HIV positive		patients on Antiretroviral Therapy (ART)	
	Number	**%**	**Number**	**%**
Afghanistan	8	<1	8	100
Bangladesh	87	2	69	79
Bhutan	6	<1	3	50
India	39815	3	39123	98
Maldives	1	100	1	100
Nepal	255	4	227	89
Pakistan	71	<1	68	96
Sri Lanka	12	<1	7	58
Regional	**40255**		**39506**	**98**

Source: WHO Global TB Report, 2017

In 2016, a total 40225 TB patients with known HIV status has tested in which India accounts highest number of TB patients with known HIV status who are HIV positive. Total 39506 patients are on ART in the region which is around 98 % of total TB patients with known HIV status who are HIV positive in SAARC region.

The proportion of known HIV-positive TB patients on antiretroviral therapy (ART) was 85% globally, and above 90% in India in SAARC Region. However Afghanistan and Maldives have 100 % patients on Antiretroviral Therapy (ART) in 2016.

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