SAARC
Epidemiological Response on HIV/AIDS
2016

SAARC Tuberculosis and HIV/AIDS Centre
Kathmandu, Nepal

SAARC EPIDEMIOLOGICAL RESPONSE ON HIV/AIDS

2016

SAARC Tuberculosis and HIV/AIDS Centre

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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 2015, it is estimated that the number of people living with HIV globally was 36.7million [34.0 million-39.8 million] there were 2.1 million (1.8 million-2.4 million) new HIV infections in 2015. In addition, there were 1.1 million AIDS related deaths.

SAARC Region has an estimated 2.26 million People Living with HIV and India alone bears an estimated 2.1 million of that number in year 2015. 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 14th report on HIV epidemiology. This report “SAARC Epidemiological Response on HIV and AIDS – 2016” has incorporates the updated information and brief analysis on HIV/AIDS as of December 2015. 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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Dr. R. P. Bichha
Director
SAARC TB & HIV/AIDS Centre

ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
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
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
HSS	HIV Sentinel Surveillance
IBBS	Integrated Behavioural and Biological Surveillance
ICTC	Integrated Counseling Testing Center
IDU	Injecting Drug Users
MARPs	Most At Risk Population
MDGs	Millennium Development Goals
MDR	Multi Drug Resistance
MLM	Male labor migrants
MSM	Men who have sex with men
NACO	National AIDS Control Organization

NACP	National AIDS Prevention and Control Program
NSP	National Strategic Plan
NTPs	National Tuberculosis Control Programms
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
SEA	South East Asia
STAC	SAARC Tuberculosis and HIV/AIDS 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

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

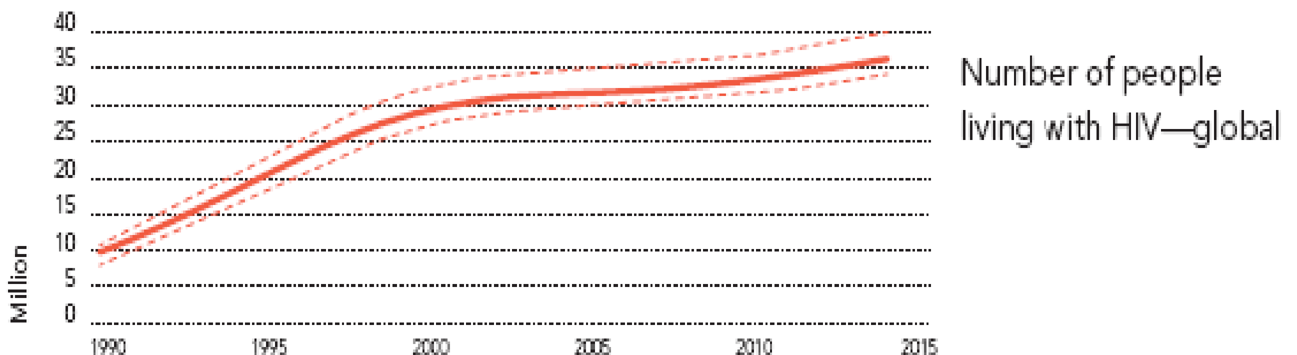
2.1 Overview of Global HIV/AIDS

- 18.2 million [CI: 16.1 million–19.0 million] people were accessing antiretroviral therapy (June 2016)
- 36.7 million [CI: 34.0 million–39.8 million] people globally were living with HIV (end 2015)
- 2.1 million [CI: 1.8 million–2.4 million] people became newly infected with HIV (end 2015)
- 1.1 million [CI: 940 000–1.3 million] people died from AIDS-related illnesses (end 2015)
- 78 million [CI: 69.5 million–87.6 million] people have become infected with HIV since the start of the epidemic (end 2015)
- 35 million [CI: 29.6 million–40.8 million] people have died from AIDS-related illnesses since the start of the epidemic (end 2015)

People living with HIV

In 2015, there were 36.7 million [CI: 34.0 million–39.8 million] people living with HIV.

Figure 1: Number of People living with HIV-global

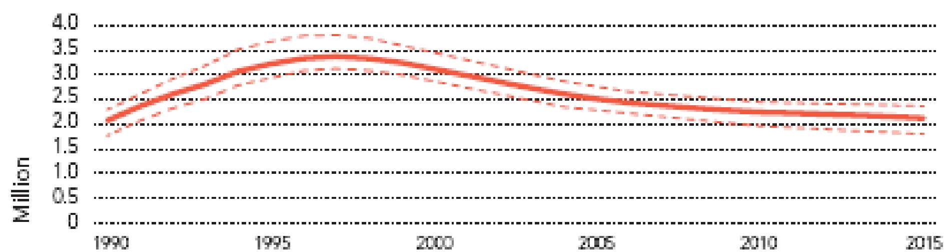


Source: Get on the Fast-Track, UNAIDS 2016

New HIV infections

- Worldwide, 2.1 million [CI: 1.8 million–2.4 million] people became newly infected with HIV in 2015.
- New HIV infections among children have declined by 50% since 2010.
- Worldwide, 150 000 [CI: 110 000–190 000] children became newly infected with HIV in 2015, down from 290 000 [CI: 250 000–350 000] in 2010.
- Since 2010 there have been no declines in new HIV infections among adults.
- Every year since 2010, around 1.9 million [CI: 1.9 million–2.2 million] adults have become newly infected with HIV.

Figure 2: Number of new HIV infections-global 1990-2015



Source: Get on the Fast-Track, UNAIDS 2016

About 5700 new HIV infections (adults and children) a day

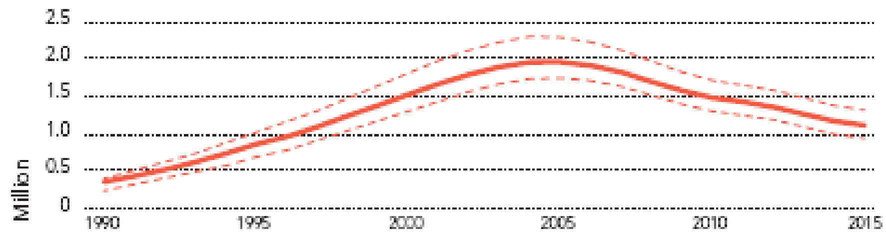
- About 66% are in sub-Saharan Africa
- About 400 are among children under 15 years of age
- About 5300 are among adults aged 15 years and older, of whom:
  - almost 47% are among women
  - about 35% are among young people (15–24)
  - about 20% are among young women (15–24)

AIDS-related deaths

- AIDS-related deaths have fallen by 45% since the peak in 2005.
- In 2015, 1.1 million [CI: 940 000–1.3 million] people died from AIDS-related causes worldwide, compared to 2 million [CI: 1.7 million–2.3 million] in 2005.

Number of AIDS-related deaths-global

Figure 3: AIDS related deaths 1990-2015



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- *Source: Get on the Fast-Track, UNAIDS 2016*

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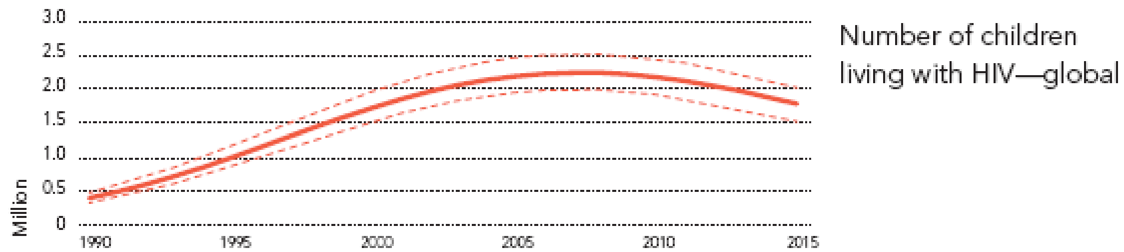
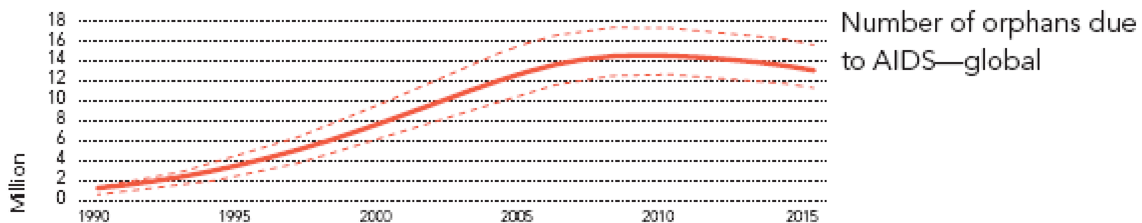
Figure 4: New HIV infection among children (1990-2015)



Source: Get on the Fast-Track, UNAIDS 2016

Figure 5: Number of orphans due to AIDS-global (1990-2015)



Source: Get on the Fast-Track, UNAIDS 2016

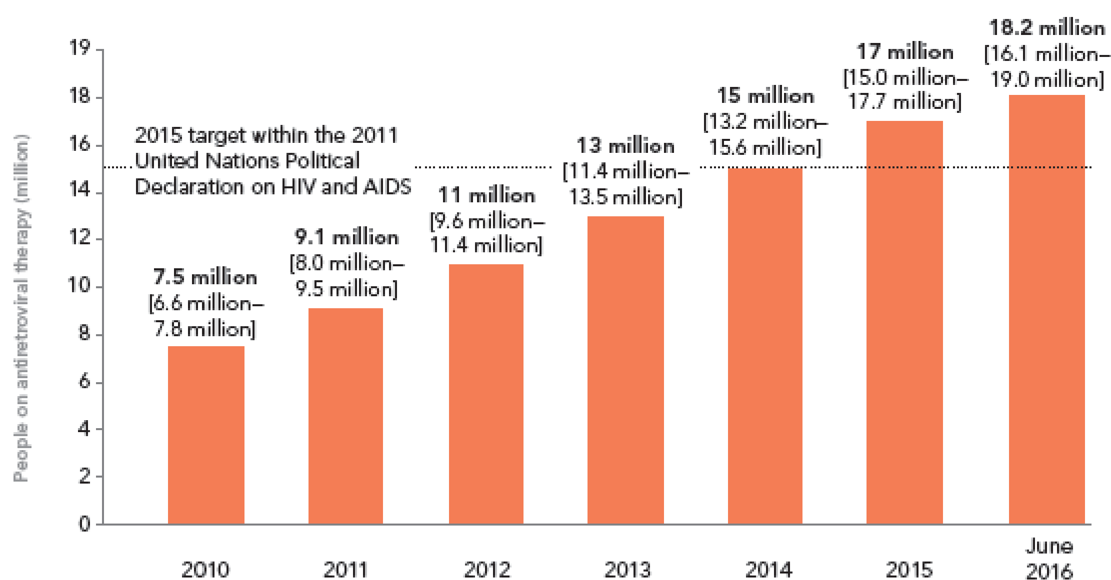
People living with HIV accessing antiretroviral therapy

❖ As of June 2016, 18.2 million [CI: 16.1 million–19.0 million] people living with HIV were accessing antiretroviral therapy, up from 15.8 million in June 2015 and 7.5 million in 2010.

❖ In 2015, around 46% [CI: 43–50%] of all people living with HIV had access to treatment.

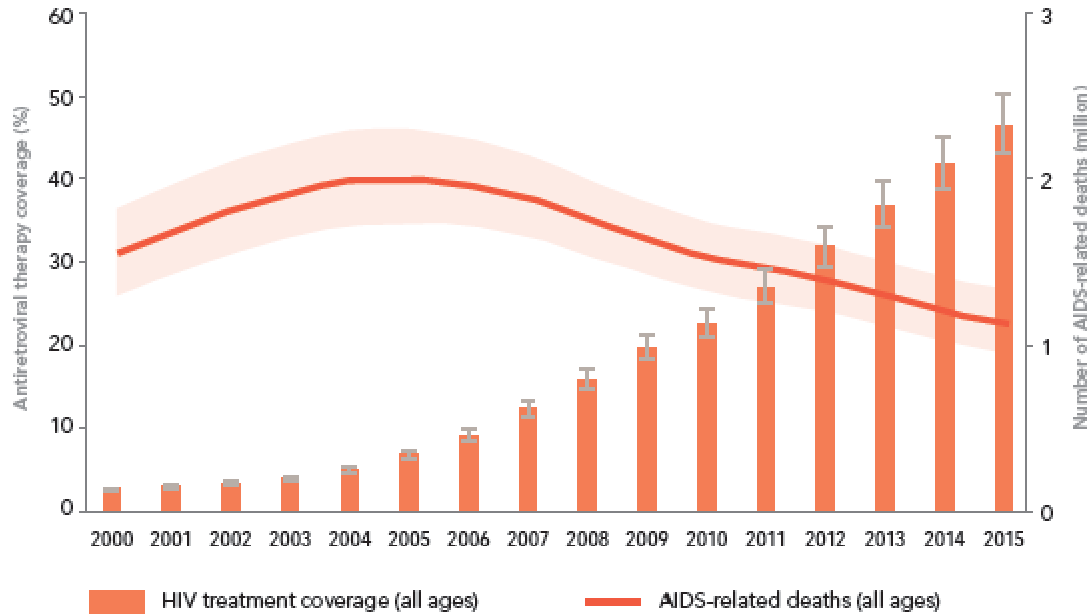
❖ In 2015, some 77% [CI: 69–86%] of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their babies.

Figure 6: Number of people living with HIV on antiretroviral therapy, global, 2010–2016



Sources: Global AIDS Response Progress Reporting (GARPR) 2016; UNAIDS 2016 estimates

Figure 7: Antiretroviral therapy coverage and number of AIDS-related deaths, global, 2000–2015



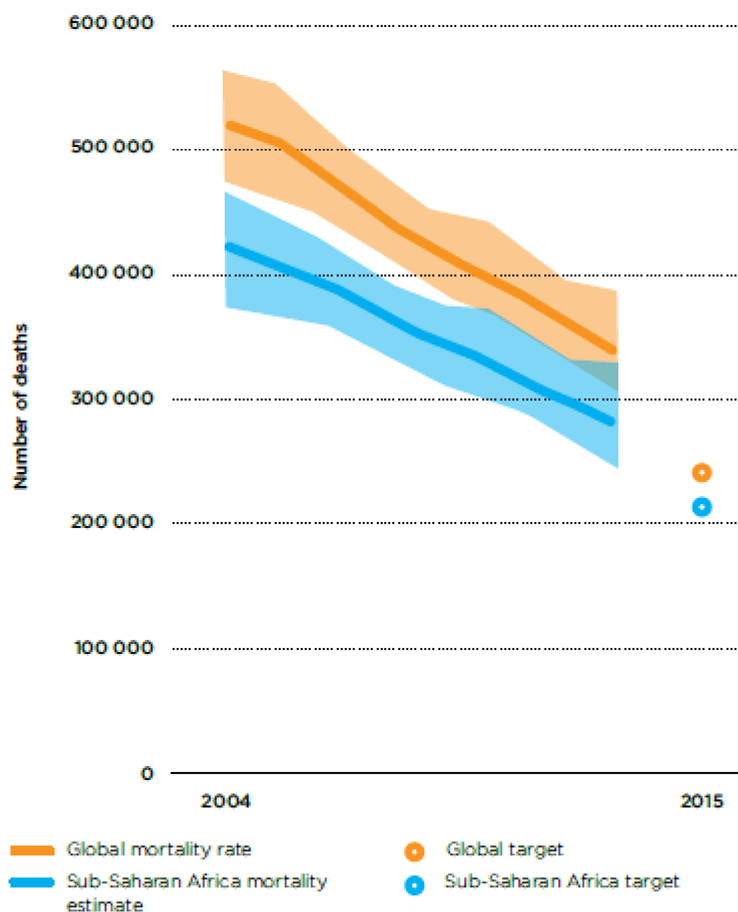
Sources: GARPR 2016; UNAIDS 2016 estimates.

Tuberculosis-Related Deaths among People Living With HIV

People living with HIV are 29 times more likely to develop tuberculosis (TB) than people who are not living with HIV. TB remains a leading cause of death among people living with HIV, accounting for one in five AIDS-related deaths globally. TB-related deaths among people living with HIV have declined steadily since 2004. As of 2013, TB-related deaths among people living with HIV worldwide have fallen by 33% since 2004 **(Figure 08)**. Among 41 countries with the highest burden of HIV/TB, 17 are estimated to have met by 2013 the target for reducing mortality by 50%. An important factor in the decline in TB-related deaths among people living with HIV is the rapid increase in antiretroviral treatment, which reduces the risk that a person living with HIV will develop TB by 65%. The most recent updated antiretroviral treatment guidelines from the World Health Organization (WHO) recommend initiation of HIV treatment for all people living with HIV who are diagnosed with TB, regardless of CD4 count.

HIV treatment coverage for people living with HIV/TB has increased. In terms of numbers of patients, the largest increases in antiretroviral therapy among people living with HIV/TB have occurred in India, South Africa, United Republic of Tanzania and Zambia.

Figure 08: Estimated number of tuberculosis-related deaths among people living with HIV, globally and in sub-Saharan Africa, 2004-2015



Source: UNAIDS report "How AIDS changed everything-2015"

2.2 Millennium Development Goals to Sustainable Development Goals

The world has exceeded the AIDS targets of Millennium Development Goal (MDG) 6, halting and reversing the spread of HIV, and more and more countries are getting on the Fast-Track to end the AIDS epidemic by 2030 as part of the Sustainable Development Goals (SDGs). New HIV infections have fallen by 35% since 2000 (by 58% among children) and AIDS-related deaths have fallen by 42% since the peak in 2004. The global response to HIV has averted 30 million new HIV infections and nearly 8 million (7.8 million) AIDS-related deaths since 2000, when the MDGs were set.

Ensuring access to antiretroviral therapy for 15.8 million people is an achievement deemed impossible 15 years ago. In 2000, less than 1% of people living with HIV in low- and middle-income countries had access to treatment. In 2014, the global coverage of people receiving antiretroviral therapy was 40%. But HIV continues to shine a harsh light on the inequalities of the world. AIDS is unfinished business. The case for change is compelling and commanding. Significant gaps and shortcomings of the response must be rectified. Accelerating the AIDS response in low- and middle-income countries could avert 28 million new HIV infections and 21 million AIDS-related deaths between 2015 and 2030. The AIDS response has a single priority for the next 15 years: ending the AIDS epidemic by 2030.

Table 01:

Global Summary of HIV/AIDS, 2001 – 2015

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
2015**	36.7 million	2.1 million		1.1 million
2014*	36.9 million	2 million	-	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: GLOBAL REPORT, UNAIDS report on the global AIDS epidemic 2013, * UNAIDS report "How AIDS Changed everything"-2015, ** Get on the Fast-Track, UNAIDS 2016*

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 2.26 million HIV infected people and 75800 AIDS deaths in 2015. **Table 02** shows the estimated number of People Living with HIV (PLHIV) in eight Member States of the SAARC Region in the year 2015. 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-2015

Country	*Population ('000)***	*Estimated No. of PLHA*	*HIV Prevalence Rate (%)*	*Estimated New HIV infection in 2015(all ages)*	*Incidence Rate among adults (15-49)*	**Number of AIDS Deaths**
Afghanistan	33000	6900	< 0.1	< 1000	<0.01	<500
Bangladesh	161000	9600	< 0.1	1100	<0.01	< 1000
Bhutan	757[a]	1000	0.1	<100	NA	<100
India	1311000	2.1 million	0.26*	86000	0.01	68000
Maldives	357[b]	<100	<0.1	<100	NA	<100
Nepal	29000	39,000	0.2	1300	<0.01	2300
Pakistan	189000	100,000	< 0.1	17000	0.02	3600
Sri- Lanka[c]	21000	3900	< 0.1	550	<0.01	110
Regional	**1745114**	**2.26 million**		**0.1 million**		**75800**

Source: http://aidsinfo.unaids.org -2016

** NACO Annual report 2015-2016*

*** Population taken from WHO Global Tuberculosis Report-2016*

[a] population taken from NTP Bhutan TB Report-2016

[b] Tuberculosis control in the South-East Asia Region, Annual report 2016

[c] National STD/AIDS Control programme Sri Lanka, Annual Report 2016

The overall adult HIV prevalence in SAARC region remains below 1%. However, there are important variations existing between countries. Of the estimated number of 2.26 million PLHIV in SAARC region, 2.1 million were living in India in 2015 (Table 2).

Table 03: Estimated number of PLHIV in key population in SAARC Region-2015

Country	Sex Worker	Men who have sex with men	People who inject drugs	Transgender
Afghanistan	12500	10700	40900	NA
Bangladesh	136073	101695	33066	10199
Bhutan	NA	NA	NA	NA
India	734186	289444	147078	62137
Maldives	NA	NA	NA	NA
Nepal	37880	196270	52174	9474
Pakistan	263441	150000	104848	NA
Sri- Lanka	14132	7551	423	NA
Regional	**1198212**	**755660**	**378489**	**81810**

Source: http://aidsinfo.unaids.org -2016

The estimated number of PLHIV in key population among Sex worker were 1.2 million, Men who have sex with men 0.76 million, people who inject drugs.0.37 million and 0.08 million transgender in 2015 in the SAARC Region (Table 3).

Table 4: % of HIV Prevalence in key population in SAARC Region-2015

Country	Sex Worker	Men who have sex with men	People who inject drugs	Transgender
Afghanistan	0	0	0	NA
Bangladesh	0.4	0.2	0	1.4
Bhutan	NA	NA	NA	NA
India	2.2	4.3	9.9	8.82
Maldives	NA	NA	NA	NA
Nepal	NA	2.4	6.4	6
Pakistan	2.5	3.5	0	NA
Sri- Lanka	0.8	0.6	0	NA

Source: http://aidsinfo.unaids.org -2016

The percentage of HIV Prevalence in key populations has shown in table 4, in which Pakistan has high percentage of HIV prevalence in sex worker and High HIV prevalence among MSM, PWID and TG in India in 2015 among all SAARC Member States.

Table 5: % of condom use by key population and number of needles per IDU in SAARC Region-2015

Country	Sex Worker	Men who have sex with men	People who inject drugs	No. of needles per IDUs
Afghanistan	0	0	0	80
Bangladesh	66.7	45.8	34.9	243
Bhutan	NA	NA	0	NA
India	90.8	83.9	77.4	259
Maldives	NA	NA	NA	NA
Nepal	NA	86	52.5	25
Pakistan	35.5	NA	0	194
Sri- Lanka	93.1	47.1	25.9	0

Source: http://aidsinfo.unaids.org -2016

Table 5 shows, the percentage of condom use by key population, in which Sri Lanka has highest condom use in sex worker, Nepal has highest condom use in Men who have sex with men and India has highest condom use in PWID. However, no. of needles per IDUs was high in India i.e. 259 in year 2015.

Table 6: % of HIV testing coverage in key population and number of needles per IDU in SAARC Region-2015

Country	Sex Worker	Men who have sex with men	People who inject drugs
Afghanistan	5.9	17.4	22.5
Bangladesh	47.6	41.7	54.4
Bhutan	NA	NA	0
India	90.8	70.6	64.1
Maldives	NA	NA	NA
Nepal	NA	43.8	27.9
Pakistan	8	NA	9.1
Sri- Lanka	33.9	14.1	8.3

Source: http://aidsinfo.unaids.org -2016

Table 6 shows the Percentage of HIV testing coverage in key population was high in India among the SAARC Member States in year 2015.

Table 7: HIV positive pregnant women received ARV for PMTCT in SAARC Region-2015

Country	Pregnant women needing ARV for PMTCT	Pregnant women who received ARV for PMTCT	ARV for PMTCT Coverage (%)
Afghanistan	<200	7	4
Bangladesh	<200	20	14
Bhutan	NA	NA	NA
India	35000	13511	38
Maldives	NA	NA	NA
Nepal	<500	145	35
Pakistan	2400	103	4
Sri- Lanka	<100	16	24
Regional	**37400**	**13802**	**37**

Source: http://aidsinfo.unaids.org -2016

In SAARC Region, there were 37400 Pregnant women needing ARV for PMTCT and 13802 Pregnant women who received ARV for PMTCT. However, ARV for PMTCT Coverage was 37% in 2015 (Table 7). About one million people receiving ART in year 2016 and deaths averted due to ART in 2015 81000 in SAARC Region (Table 8)

Table 8: Reported no. of people receiving ART and deaths averted due to ART

Country	No. of People receiving ART (2016)	Deaths averted due to ART (2015)
Afghanistan	455	<100
Bangladesh	1666	<200
Bhutan	310	NA
India	965292	80000
Maldives	0	NA
Nepal	12446	1000
Pakistan	7531	<500
Sri- Lanka	945	<100
Regional	**988645**	**81000**

Source: http://aidsinfo.unaids.org -2016

4. COUNTRY PROFILES

Afghanistan

Bangladesh

Bhutan

India

Maldives

Nepal

Pakistan

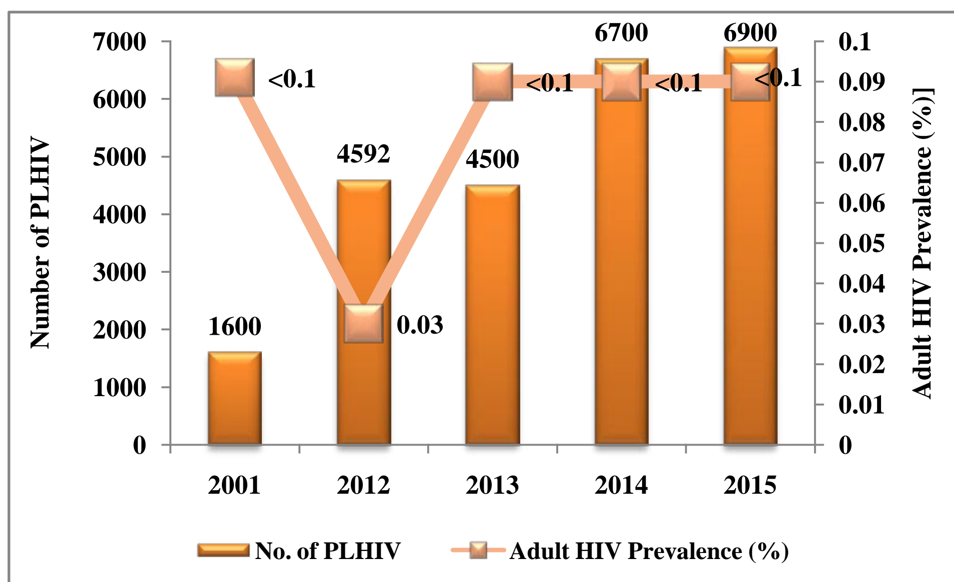
Sri-Lanka

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 33 million (WHO Global Tuberculosis Report-2016). Afghanistan consists of 34 provinces and 398 districts.

Overview of the HIV/AIDS epidemic

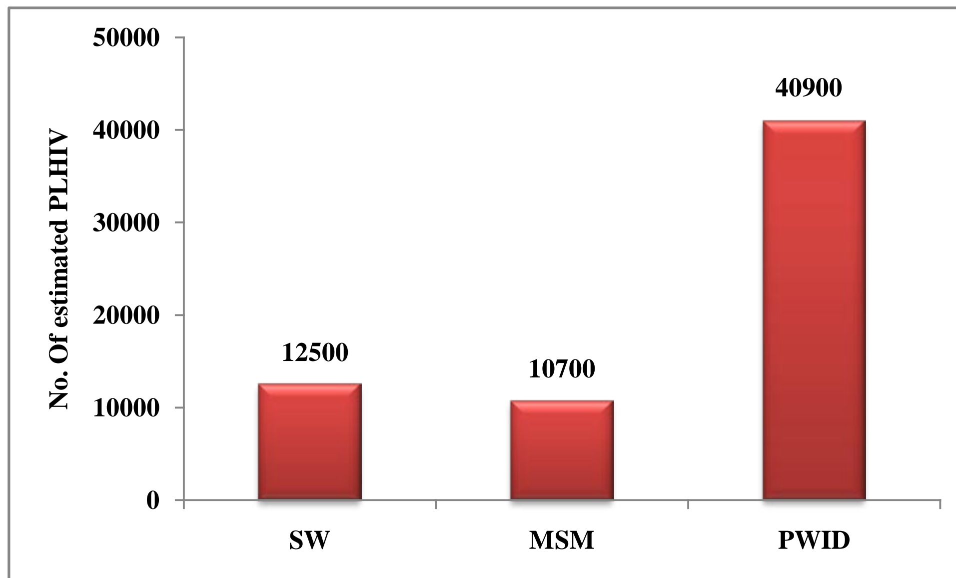
Based on available data HIV epidemic in Afghanistan seems to be low and step to concentrated and HIV prevalence in adults (15-49 Years) remains less than 0.1%. Figure 09 shows the trend of estimated adult HIV prevalence and number of PLHIV in Afghanistan from 2001 to 2015.A total 6900 estimated Number of People Living with HIV/AIDS (PLHIV) in the country in 2015. Less than 1000 estimated newly infected PLHIV and less than 500 an estimated number of deaths due to AIDS were in 2015 also, Figure 10 shows the estimated number of PLHIV in Key Populations in Afghanistan, 2015.

Figure 09: Estimated Adult HIV Prevalence & Number of PLHIV, Afghanistan, 2001-2015



Source: http://aidsinfo.unaids.org -2016

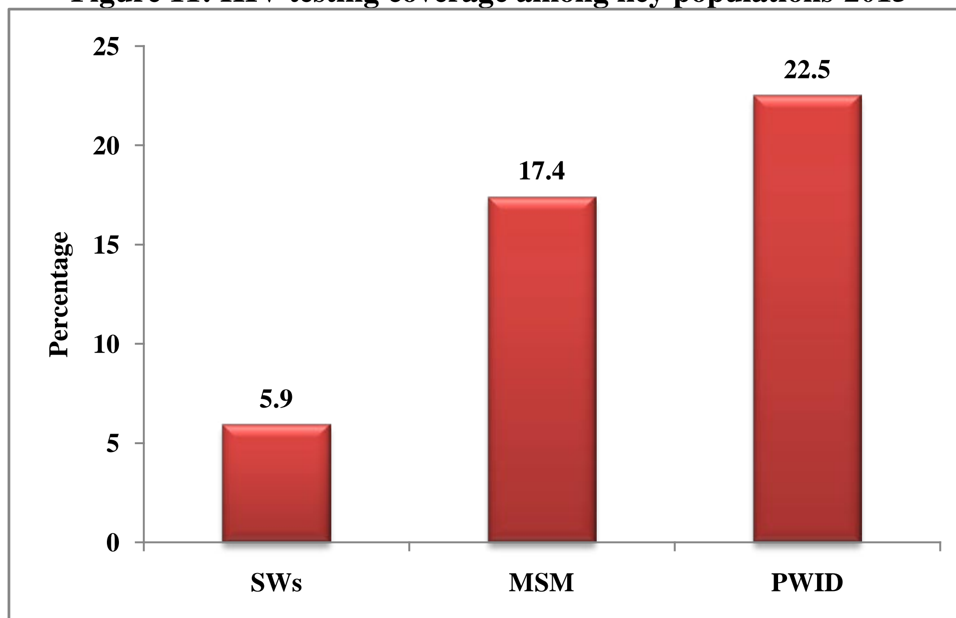
Figure 10: Number of estimated PLHIV in Key Populations-2015



Source: http://aidsinfo.unaids.org -2016

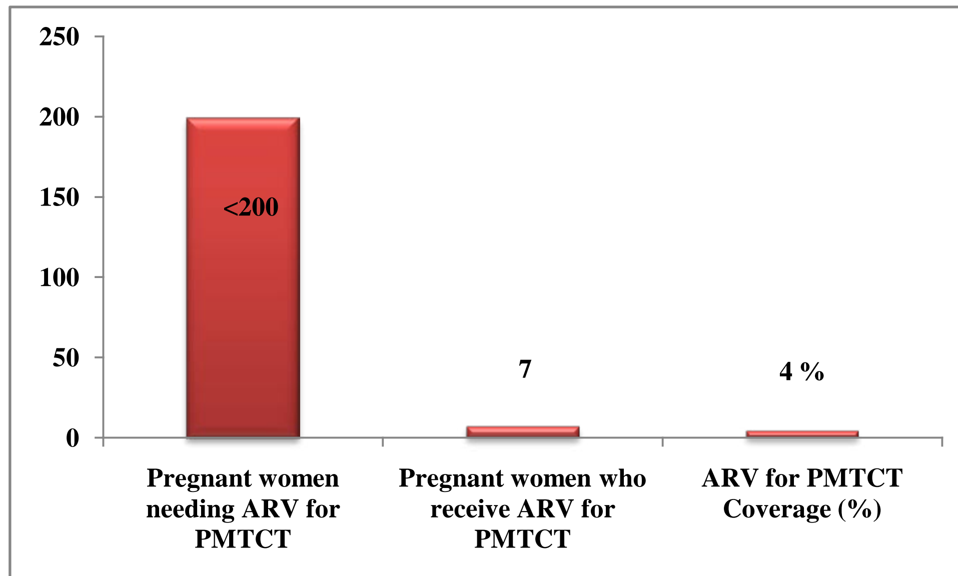
HIV testing coverage among key population in Afghanistan, were 5.9 % in SW, 17.4% in MSM and 22.5% in PWID in 2015 (Figure 11). However, <200 pregnant women needing ARV for PMTCT and there was 7 HIV positive pregnant women who had received ARV for PMTCT, also there were 4% ARV for PMTCT coverage in Afghanistan in year 2015 (Figure 12).

Figure 11: HIV testing coverage among key populations-2015



Source: http://aidsinfo.unaids.org -2016

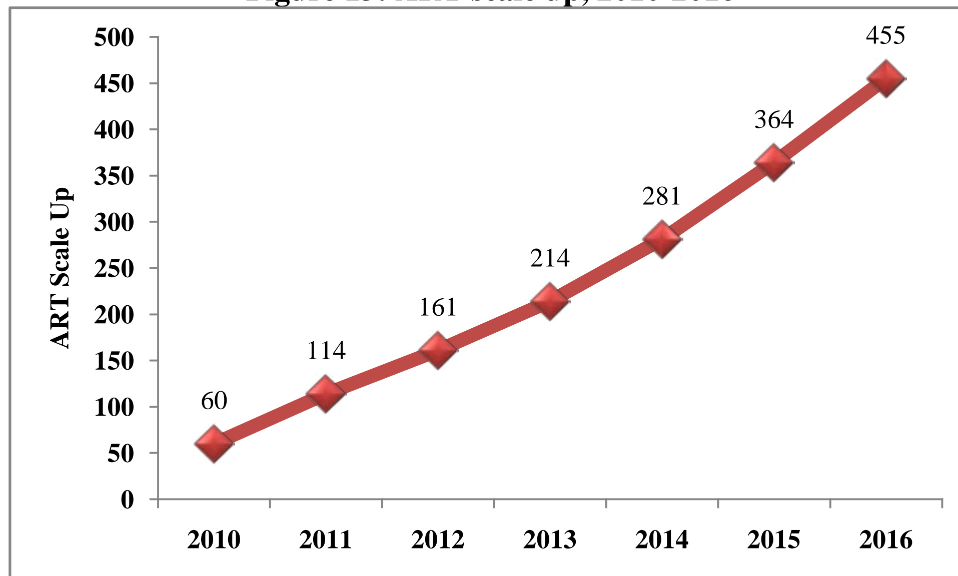
Figure: 12 pregnant women needing, received ARV for PMTCT and its coverage in Afghanistan-2015



Source: http://aidsinfo.unaids.org -2016

Figure 13 shows, ART scale up of Afghanistan from 2010-2016, which has increased from 60 to 455, however deaths averted due to ART in 2015 was <100.

Figure 13: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org -2016

Afghanistan

Epidemic Overview, 2015	
Population(***WHO Global Tuberculosis Report 2016***)	**32 million**
Estimated Number of people living with HIV/AIDS	6900
Estimated newly infected	<1000
Incidence rate among adults (15-49)	<0.01
Estimated number of deaths due to AIDS	<500
Estimated number of PLHIV in Sex workers	12500
Estimated number of PLHIV in Men who have sex with men	10700
Estimated number of PLHIV in PWIDs	40900
Number of needles per IDU	80
Estimated number of PLHIV in Transgender	NA
HIV Prevalence	
Adult (15 - 49)	<0.1%
Sex workers (SW)	0.00%
Men who have Sex with Men (MSM)	0.00%
People Who Inject Drugs (PWID)	0.00%
Transgender	NA
Condom use at last sex	
SW	0%
MSM	0%
PWID	0%
HIV Testing Coverage	
SW	5.9%
MSM	17.4%
PWID	22.5%
Treatment	
Reported number of people receiving ART (2016)	455
Deaths averted due to ART (2015)	<100
Pregnant women needing ARV for PMTCT	<200
HIV-positive pregnant women received ARV for PMTCT	7
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	4%

Source: http://aidsinfo.unaids.org -2016

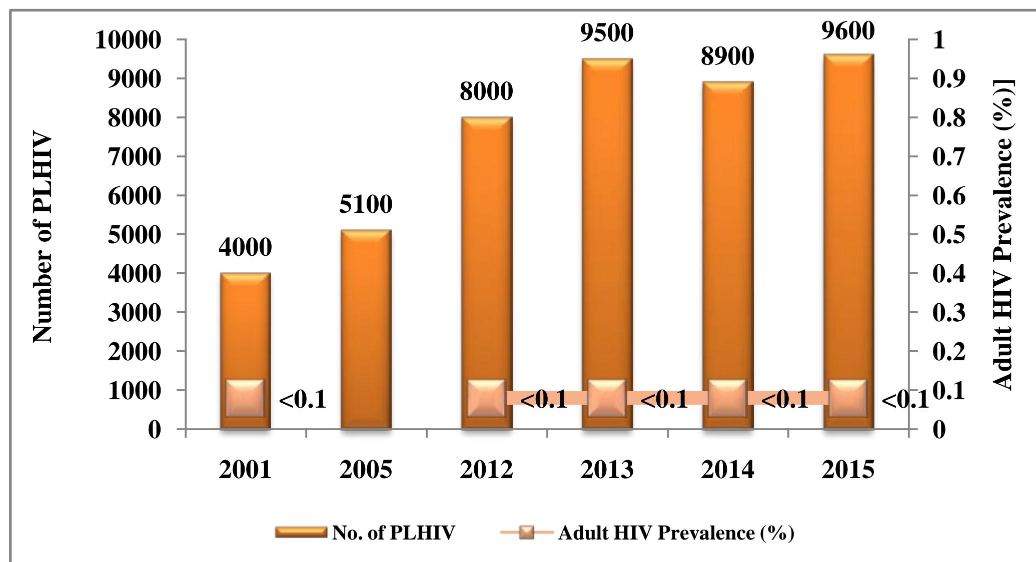
BANGLADESH

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 161 million (*WHO Global Tuberculosis Report -2016*), 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

In Bangladesh the first case of HIV was detected in 1989.In 2015 the Number of New HIV infected is 1100 and the Number of HIV/AIDS related Death is <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 14 shows the trend of estimated PLHIV from 2001 to 2015.

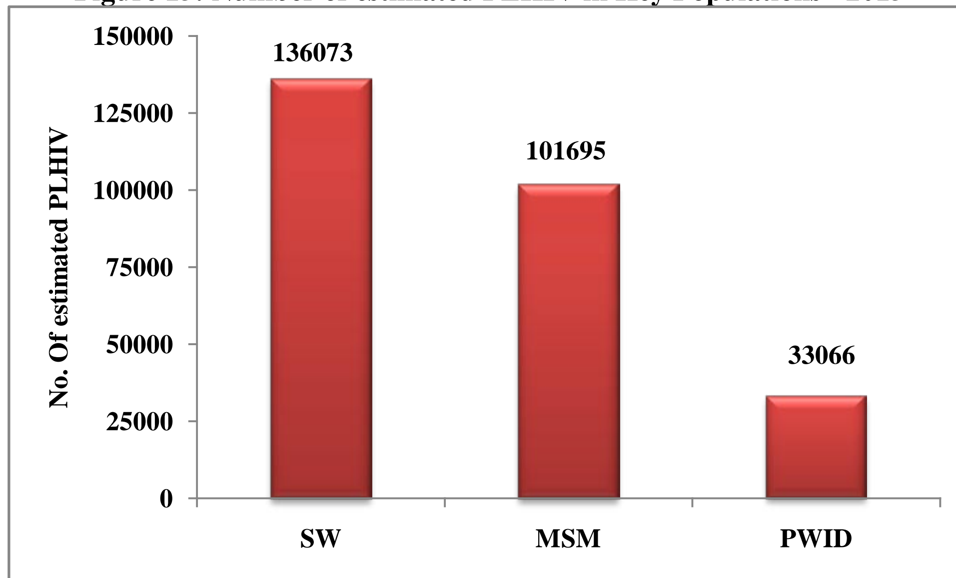
Figure 14: Estimated Adult HIV Prevalence & Number of PLHIV, 2001-2015



Source: http://aidsinfo.unaids.org -2016

The number of estimated PLHIV in Key population were 136073 in SW, 101695 in MSM, 33066 in PWID and 10199 in transgender (Figure 15). The coverage of needles per IDU who inject drugs per year was 243 in the year 2015.

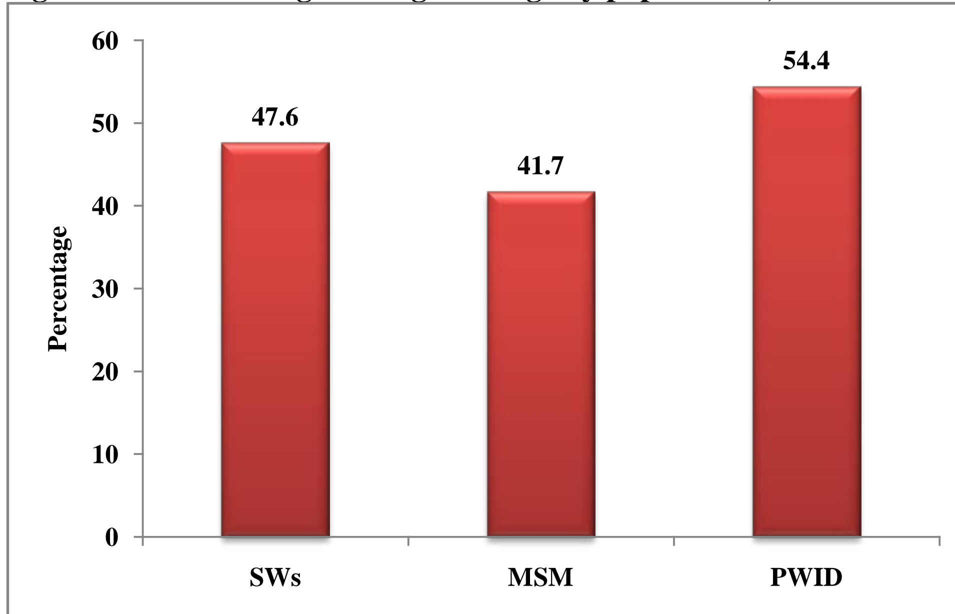
Figure 15: Number of estimated PLHIV in Key Populations - 2015



Source: http://aidsinfo.unaids.org/data sheet 2016

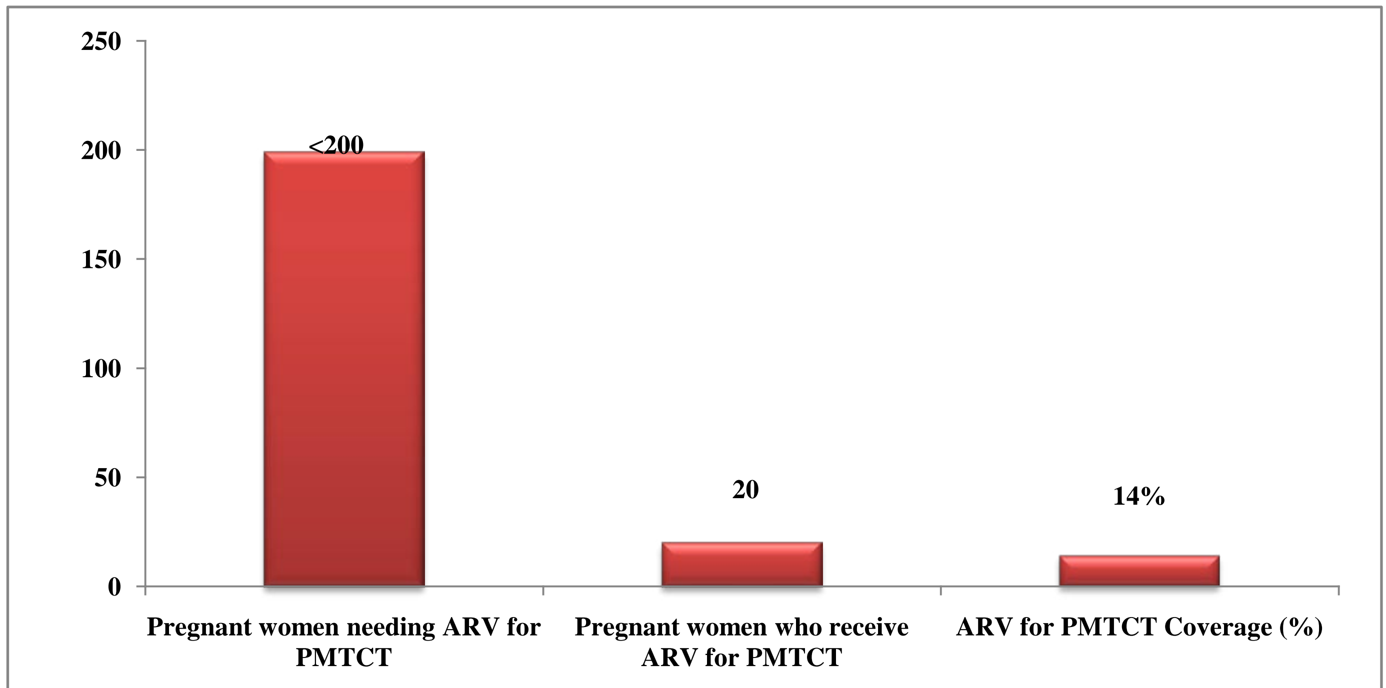
The HIV testing coverage among key population in Afghanistan were 47.6%, 41.7% and 54.4% in SWs. MSM and PWID respectively in year 2015 (Figure 16).

Figure 16: HIV testing coverage among key populations, 2015



Source: http://aidsinfo.unaids.org/data sheet 2016

Figure 17: pregnant women needing, received ARV for PMTCT and its coverage-2015



Source: http://aidsinfo.unaids.org/data sheet 2016

Figure 18: ART scale up, 2010-2016

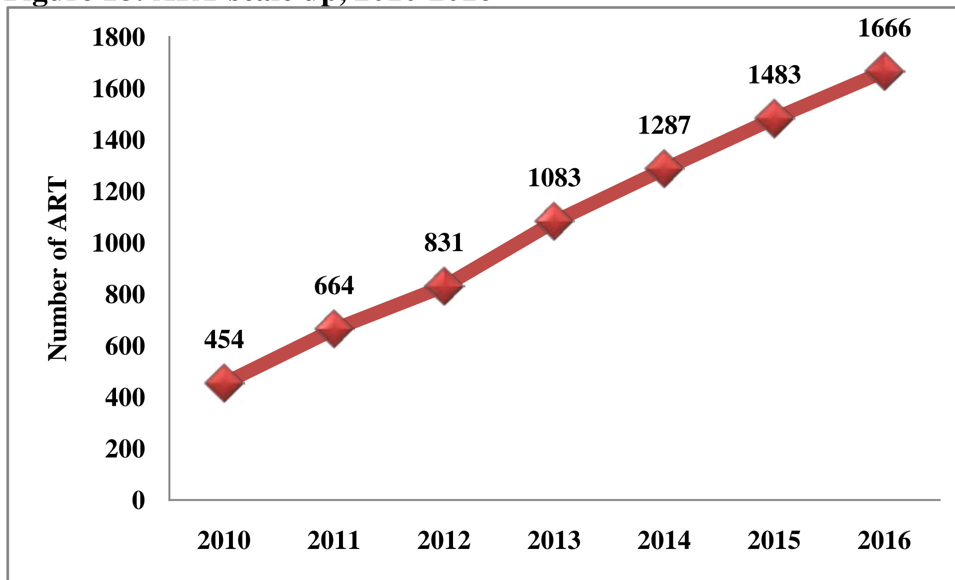


Figure 17 shows less than 200 pregnant women needing ARV for PMTCT however, 20 Pregnant women had received ARV for PMTCT and its coverage was 14% in the year 2015. Figure 18 shows the scaling up of number of people on ART from 454 in 2010 to 1666 in 2016.

Bangladesh

Epidemic Overview, 2015	
Population (*WHO Global Tuberculosis Report-2016*)	**161 million**
Estimated Number of people living with HIV/AIDS	9600
Estimated newly infected	1100
Incidence rate among adults (15-49)	<0.01
Estimated number of deaths due to AIDS	<1000
Estimated number of PLHIV in Sex workers	136073
Estimated number of PLHIV in Men who have sex with men	101695
Estimated number of PLHIV in PWIDs	33066
Number of needles per IDU	243
Estimated number of PLHIV in Transgender	10199
HIV Prevalence	
Adult (15 - 49)	<0.1
Sex workers (SW)	0.40%
Men who have Sex with Men (MSM)	0.20%
People Who Inject Drugs (PWID)	0.00%
Transgender	1.40%
Condom use at last sex	
SW	66.7%
MSM	45.8%
PWID	34.9%
HIV Testing Coverage	
SW	47.6%
MSM	41.7%
PWID	54.4%
Treatment	
Reported number of people receiving ART (2016)	1666
Deaths averted due to ART (2015)	<200
Pregnant women needing ARV for PMTCT	<200
HIV-positive pregnant women received ARV for PMTCT	20
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	14%

Source: http://aidsinfo.unaids.org -2016

BHUTAN

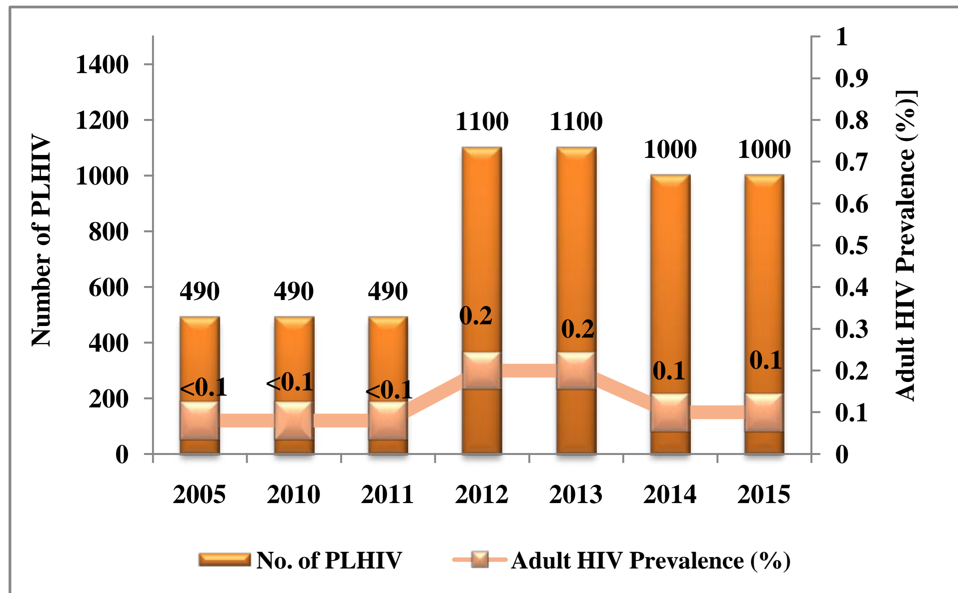
Bhutan is a land locked country situated in the Himalayas, it has border with China and India. Bhutan has an area of 38,394 sq km and the altitude varying from 180 m to 7,550 m above sea level. The total population of Bhutan is 757000 (Data from NTP Bhutan-2016). The country is divided into 20 districts 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. 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 0.2per cent (0.1-0.6%). Estimated 1000 PLHIV cases in Bhutan in year 2015 (Figure 19), 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.

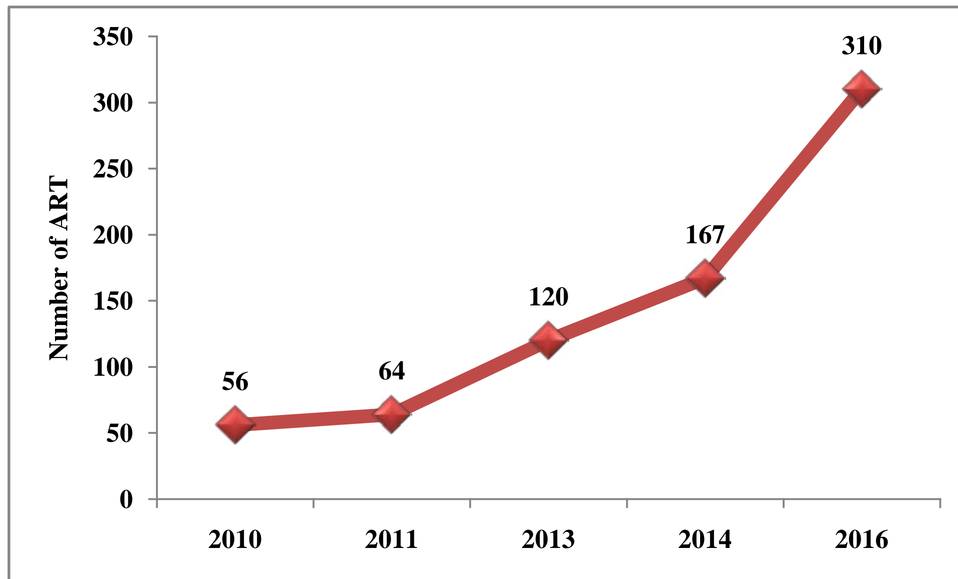
Figure 19: Estimated Adult HIV Prevalence & Number of PLHIV, Bhutan 2005-2015



Source: http://aidsinfo.unaids.org

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 20: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org/data sheet 2016

Figure 20 shows, the trend of ART scale up from 2010-2016.Till date there are 310 people on ART.

Bhutan

Epidemic Overview, 2015	
Population(Data from NTP Bhutan-2016)	**757000**
Estimated Number of people living with HIV/AIDS	1000
Estimated newly infected	<100
Incidence rate among adults (15-49)	NA
Estimated number of deaths due to AIDS	<100
Estimated number of PLHIV in Sex workers	NA
Estimated number of PLHIV in Men who have sex with men	NA
Estimated number of PLHIV in PWIDs	NA
Number of needles per IDU	NA
Estimated number of PLHIV in Transgender	NA
HIV Prevalence	
Adult (15 - 49)	0.10%
Sex workers (SW)	NA
Men who have Sex with Men (MSM)	NA
People Who Inject Drugs (PWID)	NA
Transgender	NA
Condom use at last sex	
SW	NA
MSM	NA
PWID	0%
HIV Testing Coverage	
SW	NA
MSM	NA
PWID	0.0%
Treatment	
Reported number of people receiving ART (2016)	310
Deaths averted due to ART (2015)	NA
Pregnant women needing ARV for PMTCT	NA
HIV-positive pregnant women received ARV for PMTCT	NA
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	NA

Source: http://aidsinfo.unaids.org -2016

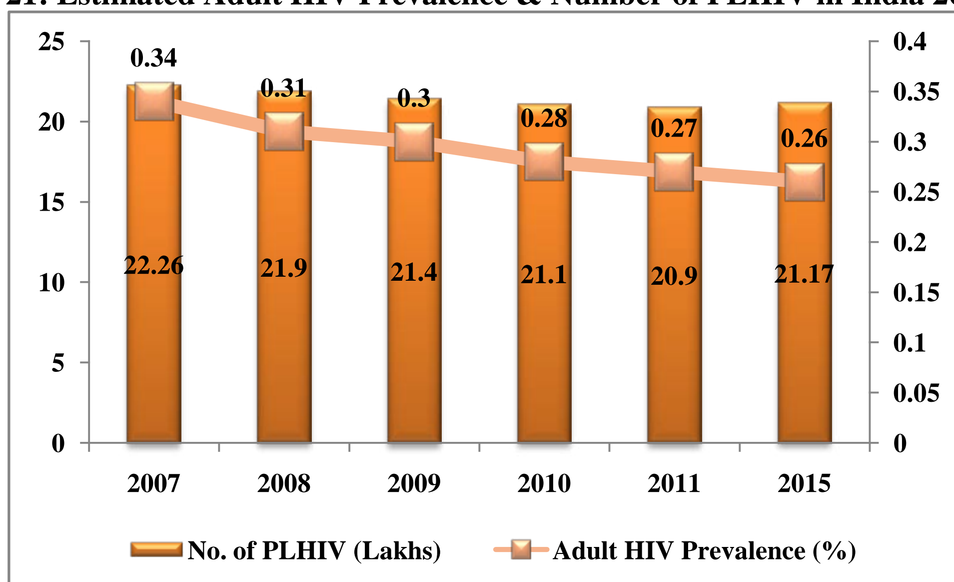
INDIA

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 1311 million (WHO Global Tuberculosis Report-2016). 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 0.26% (0.22%– 0.32%) in 2015. In 2015, adult HIV prevalence is estimated at 0.30% among males and at 0.22% among Females. 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 21: Estimated Adult HIV Prevalence & Number of PLHIV in India 2007-2015

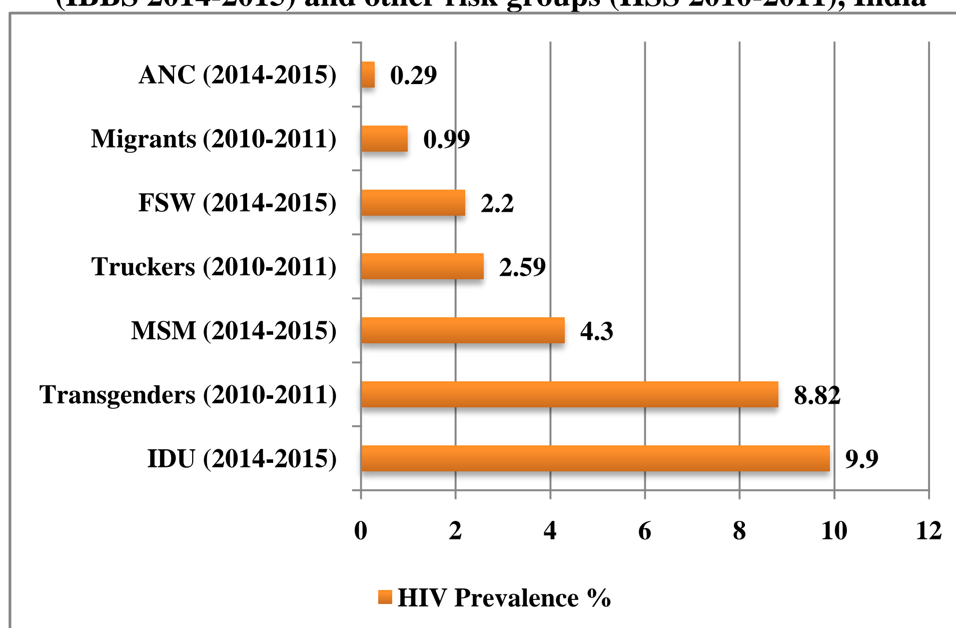


Source: NACO Annual Report 2015-2016

The total number of People Living with HIV (PLHIV) in India is estimated at 21.17 lakhs (17.11 lakhs–26.49 lakhs) in 2015 compared with 22.26 lakhs (18.00 lakhs-27.85 lakhs) in 2007. Children (< 15 years) account for 6.54%. (Figure 21)

India continues to portray a concentrated epidemic. HIV prevalence among different risk groups is given in Figure 22. National Integrated Behavioural and Biological Surveillance (IBBS) has estimated HIV prevalence among Female Sex Workers (FSWs), nationally, level at 2.2% (95% CI: 1.8 - 2.6). HIV Prevalence among MSM recorded at the national level was 4.3% (95% C I: 3.7 – 5.1) while among IDU, the prevalence of HIV recorded among IDU at the national level was 9.9% (95% CI: 9.0 - 10.9).

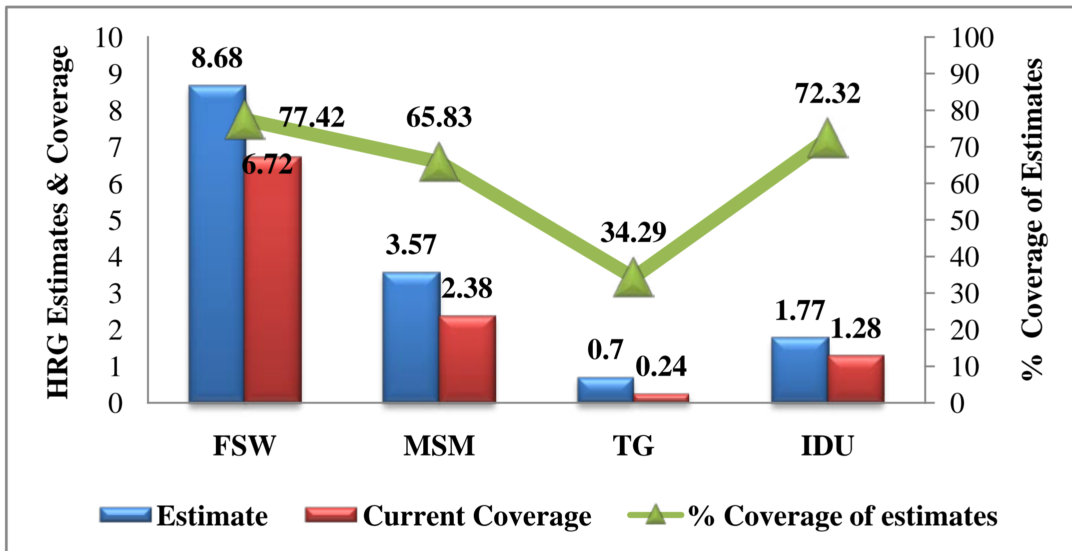
Figure 22: HIV Prevalence (%) among ANC clients (HSS 2014-2015), FSW, MSM, IDU (IBBS 2014-2015) and other risk groups (HSS 2010-2011), India



Source: NACO Annual Report 2015-2016

The coverage data for core group HRGs is based on the periodic reports received at NACO, as depicted in Figure 23 the key performance of TIs, shows that FSW coverage compared to the estimates has been the highest among the core groups (77.42%) and from last year coverage for TG has increased from 0.18 to 0.24 lakhs while for others it has slightly decreased.

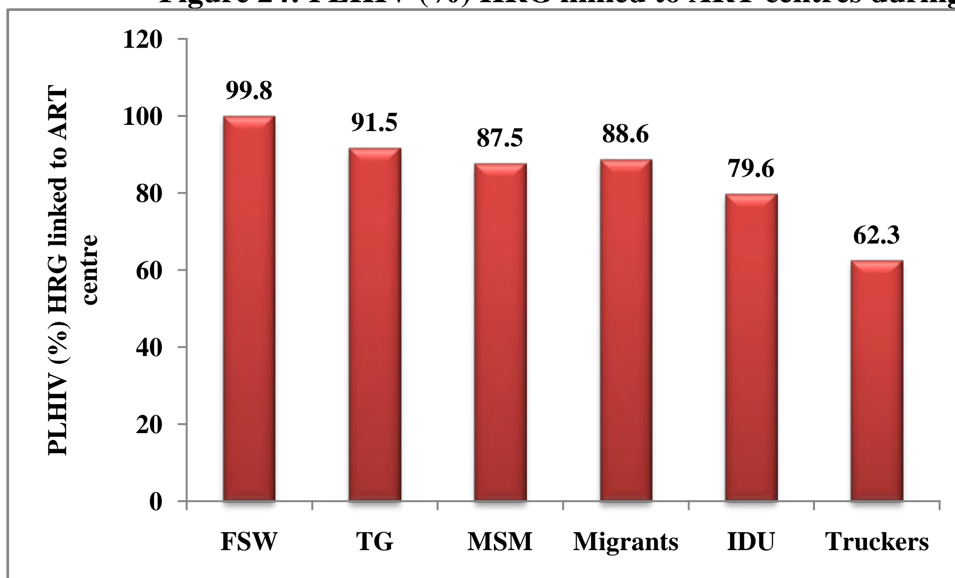
Figure 23: Coverage of Core HRG (FSW, MSM, IDU) during 2015-2016



Source: NACO Annual Report 2015-2016

Figure 24 depicts the PLHIV HRG linked to ART centers during the period 2015-16 (Up to Sept 2015). Due to the mobility of long distance truck drivers the percentage of HIV positive truckers being linked to ART centers is low at 62.3%, while for other HRGs more than 80% of the PLHIV identified are linked to ART centers. As part of increasing the coverage especially amongst bridge group (where the % of HIV testing is hovering around 10-15%) community based testing is being experimented. This year HIV testing through TIs would focus and prioritise on the left out HRG Population who could not access HIV testing facility at ICTCs even once as per old strategy. This should pave the way for ease of access for HIV testing facility for HRGs.

Figure 24: PLHIV (%) HRG linked to ART centres during 2015-2016

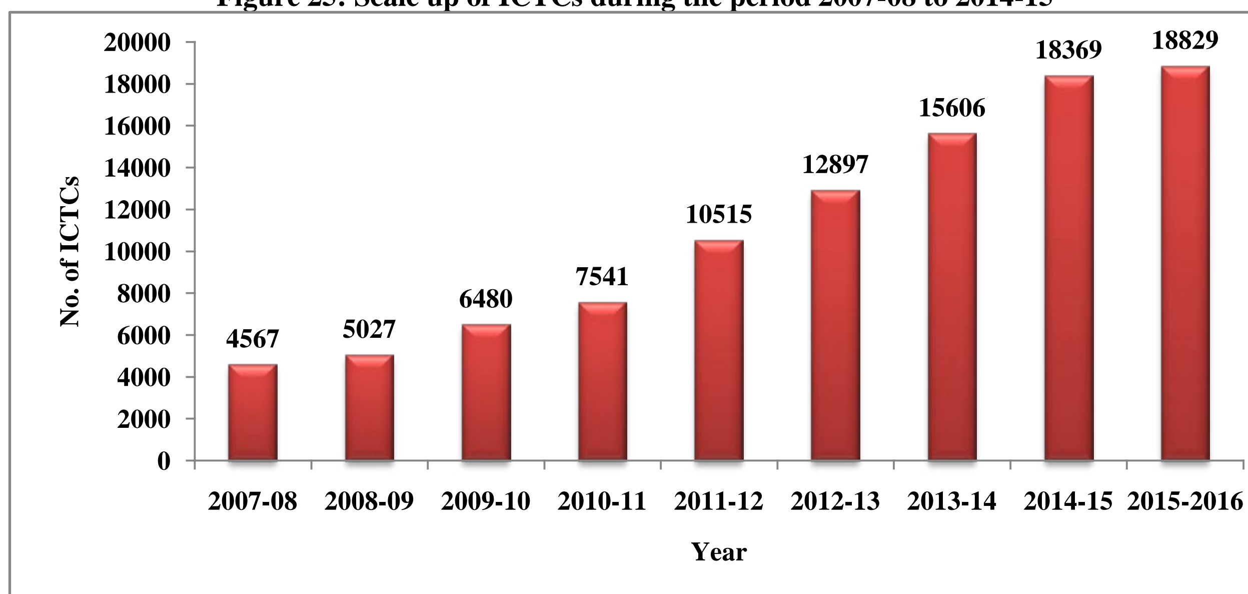


Source: NACO Annual Report 2015-2016

There is an increase in the number of ICTCs in the country, clearly portraying integration of counselling and testing services under general health services, increase in geographical coverage of these services below block level, better accessibility and addressing sustainability (Figure 25)

The Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) programme was started in the country in the year 2002. Currently there are more than 18,000 ICTCs in the country which offer PPTCT services to pregnant women. The aim of the PPTCT programme is to offer HIV testing to every pregnant woman (universal coverage) in the country, so as to cover all estimated HIV positive pregnant women and eliminate transmission of HIV from mother-to-child.

Figure 25: Scale up of ICTCs during the period 2007-08 to 2014-15

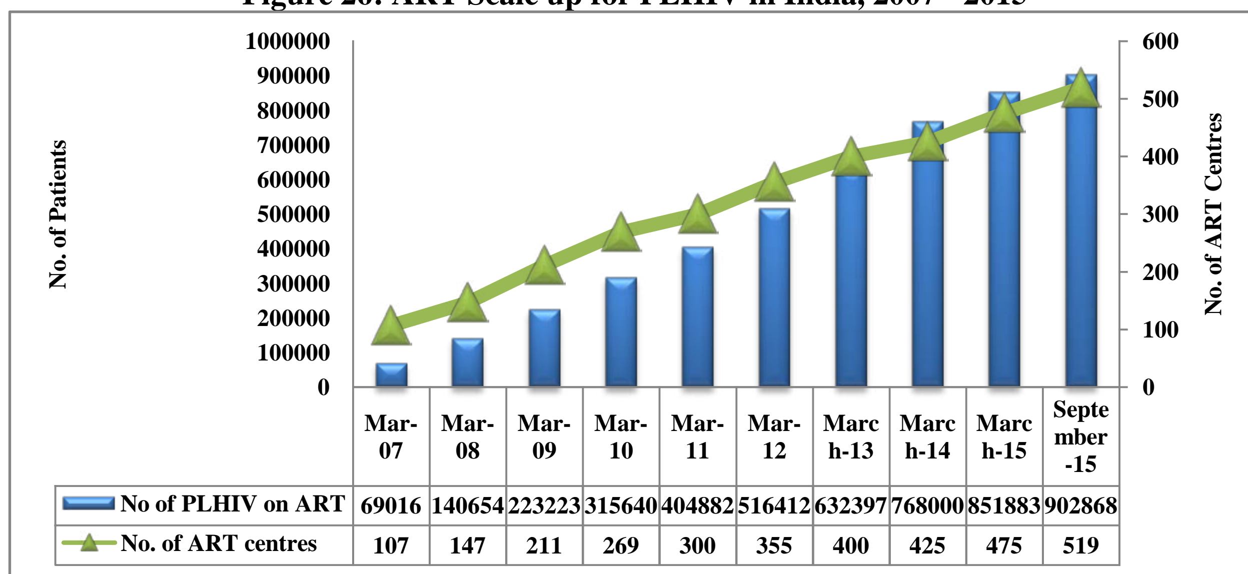


Source: NACO Annual Report 2015-2016

Figure 26 shows the scaling up of service provisioning under CST component since March 2007. All measures of service provisioning, viz. number of ART centers, PLHIV ever registered and PLHIV on 1st line treatment have increased exponentially.

The National Pediatric HIV/AIDS Initiative was launched on 30th Nov 2006. Till September 2015, nearly 77,729 Children Living with HIV/AIDS (CLHIV) are active in HIV care at ART centers and of whom, 49,909 are receiving free ART. Pediatric formulations of ARV drugs are available at all ART centers.

Figure 26: ART Scale up for PLHIV in India, 2007 - 2015



	Mar-07	Mar-08	Mar-09	Mar-10	Mar-11	Mar-12	March-13	March-14	March-15	September-15
No of PLHIV on ART	69016	140654	223223	315640	404882	516412	632397	768000	851883	902868
No. of ART centres	107	147	211	269	300	355	400	425	475	519

Source: NACO Annual Report 2015-2016

India

Epidemic Overview, 2015	
Population (***WHO Global Tuberculosis Report-2016***)	**1311 million**
Estimated Number of people living with HIV/AIDS	2.1 million
Estimated newly infected	86000
Incidence rate among adults (15-49)	0.01
Estimated number of deaths due to AIDS	68000
Estimated number of PLHIV in Sex workers	734186
Estimated number of PLHIV in Men who have sex with men	289444
Estimated number of PLHIV in PWIDs	147078
Number of needles per IDU	259
Estimated number of PLHIV in Transgender	62137
HIV Prevalence	
Adult (15 - 49)	0.26%
Sex workers (SW)	2.20%
Men who have Sex with Men (MSM)	4.30%
People Who Inject Drugs (PWID)	9.90%
Transgender	8.82%
Condom use at last sex	
SW	90.8%
MSM	83.9%
PWID	77.4%
HIV Testing Coverage	
SW	90.8%
MSM	70.6%
PWID	64.1%
Treatment	
Reported number of people receiving ART (2016)	965292
Deaths averted due to ART (2015)	80000
Pregnant women needing ARV for PMTCT	35,000
HIV-positive pregnant women received ARV for PMTCT	13,511
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	38%

Source: http://aidsinfo.unaids.org -2016

MALDIVES

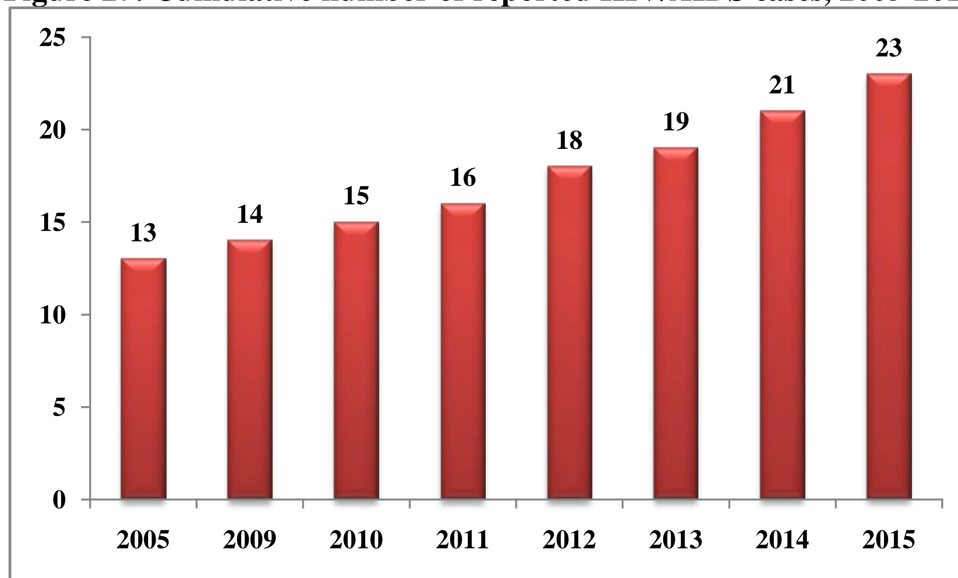
Republic of Maldives is a country formed by a number of natural atolls plus a few islands and isolated reefs which form a pattern from North to South. Maldives is situated in the Indian Ocean, close to India and Sri Lanka. It is located southwest of the Indian subcontinent stretching 860 km north to 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 352000 (HIV and AIDS data hub for Asia Pacific-2015) in year 2014. 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 27: Cumulative number of reported HIV/AIDS cases, 2005-2015



Source: http://aidsinfo.unaids.org-2016

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%).

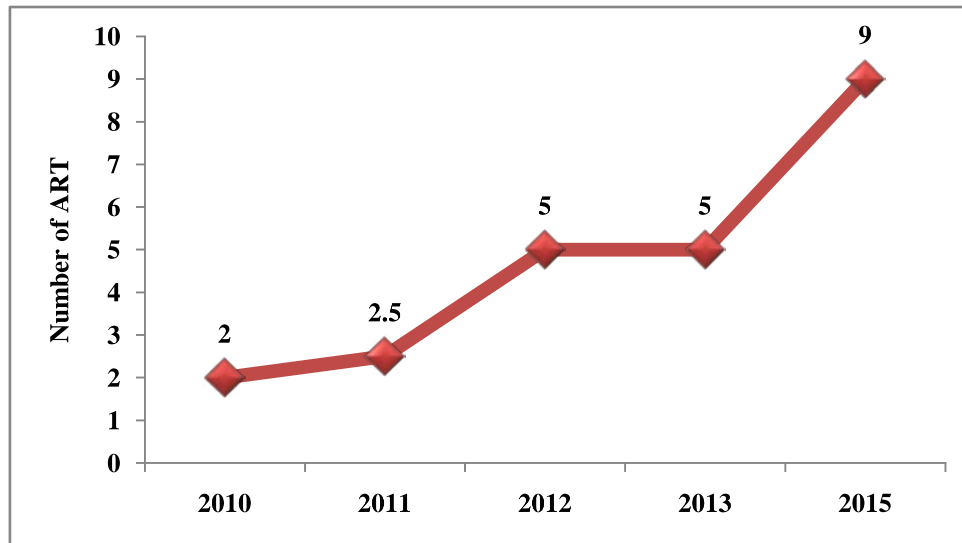
Although HIV prevalence is still below 1%, sexually transmitted infections (STIs), particularly, syphilis, an ulcerative STI, was detected among the resort workers with a prevalence of 1.2%. Likewise, Hepatitis B was also detected among the resort workers, MSM, seafarers, construction workers and IDU.

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 28: ART scale up, 2008-2015



Source: http://aidsinfo.unaids.org-2016

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 28 shows the ART scale up from 2008 to 2015.

Maldives

Epidemic Overview, 2015	
Population (*WHO Tuberculosis Control in South East Asia Region-Annual Report 2016)*	**357000**
Estimated Number of people living with HIV/AIDS	<100
Estimated newly infected	<100
Incidence rate among adults (15-49)	NA
Estimated number of deaths due to AIDS	<100
Estimated number of PLHIV in Sex workers	NA
Estimated number of PLHIV in Men who have sex with men	NA
Estimated number of PLHIV in PWIDs	NA
Number of needles per IDU	NA
Estimated number of PLHIV in Transgender	NA
HIV Prevalence	
Adult (15 - 49)	<0.1%
Sex workers (SW)	NA
Men who have Sex with Men (MSM)	NA
People Who Inject Drugs (PWID)	NA
Transgender	NA
Condom use at last sex	
SW	NA
MSM	NA
PWID	0%
HIV Testing Coverage	
SW	NA
MSM	NA
PWID	NA
Treatment	
Reported number of people receiving ART (2015)	9
Deaths averted due to ART (2015)	NA
Pregnant women needing ARV for PMTCT	NA
HIV-positive pregnant women received ARV for PMTCT	NA
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	NA

Source: http://aidsinfo.unaids.org -2016

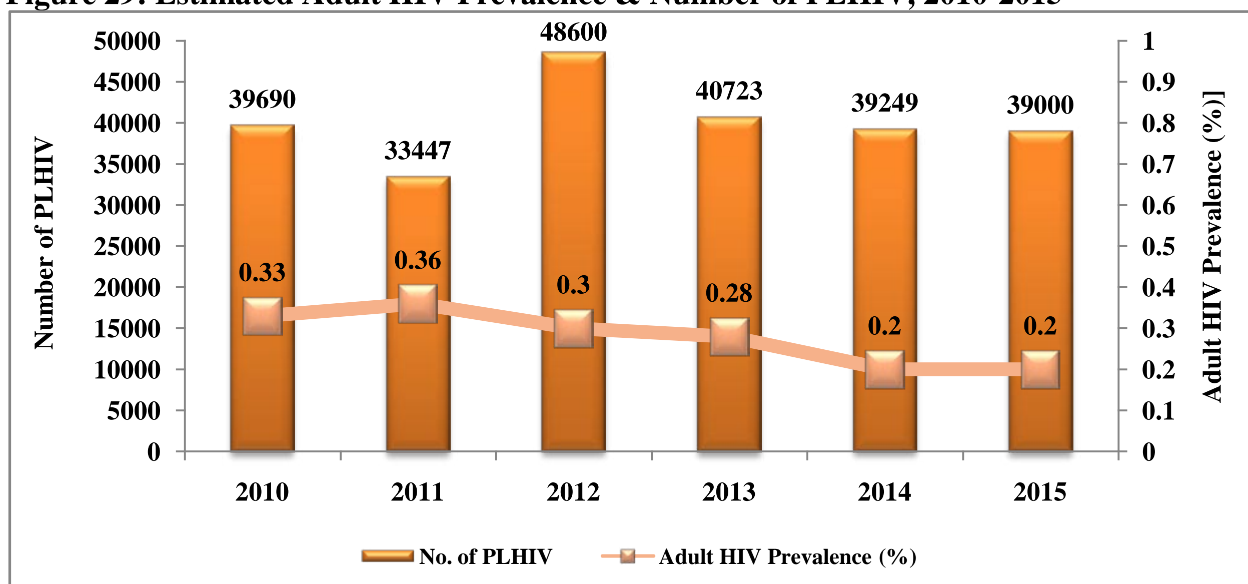
NEPAL

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 75 districts. It has an area of 147,181 square kilometers and a population of approximately 29 million (WHO Global Tuberculosis Report-2016). The urban population is largely concentrated in the Kathmandu valley. Nepal has a market economy mainly based on farming and tourism.

Overview of the HIV/AIDS epidemic

Nepal's HIV prevalence has not changed much over the last five years, it has remained within 0.3 - 0.2 percent. It is estimated that there are around 39,000 people living with HIV in 2015, decreasing from 39249 in 2014 (Figure 29). An estimated number of 2300 deaths were due to AIDS in 2015 declining from 2576 deaths in 2014. 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 2015 is 1300 as compared to 1493 in 2014. Overall, the epidemic is largely driven by sexual transmission that accounts for more than 85% of the total new HIV infections.

Figure 29: Estimated Adult HIV Prevalence & Number of PLHIV, 2010-2015

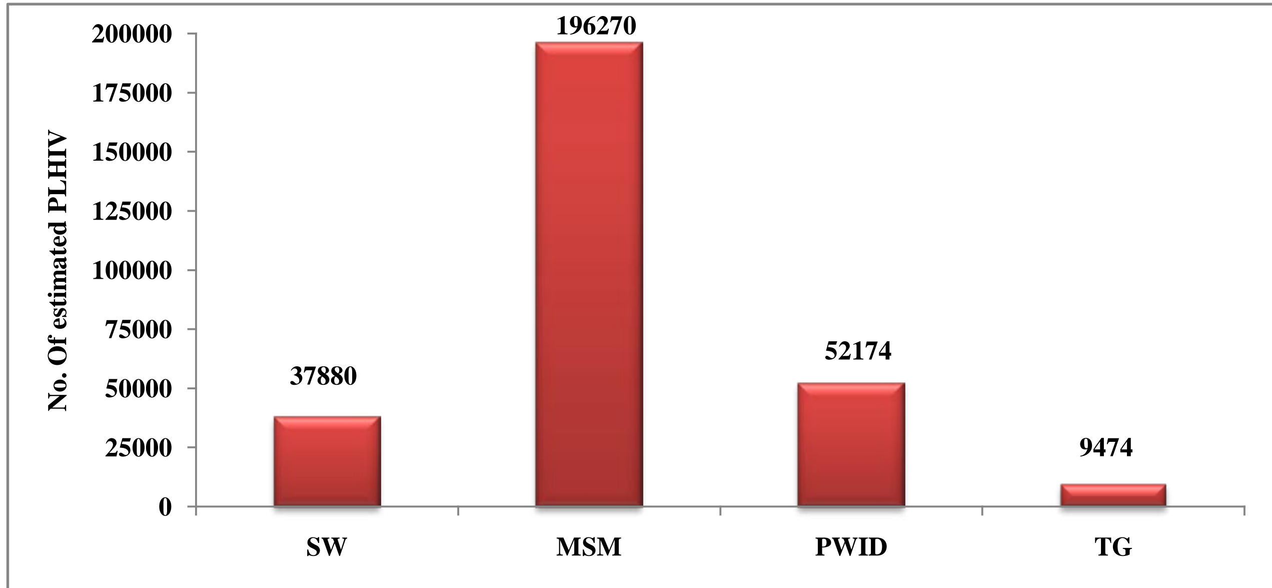


source: HIV/AIDS SAARC Region-2010-2013, SAARC Epidemiological response on HIV/AIDS-2014-2015, http://aidsinfo.unaids.org/data sheet 2016

The HIV epidemic in Nepal remains concentrated among the key affected population notably; people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), male sex workers (MSW), female sex workers (FSW) and male labor migrants (MLM) as well as their spouses. Figure 30

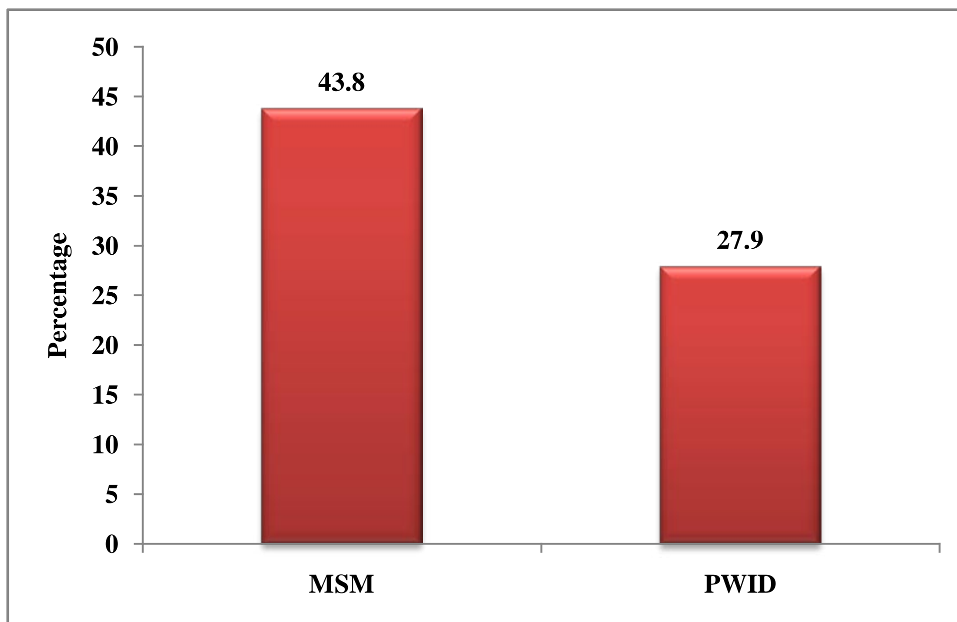
shows the number of estimated PLHIV in key populations (SW, MSM, PWID, TG) in Nepal 2015. Also figure 31 shows HIV testing coverage among MSM and PWID in year 2015.

Figure 30: Number of estimated PLHIV in Key Populations -2015



Source: *http://aidsinfo.unaids.org - 2016*

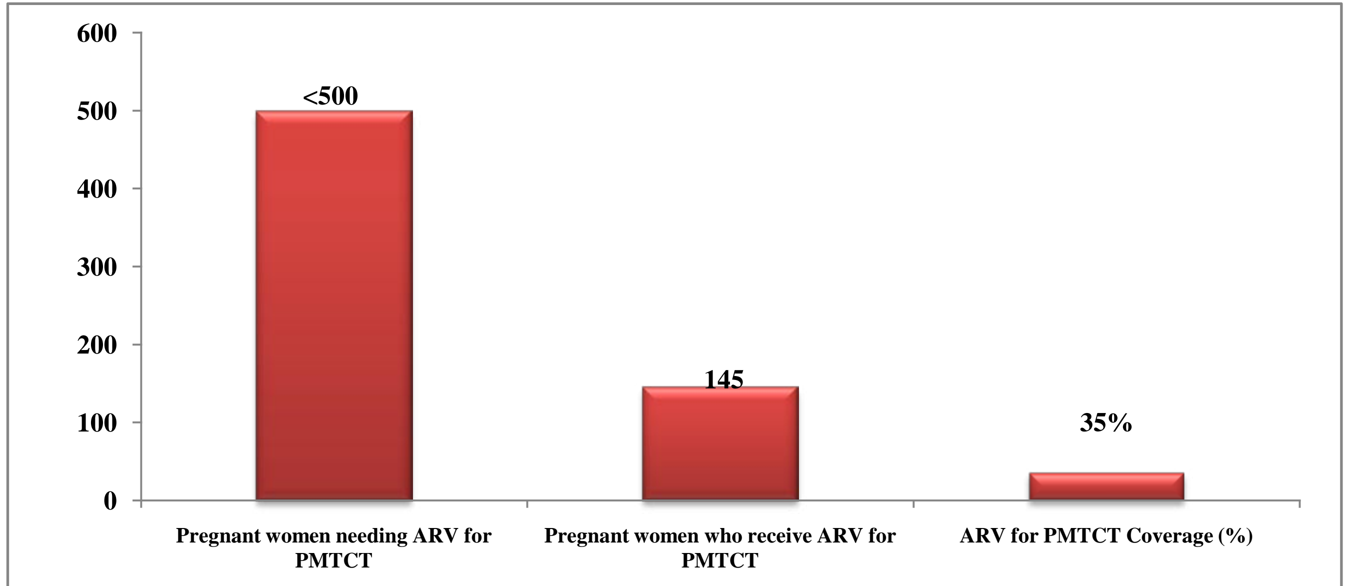
Figure 31: HIV testing coverage among key populations, 2015



Source: *http://aidsinfo.unaids.org -2016*

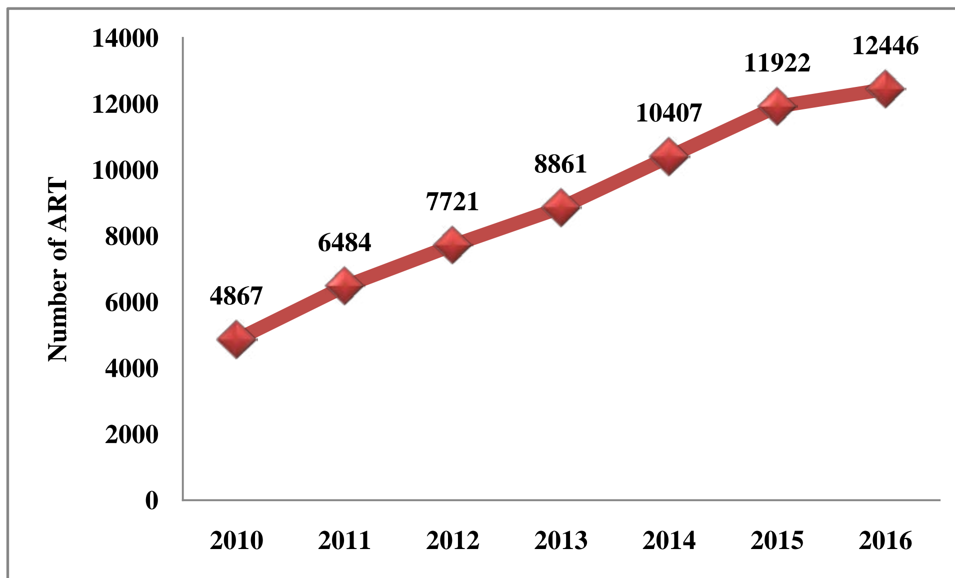
Figure 32 shows less than 500 pregnant women needing ARV for PMTCT however, 145 Pregnant women had received ARV for PMTCT and its coverage was 35% in the year 2015. Likewise figure 33 shows the scaling up of number of people on ART from 4867 in 2010 to 12446 in 2016.

Figure: 32 pregnant women needing, received ARV for PMTCT and its coverage -2015



Source: *http://aidsinfo.unaids.org -2016*

Figure 33: ART scale up, 2010-2016



Source: *http://aidsinfo.unaids.org -2016*

Nepal

Epidemic Overview, 2015	
Population (***WHO Global Tuberculosis Report-2016***)	**29 million**
Estimated Number of people living with HIV/AIDS	39000
Estimated newly infected	1300
Incidence rate among adults (15-49)	<0.01
Estimated number of deaths due to AIDS	2300
Estimated number of PLHIV in Sex workers	37880
Estimated number of PLHIV in Men who have sex with men	196270
Estimated number of PLHIV in PWIDs	52174
Number of needles per IDU	25
Estimated number of PLHIV in Transgender	9474
HIV Prevalence	
Adult (15 - 49)	0.20%
Sex workers (SW)	NA
Men who have Sex with Men (MSM)	2.40%
People Who Inject Drugs (PWID)	6.40%
Transgender	6.00%
Condom use at last sex	
SW	NA
MSM	86.0%
PWID	52.5%
HIV Testing Coverage	
SW	NA
MSM	43.8%
PWID	27.9%
Treatment	
Reported number of people receiving ART (2016)	12446
Deaths averted due to ART (2015)	1000
Pregnant women needing ARV for PMTCT	<500
HIV-positive pregnant women received ARV for PMTCT	145
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	35%

Source: http://aidsinfo.unaids.org -2016

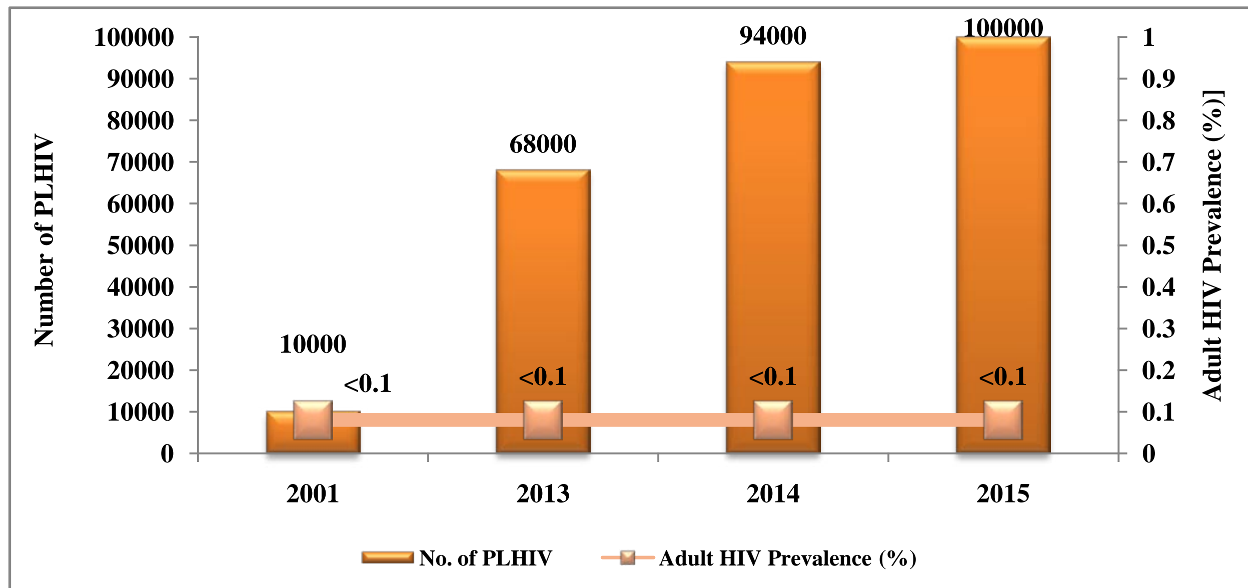
PAKISTAN

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 189 million (WHO Global Tuberculosis Report-2016) at the end of 2015.

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 100 000 people living with HIV by the end of 2015, with 17,000 estimated new HIV infection and 3600 deaths due to AIDS. Adult HIV Prevalence remain same (<0.1) since 2001 to 2015(Figure 34).

Figure 34: Estimated Adult HIV Prevalence & Number of PLHIV, 2001-2015

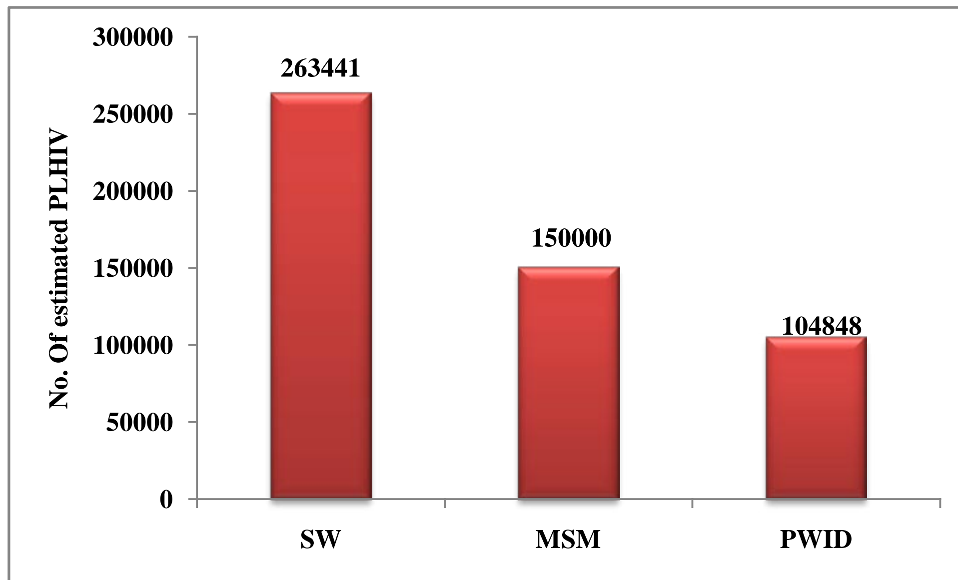


Source: http://aidsinfo.unaids.org -2016

Pakistan is concentrated HIV epidemic among Key Affected Population. The size of PLHIV in SW was highest (263441) among key affected population in year 2015 (figure 35). However, HIV prevalence in MSM was high (3.5%) in year 2015. Other than the Key Affected Population, evidence also exists of either HIV-related risk factors or infection among certain vulnerable

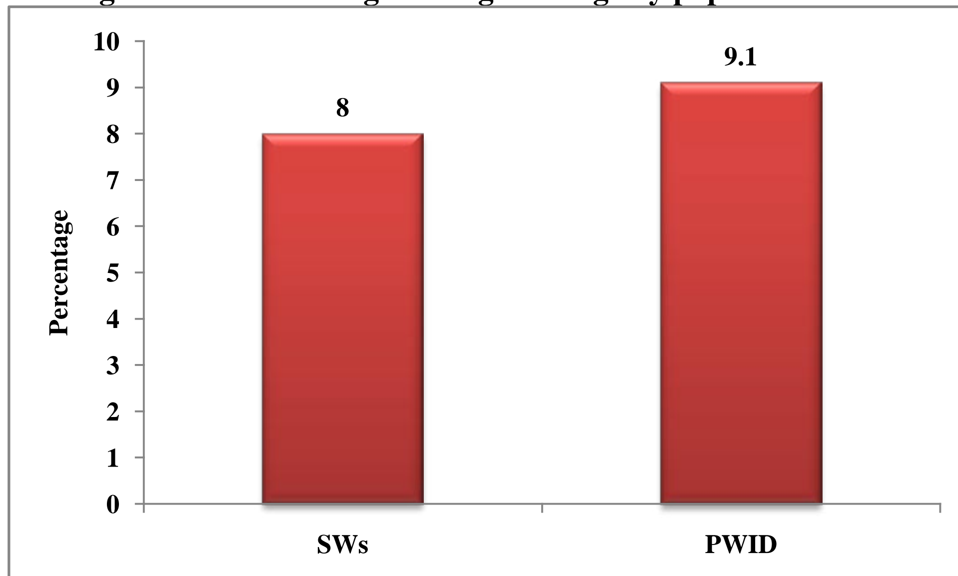
population, such as the spouses of key affected population, imprisoned population, at-risk adolescents and in certain occupational settings, including in some cases through nosocomial infection. Figure 36 shows the HIV testing coverage among key affected populations in which Pakistan has 9.1 % PWID followed by 8% in SW.

Figure 35: Number of estimated PLHIV in Key Populations-2015



Source: http://aidsinfo.unaids.org -2016

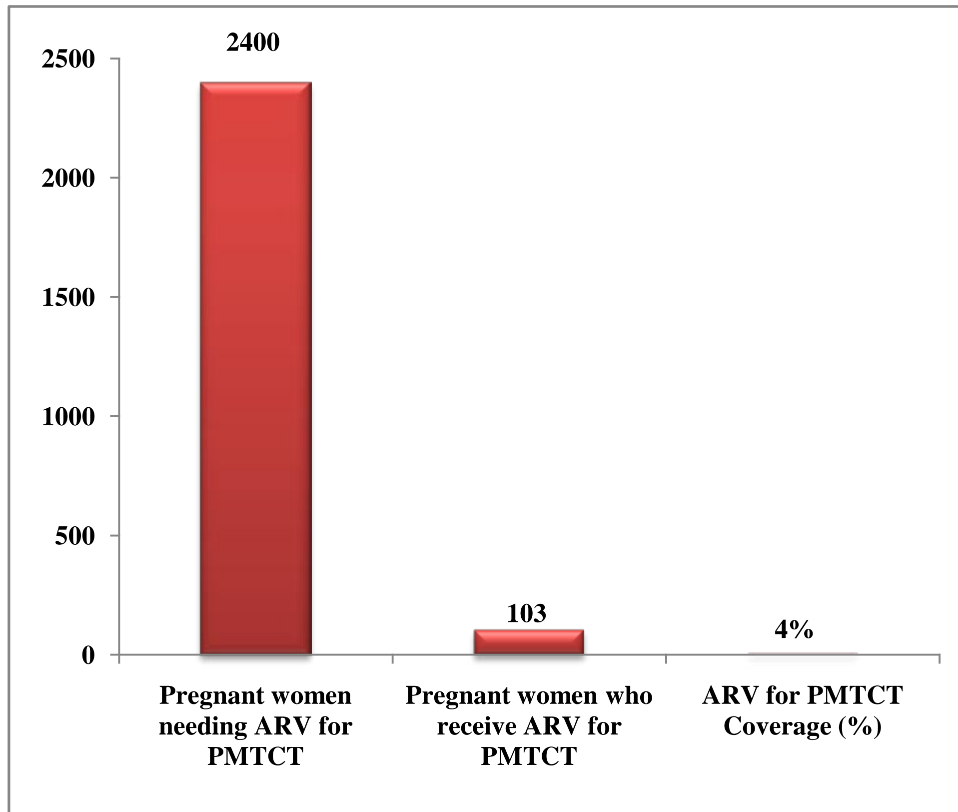
Figure 36: HIV testing coverage among key populations-2015



Source: http://aidsinfo.unaids.org -2016

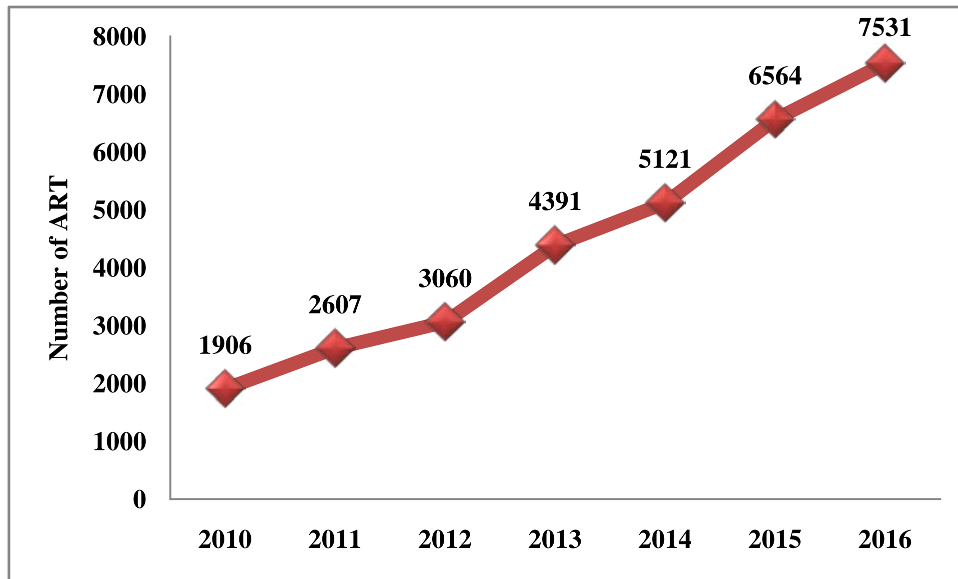
Figure 37shows 24000 pregnant women needing ARV for PMTCT however, 103 Pregnant women had received ARV for PMTCT and its coverage was 4% in the year 2015. Likewise figure 38 shows the scaling up of number of people on ART from 1906 in 2010 to 7531 in 2016.

Figure: 37 pregnant women needing, received ARV for PMTCT and its coverage -2015



Source: http://aidsinfo.unaids.org -2016

Figure 38: ART scale up, 2010-2016



Source: http://aidsinfo.unaids.org -2016

Pakistan

Epidemic Overview, 2015	
Population (***WHO Global Tuberculosis Report-2016***)	**189 million**
Estimated Number of people living with HIV/AIDS	100000
Estimated newly infected	17000
Incidence rate among adults (15-49)	0.02
Estimated number of deaths due to AIDS	3600
Estimated number of PLHIV in Sex workers	263441
Estimated number of PLHIV in Men who have sex with men	150000
Estimated number of PLHIV in PWIDs	104848
Number of needles per IDU	194
Estimated number of PLHIV in Transgender	NA
HIV Prevalence	
Adult (15 - 49)	<0.1
Sex workers (SW)	2.50%
Men who have Sex with Men (MSM)	3.50%
People Who Inject Drugs (PWID)	0.00%
Transgender	NA
Condom use at last sex	
SW	35.5%
MSM	NA
PWID	0.0%
HIV Testing Coverage	
SW	8.0%
MSM	NA
PWID	9.1%
Treatment	
Reported number of people receiving ART (2016)	7531
Deaths averted due to ART (2015)	<500
Pregnant women needing ARV for PMTCT	2400
HIV-positive pregnant women received ARV for PMTCT	103
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	4%

Source: http://aidsinfo.unaids.org -2016

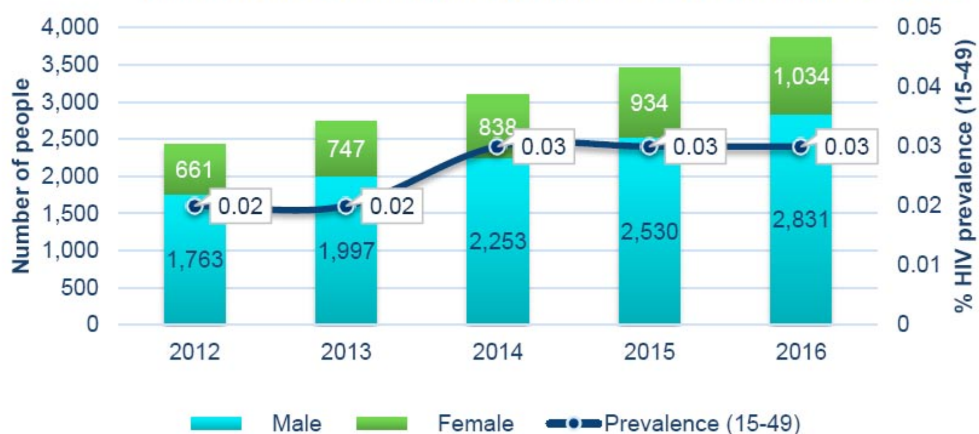
SRI-LANKA

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

Sri-Lanka had an estimated 3900 people living with HIV by the end of 2016, with 550 estimated new HIV infection and 110 deaths due to AIDS. Adult HIV Prevalence remain same (<0.1) since 2001 to 2016.

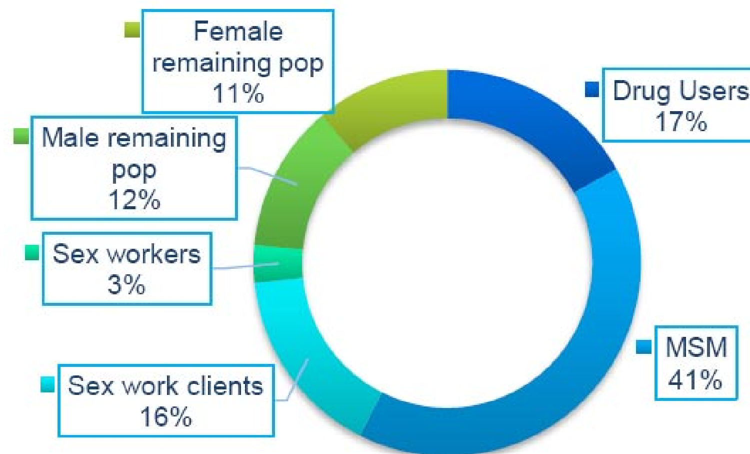
Figure 39: Estimated HIV population by sex and HIV % prevalence in 15-49 yrs.



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

The figure 39 shows the estimated total (male and female) HIV population for the period of 2012-2016 and estimated percentage HIV prevalence in the 15-49 year age group.

Figure 40: Estimated new HIV infections by risk group during 2016



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

The figure 40 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.

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.

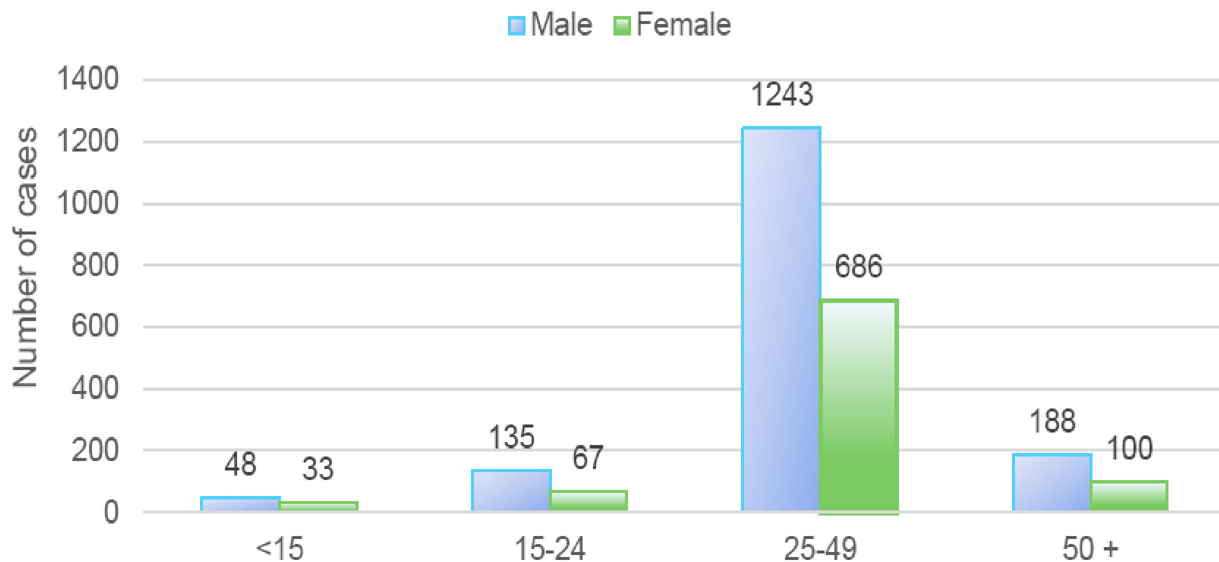
Figure 41 shows the trend of reported HIV cases by sex during last 10 years. Although the percent increase in number of HIV cases reported is nearly 110% over last 10 years, this increase is mainly due to increase among males. The percentage increase among males is 190% whereas number of females has 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 41: 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 41). 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.

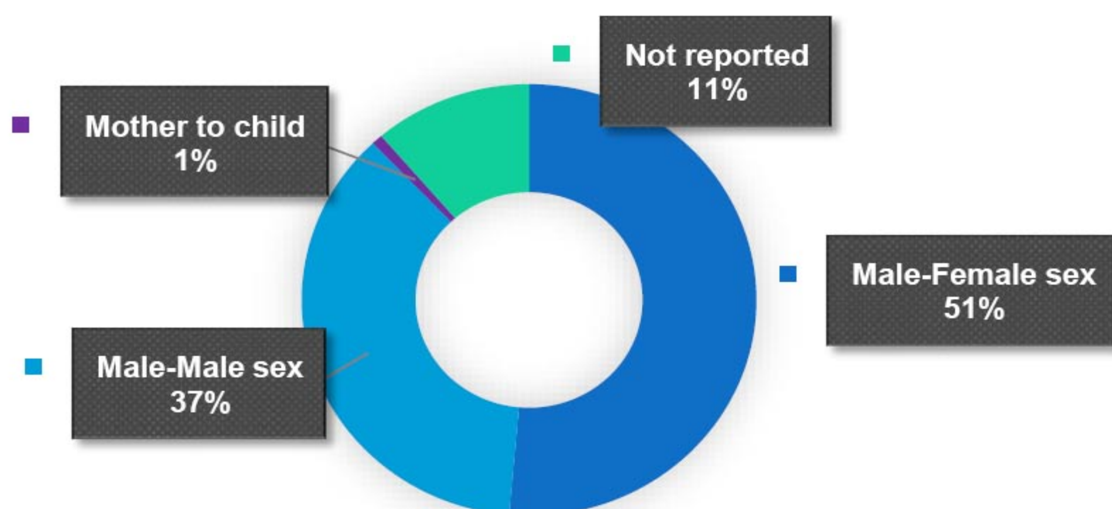
Figure 42: Cumulatively reported HIV cases by Age and Sex by end of 2016



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

Figure 42 shows age and sex distribution of cumulative reported HIV cases since 1987 (N=2500, age and sex not reported in 57 cases).

Figure 43: Probable modes of transmission of HIV cases reported in 2016 (N=249)

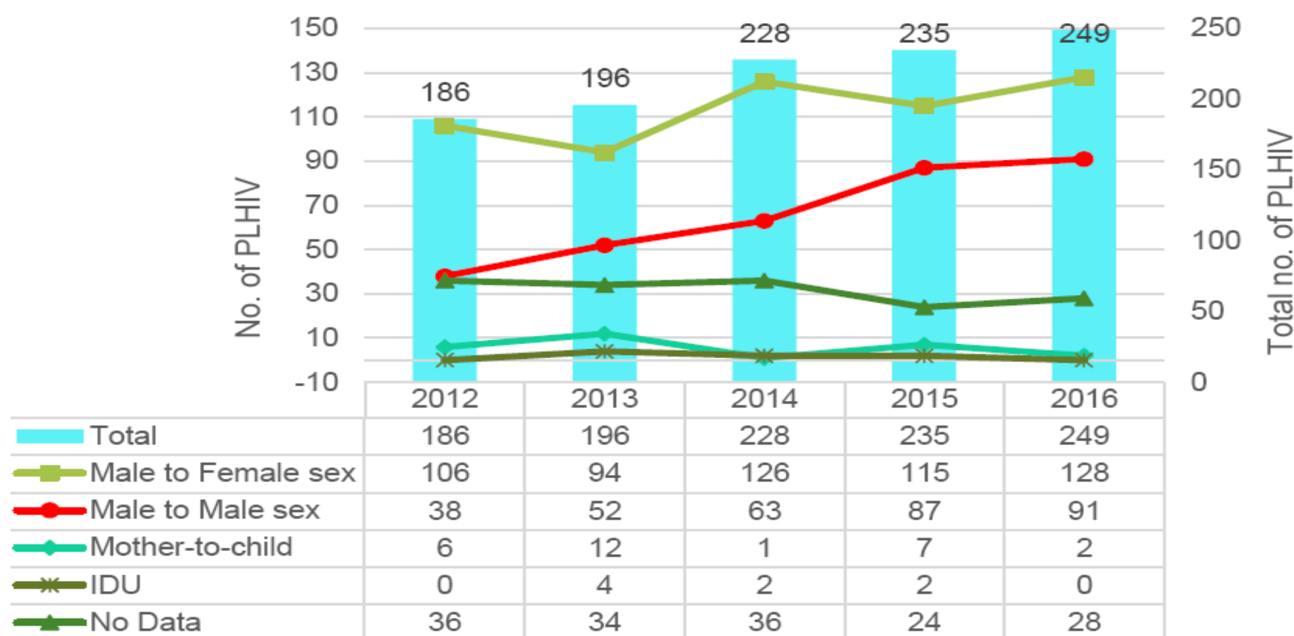


Source: *National STD/AIDS Control programme Sri Lanka, Annual Report 2016*

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.

According to figure 43 and 44, 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.

Figure 44: 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

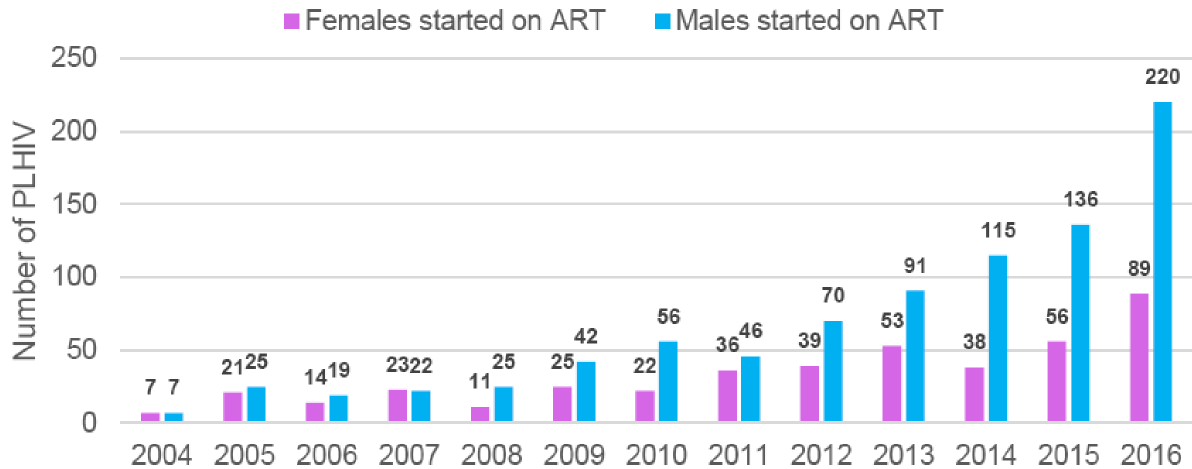
Source: *National STD/AIDS Control programme Sri Lanka, Annual Report 2016*

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

In the year 2016, the number of newly diagnosed PLHIV was 249. Of this 227 (90%) were linked to HIV care services. According to the progress report of WHO SEA Region in 2016, the ratio of newly enrolled in care to newly diagnosed HIV cases is closer to 1 in Sri Lanka, suggesting strong linkages.

During 2016, 54 AIDS cases were newly diagnosed. Out of 47 AIDS related deaths reported in 2016, 24 were newly diagnosed in 2016. Eight deaths were among those diagnosed in 2015 in the late stage with AIDS. Most of others were due to loss to follow up and poor adherence to ART.

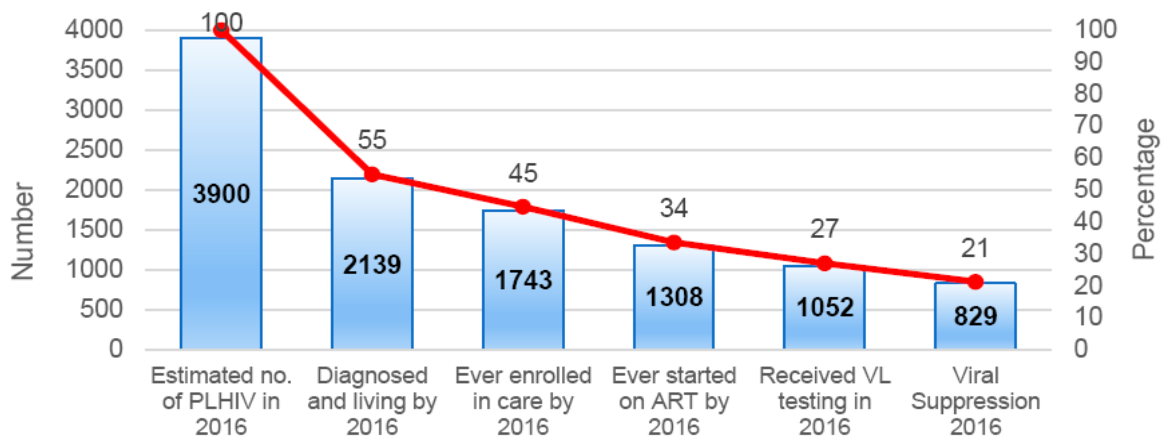
Figure 45: Number of PLHIV who initiated ART, 2004-2016



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

Figure 45 shows the number of PLHIV started on ART annually since 2004. The highest number of ART initiation done during 2016. Of this majority were males. 192 PLHIV who initiated ART during 2015, 87% were alive and on ART after 12 months.

Figure 46: Cumulative cross-sectional cascade graph of HIV services for PLHIV - 2016



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

Figure 46 shows the estimated number of PLHIV was 3900 and the total of 2139 have been diagnosed and living at the end of 2016 (this number was calculated by subtracting all reported deaths from all reported HIV cases). Out of them, 1743 were linked to care and 1308 were started

on ART by the end of 2016. The viral load testing was done for 1052 during 2016. Of these PLHIV, 829 had achieved viral suppression by the end of 2016 (less than 1000 copies/mL).

Sri Lanka

Epidemic Overview, 2015	
Population (***WHO Global Tuberculosis Report-2016***)	21 million
Estimated Number of people living with HIV/AIDS (2016)	3900*
Estimated newly infected (2016)	550*
Incidence rate among adults (15-49)	<0.01
Estimated number of deaths due to AIDS (2016)	110*
Estimated number of PLHIV in Sex workers	14132
Estimated number of PLHIV in Men who have sex with men	7551
Estimated number of PLHIV in PWIDs	423
Number of needles per IDU	0
Estimated number of PLHIV in Transgender	NA
HIV Prevalence	
Adult (15 - 49)	<0.1
Sex workers (SW)	0.80%
Men who have Sex with Men (MSM)	0.60%
People Who Inject Drugs (PWID)	0.00%
Transgender	NA
Condom use at last sex	
SW	93.1%
MSM	47.1%
PWID	25.9%
HIV Testing Coverage	
SW	33.9%
MSM	14.1%
PWID	8.3%
Treatment	
Reported number of people receiving ART (2016)	945
Deaths averted due to ART (2015)	<100
Pregnant women needing ARV for PMTCT	<100
HIV-positive pregnant women received ARV for PMTCT	16
HIV-positive pregnant women received ARV for PMTCT Coverage (%)	24%

Source: http://aidsinfo.unaids.org -2016
**National STD/AIDS Control programme Sri Lanka, Annual Report 2016*

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 2015, an estimated 1.2 million (11%) of the 10.4 million people who developed TB worldwide were HIV-positive. HIV-associated TB deaths accounted for 29% of all TB deaths (among HIV-negative and HIV-positive people).

In 2015, 3.4 million notified TB patients had a documented HIV test result, equivalent to 55% of notified TB cases. This represented an 18-fold increase in testing coverage since 2004. Globally, 15% of TB patients with an HIV test result were HIV-positive. Overall, the percentage of TB patients testing HIV-positive has been falling globally since 2008. A total of 500 564 HIV-positive TB patients were reported by NTPs in 2015.

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 in SAARC Region, 2015

Country	TB Patients with known HIV status who are HIV positive		patients on Antiretroviral Therapy (ART)	
	Number	**%**	**Number**	**%**
Afghanistan	3	<1	3	100
Bangladesh	92	16	82	89
Bhutan	6	<1	6	100
India	44652	4	40925	92
Maldives	0	0	0	0
Nepal	179	8	133	74
Pakistan	59	<1	59	100
Sri Lanka	25	<1	17	68
Regional	45016		41225	

Source: WHO Global Tuberculosis Report, 2016

In 2015, a total 45016 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 41225 patients are on ART in the region which is around 92 % 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 78% globally, and above 90% in India in SAARC Region. However Afghanistan, Bhutan and Pakistan have 100 % patients on Antiretroviral Therapy (ART) in 2015.

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