Getting to Zero:
How innovation, policy reform and focused investments can help South Asia end the AIDS epidemic by 2030

SAARC

Data sources: Unless otherwise referenced, all data cited are from UNAIDS 2013 estimates; The Gap Report UNAIDS 2014 based on the 2014 Global AIDS Response Progress Reporting (GARPR); HIV in Asia and the Pacific: UNAIDS report 2013; www.aidsinfoonline.org. Synthesis of country data from aforementioned sources and also from national surveillance and other reports, and its analysis into a regional overview was conducted by the Data Team at HIV and AIDS Data Hub for Asia and the Pacific (www.aidsdatahub.org)

SAARC
SECRETARY GENERAL

SOUTH ASIAN ASSOCIATION
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Foreword

Home to a quarter of the world's population, Member States of SAARC, Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka are now on the threshold of an unprecedented social and economic transformation.

SAARC's initiatives to foster peace and cooperation, innovative policies to encourage trade and investment and a leadership committed to positive change are playing a key role in unleashing to enormous potential of the region. Above all, the most important factor in the emergence of South Asia as a global force is its people.

With progression and development, there come the questions of sustainability. Does progress mean that countries of South Asia have a secure future?

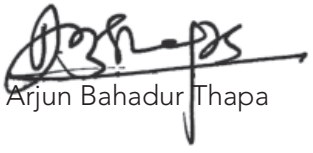
The fact is that are still a number of challenges in the region that need urgent attention, especially maintaining and developing its rich treasure of human resources in the best possible conditions to ensure future prosperity. Perhaps, one of the biggest tasks ahead for the region is to preserve the health of its populations, particularly the poor, young, vulnerable, discriminated and marginalized people, against a variety of pandemics such as HIV and AIDS that have devastated other parts of the world in recent times.

SAARC leaders deserve congratulations for their visionary recognition of HIV and AIDS as a major threat to the region's economic transformation. They demonstrated commitment during the Twelfth SAARC Summit (Islamabad, 4-6 January 2004) to reduce the spread of the epidemic in the region through the declaration to enable access to affordable prevention and treatment services to combat HIV and AIDS, TB and other infectious diseases by strengthening the SAARC TB Centre to SAARC TB and HIV/AIDS Centre.

Since then, SAARC Secretariat with the collaboration of UNAIDS, UNDP and other UN agencies and stakeholders has scaled up the AIDS responses over the last 10 years and have made remarkable progress across South Asia in line with SAARC Regional Strategy on HIV and AIDS. This vision document aims to halt and reverse the spread and impact of HIV and AIDS, to commit leaders to lead the fight against HIV and AIDS and to provide People Living with HIV and AIDS access to affordable treatment and care to enjoy a dignified life.

In line with the objectives in its Charter, SAARC remains committed to "promote the welfare of the peoples of South Asia and to improve their quality of life". Therefore, SAARC will continue to facilitate the Member States in their endeavors towards prevention and control of the HIV/AIDS epidemic within the region and alleviating the impact of the epidemic.

However, considerable challenges remain keeping in line with the draft post-2015 development goal of bringing an end to the AIDS epidemic in the region by 2030.



Arjun Bahadur Thapa

Post Box No. 4222, Kathmandu, Nepal
Tel.: 4-221785, Fax: 4-227033, 4-223991
E-mail: saarc@saarc-sec.org
Web-site: http://www.saarc-sec.org

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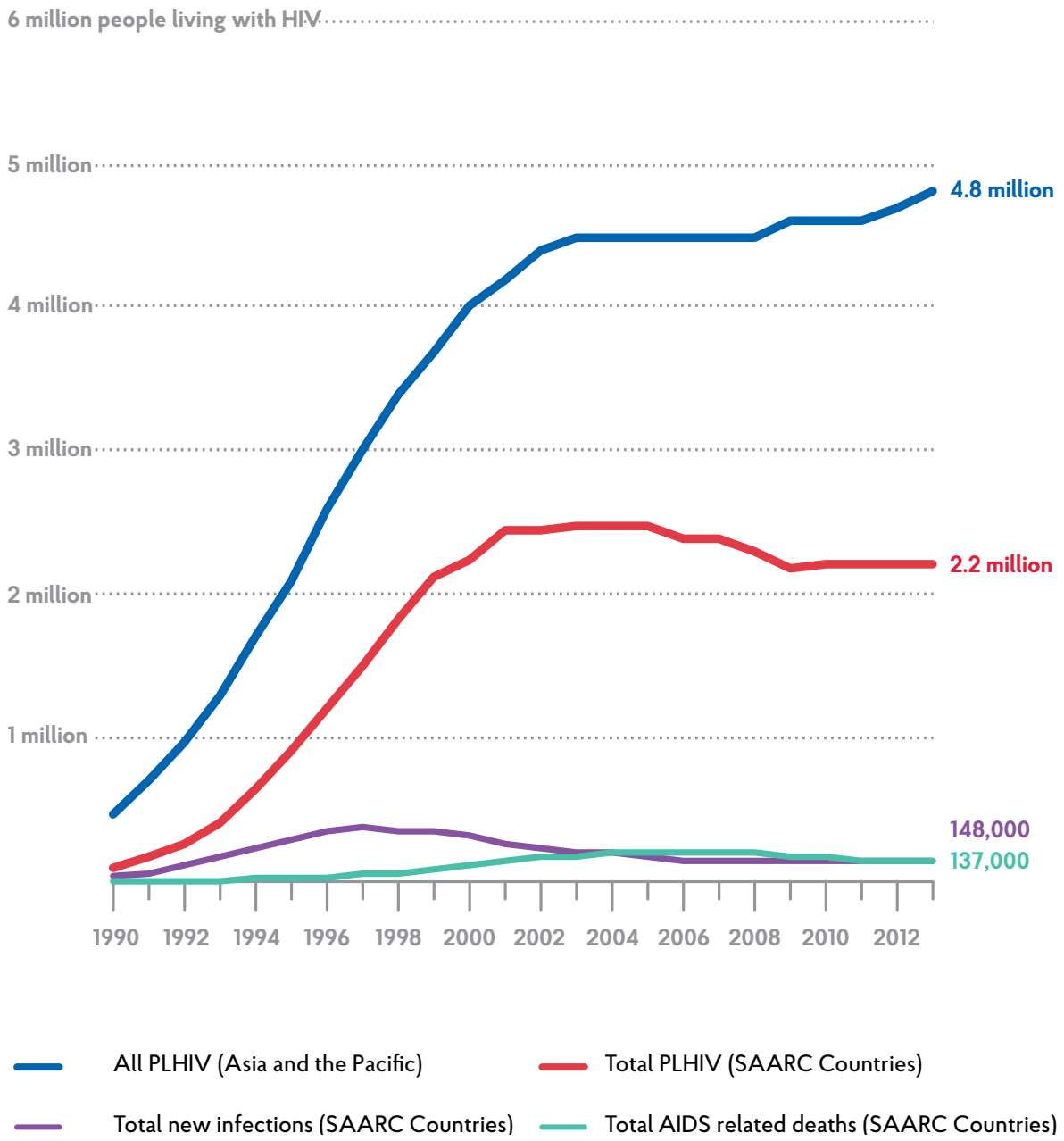


Almost 50% of PLHIV in Asia and the Pacific are within the 8 SAARC countries
Note: In 2013, India accounted for 2.1 million PLHIV and 130,000 AIDS related deaths

Source: Prepared by www.aidsdatahub.org with calculations based on UNAIDS. (2014). HIV Estimates with bounds, 1990 – 2013.

An overview on the HIV epidemic and response in South Asia:

The first HIV infected person in the SAARC Region was diagnosed in 1986 and by 1993 all member states had reported the existence of HIV infection in their countries.

There were an estimated 148,000 new HIV infections in the SAARC countries in 2013, a decline of 12% since 2005. More people than ever are receiving treatment – 762,000 in 2013. Overall treatment coverage is about 35% in the SAARC countries (an increase of 23% since 2012). Region-wide AIDS-related deaths have declined 36% since 2005 to an estimated 137,000 in 2013. For many of the 2.2 million people living with HIV, the disease is no longer a killer disease, but a manageable chronic condition.[1]

Three countries (India, Pakistan and Nepal) have nearly all the burden of people living with HIV, new infections and AIDS related deaths in the region. According to latest estimates, in 2013 India had 2.1 million people living with HIV, 130,000 new infections and 130,000 AIDS related deaths; Pakistan had 68,000 people living with HIV,14,000 new infections and 2,200 AIDS related deaths; and Nepal had 39,000 people living with HIV, 1300 new infections and 3,300 AIDS related deaths.

There are significant variations in HIV epidemics between and within countries. The epidemic are concentrated in certain geographical pockets and among key population at higher risk, which include people who inject drugs, female and male sex workers and their clients, men who have sex with men and transgender people. Other vulnerable populations include migrants, prisoners, intimate partners of key populations at higher risk and people working in certain industries such as mining, construction, and transport services.

The overall national prevalence of HIV in most SAARC countries remains low. However, the size of the regional population means low prevalence translates into large numbers of people living with HIV. Low national prevalence also masks higher HIV prevalence and incidence rates in certain geographical areas and among key populations at higher risk.

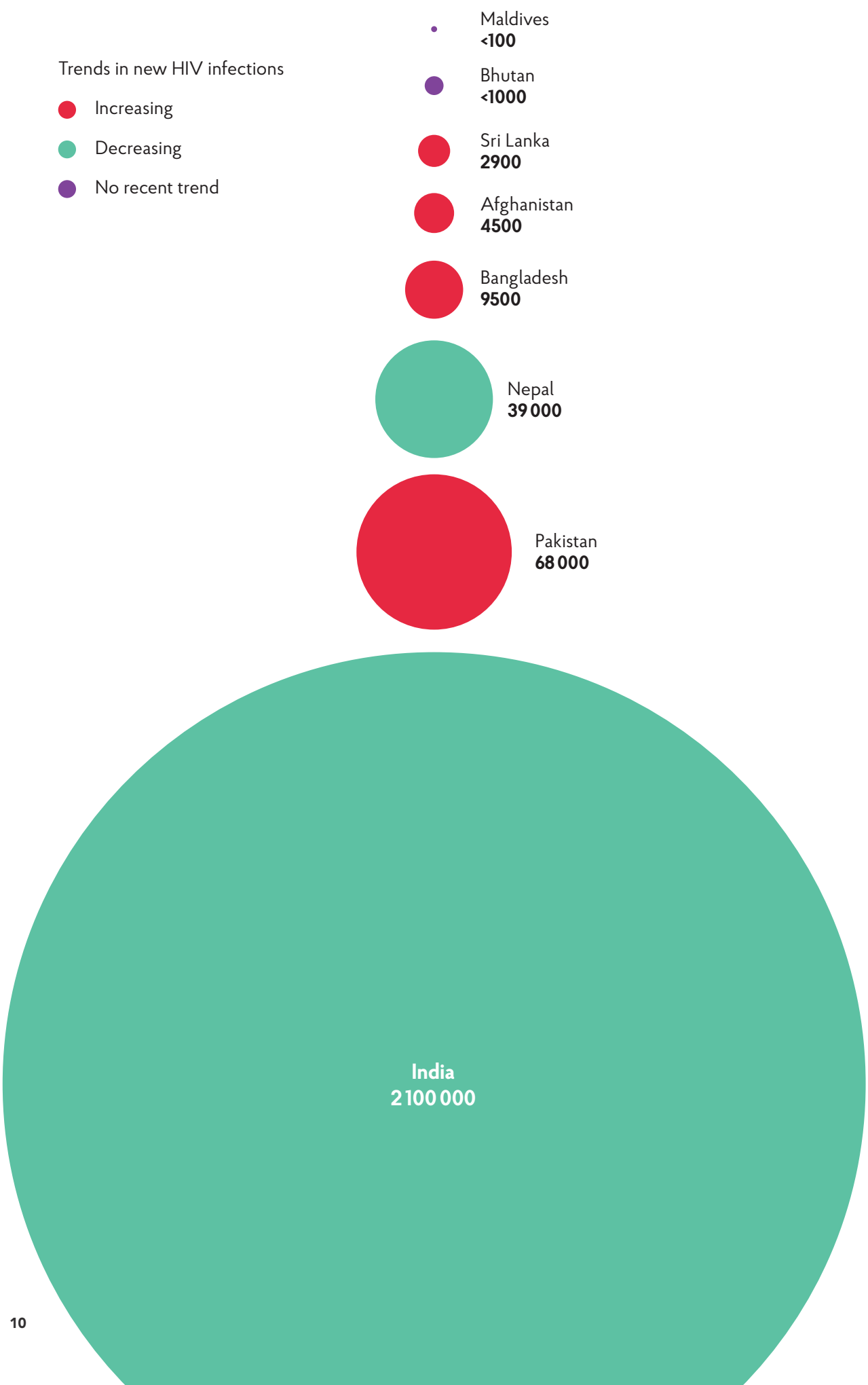
In 2013 there were an estimated 783,000 women living with HIV[2] in the region and they continued to account for about one-third of adult HIV infections.

Despite some progress, invigorated efforts are needed to eliminate mother-to-child transmission of HIV as over 60% of children (0-14 years) acquiring HIV infection in Asia and the Pacific reside in SAARC countries.

1 Estimated PLHIV, new infections and AIDS deaths value calculated as the sum of all the individual SAARC country UNAIDS 2013 Spectrum.

2 ibid

HIV situation across SAARC countries



Remarkable progress in last decade:

Fewer new HIV infections overall, but instances of rising trends

The region-wide 12% reduction in new infections since 2005 is double the rate of the rest of Asia and the Pacific region (6%). Two countries have made remarkable progress in reducing the number of new infections since 2001 by at least halve; India (50%) and Nepal (83%).

However, even in countries that have successfully reduced overall incidence, nation-wide progress belies concentrated epidemics (more than 5% prevalence) in specific geographical locations and among specific population groups at higher HIV risk.

More people than ever are receiving treatment

More than 762,000 people were receiving live saving antiretroviral treatment in 2013. Overall treatment coverage is about 35% in the SAARC countries, an increase of 23% since 2012 - up from 12% the previous year (2011-2012).

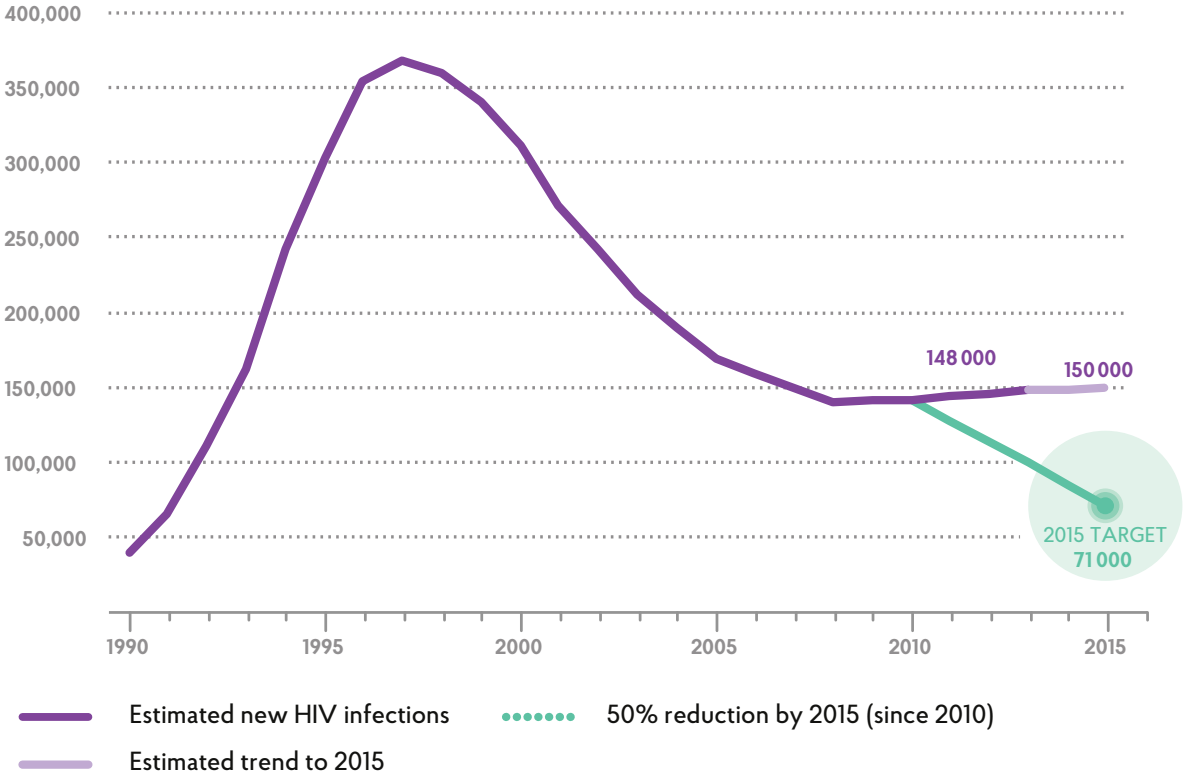
Fewer AIDS related Deaths

Due to a sharp increase in treatment coverage AIDS-related deaths in SAARC region reduced by 36% since 2005, higher than the Asia-Pacific regional average of 26%.

Challenges Ahead

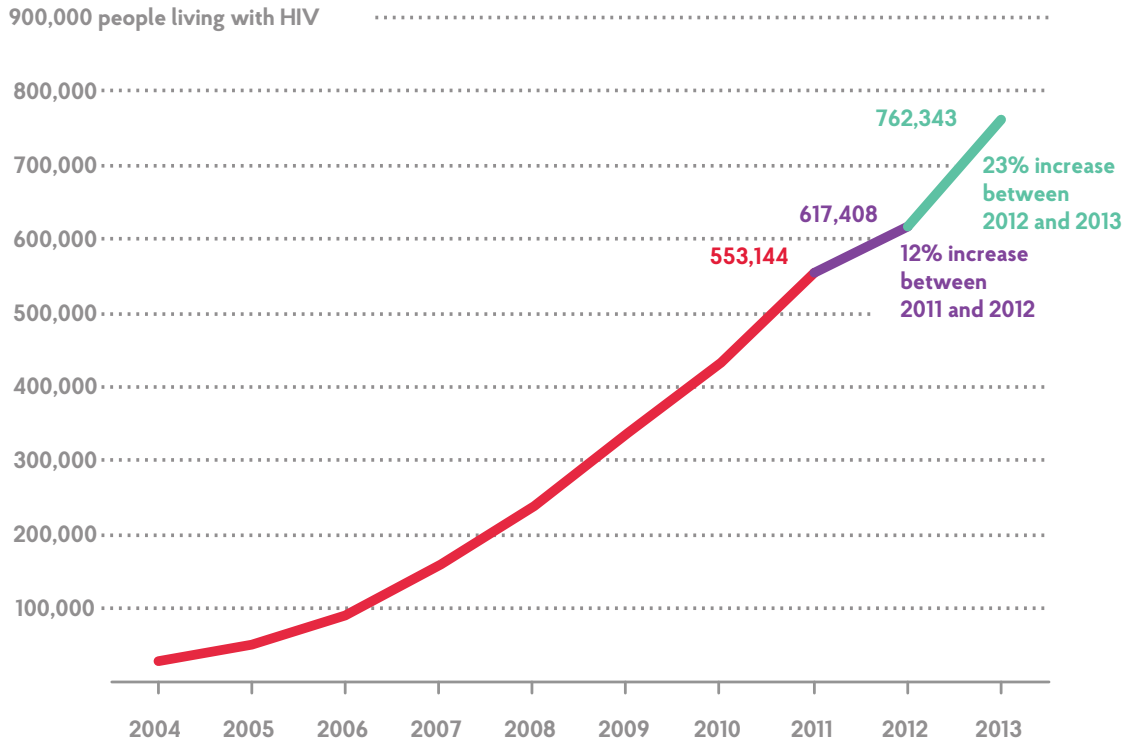
Despite remarkable progress in the response, the epidemic in South Asia is far from over and any complacency will lead to resurgence. Emerging epidemics are becoming evident in Pakistan, Bangladesh, Afghanistan and Sri Lanka and in some geographic hotspots within other SAARC member countries and among key populations. For example, between 2001 and 2012, new HIV infections in Pakistan have seen an eight -fold increase that can be attributed to high-risk behaviors among injecting drug users and an unavailability of adequate harm reduction services.

Estimated number of new HIV infections, SAARC countries, 1990–2015



Source: Prepared by www.aidsdatahub.org with calculations based on UNAIDS. (2014). HIV Estimates with bounds, 1990–2013.

762,343 people were receiving antiretroviral therapy in SAARC countries in 2013 —the pace of scale-up is increasing



Source: Prepared by www.aidsdatahub.org based on www.aidsinfoonline.org and UNAIDS. (2014). The Gap Report.

HIV remains concentrated among key populations and in cities

The fastest-growing epidemics in the region are among men who have sex with men; these epidemics are typically concentrated in major cities. HIV prevalence among men who have sex with men is over 3% in at least 16 major urban centres, 17 in India (Bangalore, Bhopal, Chennai, Delhi, Hyderabad, Imphal, Indore, Kolkata, Lucknow, Mumbai and Pune), 4 in Pakistan (Faisalabad, Karachi, Lahore and Rawalpindi) 2 cities in Nepal (Kathmandu and Pokhara). For example 12.4% in Mumbai, India, 5.2% in Lahore, Pakistan and 3.8% in Kathmandu, Napal[3].

More than 362,000 people living in SAARC countries are estimated to inject drugs. In countries with expanding epidemics, such as Pakistan, injecting drug use has been a significant factor in the spread of HIV. In 2011-12, national HIV prevalence among people who inject drugs was 27.2% in Pakistan, 7.2% in India and 6.3% in Nepal.

National trends mask significant geographical variations in HIV prevalence among injecting drug users. For example, in Mumbai, India, prevalence among people who inject drugs was estimated at 14.2% in 2011 vs. 7.2% nationally; similarly Karachi, Pakistan, had an estimated prevalence of 42.2% vs. 27.2% nationally; and Dhaka, Bangladesh, had an estimated prevalence of 5.3% vs. 1.1% nationally.

National prevalence among female sex workers is less than 5% in all SAARC countries. This can be attributed to early successful HIV interventions. National prevalence has declined in countries with early epidemics such as India and Nepal and has been kept low in some countries such as Bangladesh, Bhutan, Maldives, Afghanistan and Sri Lanka. Nevertheless, significant challenges remain. Based on a global systematic review in low- and-middle-income countries, the burden of HIV infection was disproportionately high among female sex workers, who are 13.5 times more likely to acquire HIV than the rest of the adult female population.

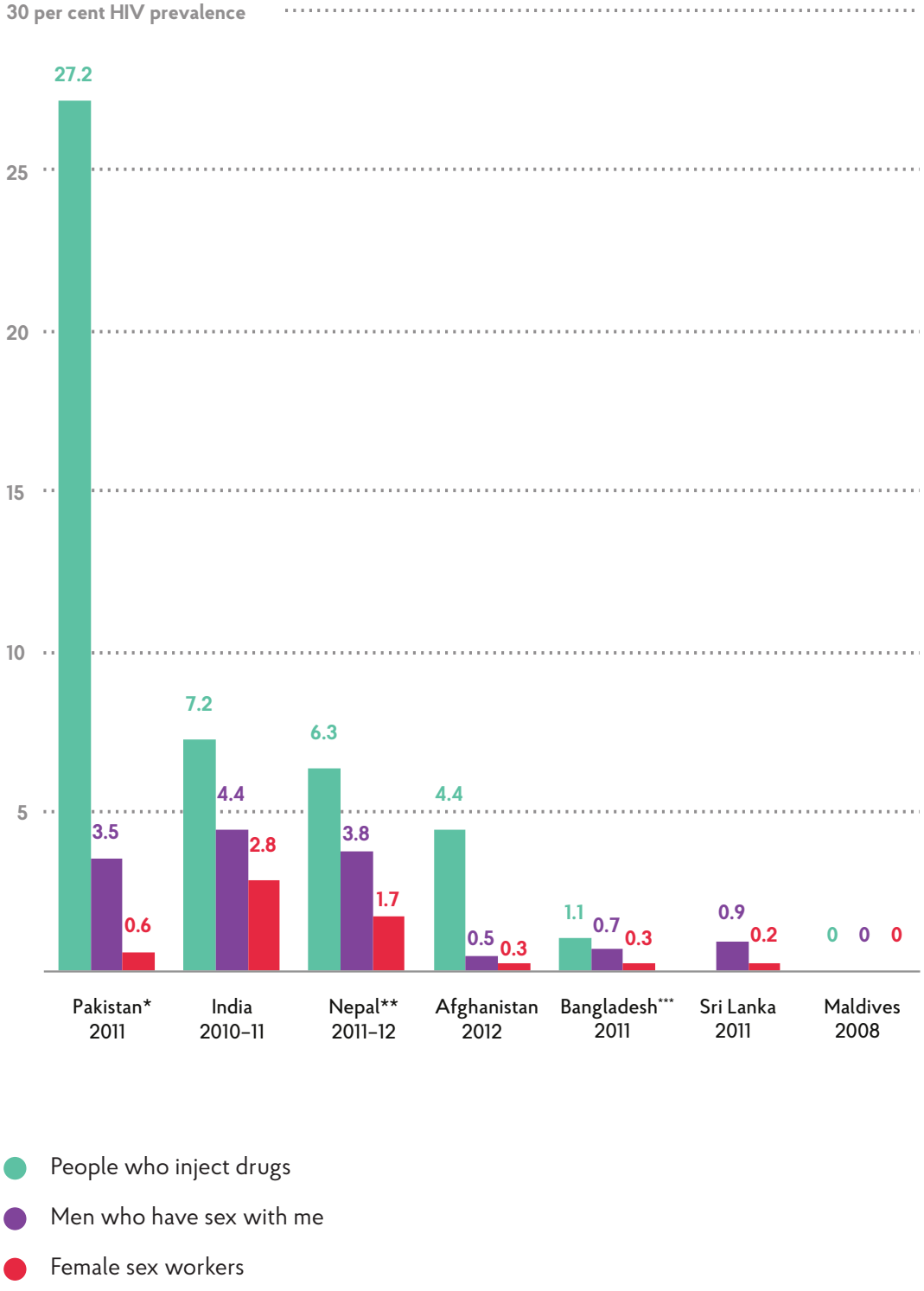
As observed with other key populations, there are geographic areas with higher HIV prevalence. Even when national HIV prevalence trends among females sex workers have declined, for example in India, there are specific high prevalence areas; 10% of female sex workers surveyed in Mumbai, India, were HIV positive.

There are many contributing factors including the sudden closure of brothels and the eviction of sex workers affect an effective prevention programmes. Intervention programmes are limited to meet the needs of sex workers that have been forcibly moved, or voluntarily relocate, potentially placing sex workers and their clients at greater risk. New technology such as mobile devices also poses a challenge for prevention programmes as they take sex work out of traditional setting and into unregulated environments that are hard to reach.

Clients of sex workers are the largest population at risk of HIV infection across SAARC countries. According to population-based surveys, 1.5%-15% of men in the region bought sex in the previous year. This population's risk behaviour determines the extent of the spread of HIV, but there are limited data available on prevalence trends among clients of sex workers, and they are underserved by current HIV programmes. This emphasizes the need for more prevention efforts among key populations and reaching the female partners of men at higher risk both through key population programming and mainstreaming sexual and reproductive health services.

3 Refer to annex 1- Map of key populations.

HIV prevalence among key populations in SAARC countries, 2008–2013



* MSM data is for male sex workers

** Kathmandu data reported as national data

*** MSM data is for 2013, survey conducted in Dhaka and reported as national data

Source: Prepared by www.aidsdatahub.org based on 1. Integrated Biological and Behavioral Survey Reports; 2.HIV Sentinel Surveillance Reports; and 3) www.aidsinfoonline.org

Data on male and transgender sex workers are relatively scarce, but where available demonstrate high HIV prevalence. For example, 15% of surveyed transgender sex workers (Hijra sex workers) in Larkana, Pakistan, tested HIV-positive in 2011, as did 19% in Maharashtra, India. This underscores both the need for better data regarding male and transgender sex workers and for HIV programmes that address the needs of female, male and transgender sex workers.

While evidence indicates that the majority of women in the region are acquiring HIV through their partners who engage in high-risk behaviour (including as clients of sex workers, through male-to-male sex, injecting drug use or migration), policies and programmes to address intimate partner transmission are limited.

Young people (15-24 years old), especially young key populations at higher risk, are also getting infected with HIV. For example, 3.5% of young men who have sex with men in India and 2.2% of young sex workers in Pakistan are living with HIV. Evidence shows HIV prevalence among people who inject drugs in Pakistan disproportionally affects youth who inject drugs(33.9%), compared to injecting drug users who are over 25 years of age (25.3%).

Research indicates low condom use among young key populations when compared to their older counterparts. Young people also have less access to HIV prevention and testing programmes and services.

Despite the evidence, only a few countries recognize the specific vulnerability and risks of young key populations. It is crucial to collect age-disaggregated data to inform programmes and to design and implement the responses geared towards the needs of young key populations.

Scale up and shifts needed in HIV prevention coverage and strategies

It is well understood that key populations at higher risk are central to the epidemic in the region, yet they are insufficiently reached by prevention programmes. Modeling shows that only by reaching 80% intervention coverage among key populations can there be a significant impact on changing risk behaviors and hence a decrease in new HIV infections. Reports from countries in the region show that median coverage of men who have sex with men and female and male sex workers by HIV prevention programmes in the region (i.e. those who knew where to get a HIV test and received condoms in the previous year) is less than 65%. This indicates that new and more innovative approaches are needed.

Female sex workers reported a median of 59% condom use at last sex with clients, while 55% of male sex workers and men who have sex with men reported using condoms at last sex.In many countries, consistent condom use (i.e. using a condom for every sex act in the previous week or months) is reported to be much lower than last time use. Countries where female sex workers report high levels of consistent condoms use (for example: more than 75% since 2006 in Mumbai, India) have turned their epidemic around. Consistent condom use among sex workers and men who have sex with men is generally much lower in most SAARC countries and at current levels is unlikely to have definitive impact on preventing new infections.

Despite overwhelming evidence that harm reduction measures decrease new infections among people who inject drugs, access to these services is inadequate in most countries. 2013 data from SAARC countries show the median distribution of needles and syringes was 131 needles per person who injects drug per year - two-thirds the recommended level of 200 per injecting drug user per year.

Data on opiate substitution therapy (OST) were reported by 5 countries; only 16,000 people were in programmes in 2013.

Slow progress on eliminating new infections among children

Over 42,000 children (0-14 years) living with HIV received antiretroviral therapy in 2013. However, treatment coverage is still inadequate - ranging from 4% (of all children living with HIV) in Pakistan to 34% in Nepal.

In 2013, 6,500 pregnant women living with HIV in the region received antiretroviral treatment to prevent their children from being infected. Coverage estimate is below 20% in all SAARC countries except in Nepal (27%), indicating the urgent need to scale-up to prevent new infections among children.

The largest unmet need for effective regimens is in India. In 2013, an estimated 35,000 pregnant women are living with HIV in India and of them only 6,200 received effective antiretroviral therapy for prevention of parents-to-child transmission.

Accelerate access to HIV testing, counseling, prevention, treatment and care to reduce AIDS-related deaths

Pakistan and India have made great strides in scaling up access to treatment, each with a rapid scale up to more than doubling the number of people receiving antiretroviral therapy in 2013. In 2013, more than 762,000 people were receiving live saving antiretroviral treatment with an overall treatment coverage of 35% in the SAARC region, in comprarison to 37% of global and 33% of Asia and the Pacific regional treatment coverage.

Between 2012 and 2013, the number of people accessing antiretroviral therapy increased by 145,000(23% increase since 2012)

However, adult treatment coverage is still inadequate - ranging from 5% (of all people living with HIV) in Afghanistan to 36% in India .This translates to only one out of three people living with HIV having access to treatment in 2013. Concerted scale-up efforts are crucial to increase treatment coverage, prevent new infections, save more lives, and increase the quality of life of people living with HIV.

It is important that SAARC countries widen the implementation of the 2013 WHO guidelines, which recommend that eligible patients receive a simplified, daily, single-pill regimen where possible, should help maintain high levels of adherence.

Early diagnosis and treatment critical

Regional data and projections show that the majority of people living with HIV in the region do not know their status and only find out when they are already seriously ill, which greatly reduces the efficacy of antiretroviral treatment. The impact of late diagnosis: one in four people who start on antiretroviral therapy in low-income countries globally have CD4 cell counts under 100, putting them at high risk of AIDS- related diseases and death. However, there is an increased trend of case reporting in the region as a whole.

Helping people living with HIV to find out about their status as early as possible and linking them successfully to HIV prevention, treatment and care services gets more people onto treatment and maximizes the prevention benefits of treatment. However, testing is low among key populations across SAARC countries. Only 14% of female sex workers, and 20% of men who have sex with men and people who inject drugs know their HIV status.

To improve quality of service delivery, acceptability and uptake of HIV testing, WHO recommends the use of rapid diagnostic test, rather than conventional laboratory based diagnostics such as enzyme immunoassay. Rapid tests allow quicker provision of test results, and can be performed with simple finger-stick collection procedure. All SAARC countries are currently using rapid testing in addition to the ELISA and Western Blot. However, SAARC countries may consider rapid scaling up of rapid testing with community based testing approach for reaching wider population with testing services

Effective national HIV responses require a significant scaling up of HIV testing to expand access to prevention, treatment and care services. Facility-based HIV testing and counselling, while essential, is less likely to reach key populations at higher risk of HIV.

A recent systematic review and meta-analysis of community-based approaches has shown that community-based testing and counselling achieve high rates of uptake, reach people with high CD4 counts and link people to care. Community- based approaches also obtain a lower HIV rate relative to facility-based ones.[4]

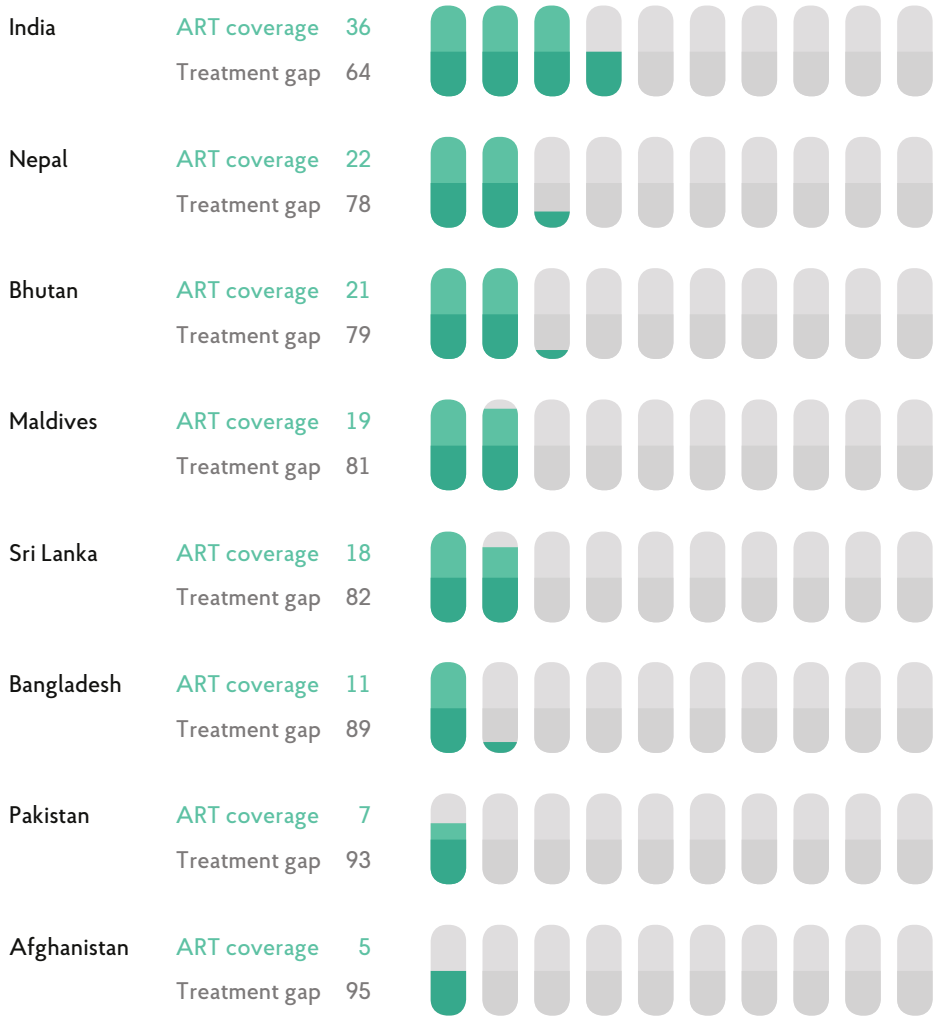
Enabling people living with HIV to find out about their status early requires: scaling up both facility and community-based HIV testing and counselling across the region; identifying the role of community in creation of demand for testing and counselling; and effective linkages to HIV prevention, care and treatment services.

4 Suthar AB, Ford N, Bachanas PJ, Wong VJ, Rajan JS, et al. Towards Universal Voluntary HIV Testing and Counselling: A Systematic Review and Meta-Analysis of Community-Based Approaches. ***PLoS Med***. 2013;10(8): e1001496. doi:10.1371/journal.pmed.1001496.

Affordable access to treatment

Affordable treatment should be available in the region. This can be achieved through various step including utilizing flexibilities under the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and/or to protect the right to exercise TRIPS flexibilities through laws, policies and programmes with key stakeholders such as parliamentarians, judges and patent examiners.

Antiretroviral treatment coverage among adults and treatment gap, SAARC countries, 2013



$$\text{Adult ART coverage (\%)} = \frac{\text{Number of adults on ART (\%)}}{\text{Adults living with HIV}}$$

Source: Prepared by www.aidsdatahub.org based on UNAIDS. (2014). The Gap Report

Tuberculosis: significant steps but more efforts needed

Globally, one-third of people living with HIV in 2012 are infected with tuberculosis and one-fifth of deaths among people living with HIV are associated with tuberculosis infection.

More than 1.3 million people living with HIV in SAARC countries were screened for tuberculosis co-infection in 2012. However, more efforts are needed to ensure antiretroviral treatment is initiated in all tuberculosis patients living with HIV, irrespective of CD4 cell count.

Median estimated coverage of co-management of tuberculosis and HIV treatment, i.e. estimated HIV-positive TB cases that received treatment for TB and HIV in 2012, is 20%, which is lower than the Asia and the Pacific median coverage of 27%.

Towards Zero discrimination

There has been some progress in addressing stigma, discrimination and punitive laws that undermine AIDS responses in the region. This has included significantly improved strategic information on stigma and legal and policy barriers; the implementation of key programmes that reduce stigma and discrimination and increase access to justice; and some reform of laws and policies that impede effective responses.

SAARC Goodwill Ambassadors for HIV and AIDS-Currently Ms. RunaLalia (Bangladesh), Shri Ajay Devgan (India), Ms. SharmeenObaid-Chinoy (Pakistan) and Ms. Shabana Azmi (India), Mr. Sanath Jayasuriya (Sri-Lanka) in the past - have played a positive role in reducing stigma and discrimination across the region. Facilitating the implementation of SAARC Regional Strategy on AIDS; to create greater awareness of HIV through public appearances and through mass media and to address the issues of stigma and discrimination prevailing in the community of SAARC Member States. Their continued work to mainstream HIV and AIDS to form part of the development agenda and advocate for affordable treatment, care and support for People Living with HIV and AIDShas benifeted the entire region.

Despite some progress, stigma and discrimination continue to be serious obstacles to effective and sustainable investments in the AIDS response. Governments in the region have acknowledged in their mid-term reviews of progress towards the goals set at the UN General Assembly High Level Meeting on AIDS in 2011 that HIV-related stigma and punitive legal environments are holding back progress on achieving zero new infections and zero AIDS related-deaths. Significantly, in countries where punitive laws, policies and practices prevail, there is evidence of slower progress on other targets.

Legal and policy reform

Current progress in tackling stigma and discrimination through reviewingpunitive laws hindering HIV responses in the region indicates growing national political commitment.

SAARC countries do not have HIV-related restrictions on entry, stay and residence, which is unique across the rest of the Asia and the Pacific region.

Half of the SAARC countries (Bangladesh, India, Nepal and Pakistan) have taken steps to legally recognize the transgender people.

Pakistan also recently passed subnational HIV or anti- discrimination laws that provide additional protection against discrimination on the grounds of HIV status and, in some cases also, on the grounds of sexual orientation and gender identity.

Aside from legislative reforms, constitutional rights have been used to enforce human rights protections for people living with HIV and key populations in the region, illustrating the important role of the judiciary in the HIV response.

Addressing punitive legal environments

Despite progress, stigma and punitive legal environments in most countries continue to have a negative impact on the rights of key populations at higher risk and other vulnerable groups, including access to HIV services.

Countries in the region are known to criminalize some or all aspects of sex work, same sex behavior and incarcerates people who inject drugs in compulsory drug detention centres - all measures that deter people from accessing HIV services.

For reaching the people who are left behind in accessing services, It is important for SAARC countries to consider strengthening their efforts to enact specific legal protections against discrimination for people living with HIV and key populations. India, Nepal and Pakistan have drafted omnibus national HIV bills for consideration by their parliaments, but yet to be passed.

Gender based violence fuels vulnerability

Discrimination on the grounds of gender, including gender-based violence and gender inequalities, hinder AIDS responses.

There is growing evidence to suggest that gender-based violence (including the threat or fear of violence) makes women, girls, men who have sex with men and transgender people more vulnerable to sexually transmitted infections, including HIV. This may be due to a variety of factors, ranging from physical trauma that increases the risk of HIV infection to being less capable of negotiating safe sex.

A study of 28,139 married women in India showed that physical violence combined with sexual violence from husbands was associated with a nearly four fold increase in HIV prevalence. The study concluded that prevention of intimate partner violence may contribute to other efforts to reduce the spread of HIV[5].

Reports suggest transgender people in the region are frequently subject to violence and hate crimes, and experience stigma and discrimination in accessing health services[6]. A study in Bangladesh demonstrated the multiple forms of gender-based violence faced by men who have sex with men, male sex workers and transgender communities, as perpetrated by family members, sexual partners, local gangsters, and community members[7,8].

Sustainable financing for the AIDS response

Latest available data from 2009-2012 indicates that average estimated domestic HIV spending in the region is US$ 40 million, which accounts for 11% of total AIDS spending. Shared responsibility through domestic sources is expected to increase, as can be seen in Sri Lanka and Pakistan which are currently using 52% and 36 % respectively of their domestic fund, while India has committed 63% for National AIDS Control Programme IV (NACP-IV, 2013-2017) from domestic funds. Bhutan reported spending 43% of domestic fund of its current HIV/AIDS expenses while the NASA report of Buthan is yet to be published.

As the region's economic growth continues, reducing eligibility for a shrinking pool of donor funding, the only way to sustain the AIDS response is to increase domestic financing, develop innovative financing mechanisms and increase spending efficiency.

Greater efficiencies in spending are required

Spending needs to be more efficient and more investments needed to align with the demographic characteristics of the HIV epidemic. Care and treatment services accounted for 6% total AIDS spending across the SAARC region (excluding India).

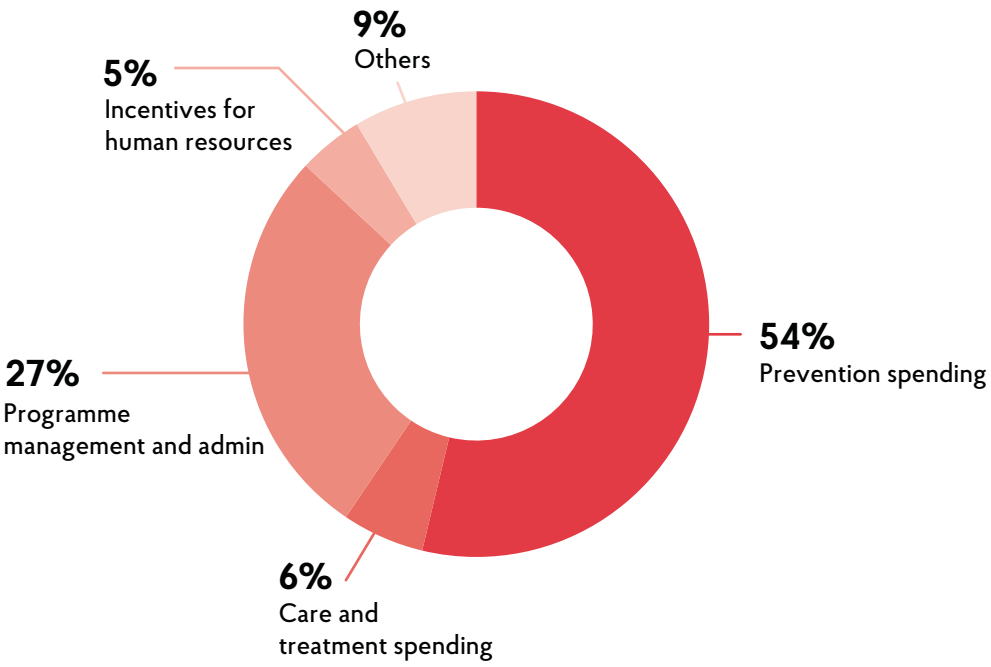
5 Silverman JG et al, Intimate Partner violence and HIV infection among married Indian women

6 JAMA. 2008;300(6):703-710. doi:10.1001/jama.300.6.703.

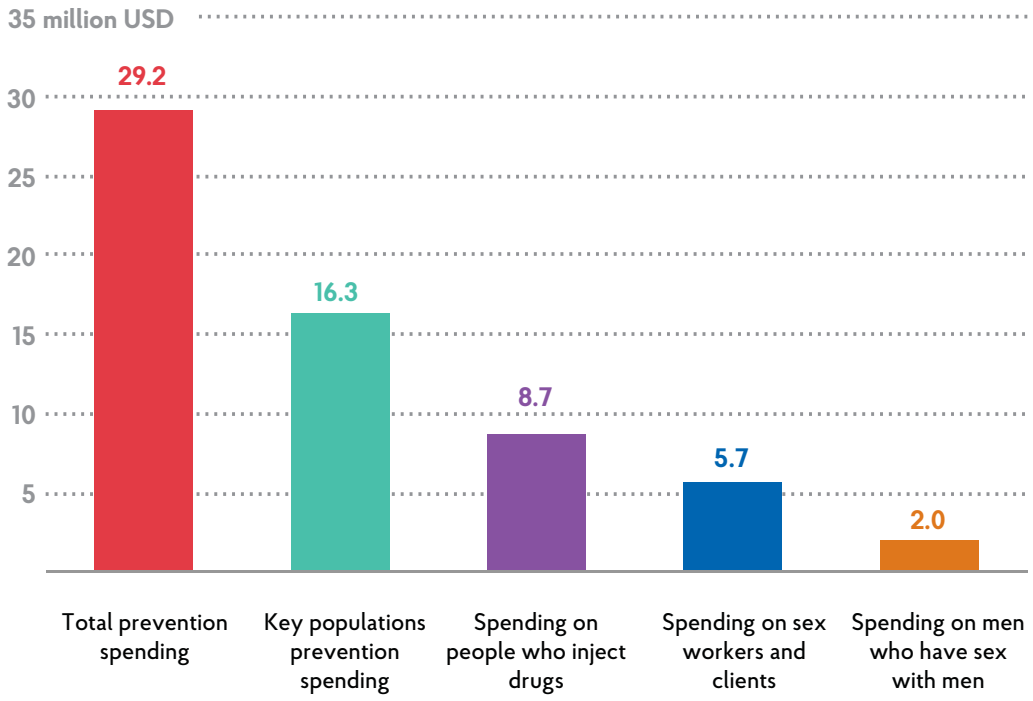
7 Lost in transition: transgender people, rights and HIV vulnerability in the Asia-Pacific region. Bangkok: UNDP Asia-Pacific Regional Centre; 2012.

8 Exploring gender-based violence among men who have sex with men (MSM), male sex worker (MSW) and transgender (TG) communities in Bangladesh and Papua New Guinea. Washington, DC: FHI 360; 2013.

AIDS spending in SAARC countries by major spending categories and prevention spending on key populations, latest available year, 2009–2012



Sustainable financing for the AIDS response



Note: 5 out of 8 SAARC countries have data on AIDS spending data by service category, i.e. Afghanistan (2012), Nepal (2009), Bangladesh (2012), Pakistan (2010) and Sri Lanka (2010). No data for India, Bhutan and Maldives

Source: Prepared by www.aidsdatahub.org based on www.aidsinfoonline.org

However a sizeable proportion (54%) was spent on prevention programmes, higher than the global low-and middle-income country average (19%).[9]

Based on latest available HIV expenditure breakdown from five countries in SAARC (Afghanistan, Bangladesh, Nepal, Pakistan, and Sri Lanka)an estimated 30% of the overall AIDS spending is for HIV prevention among key populations at higher risk. Five out of eight SAARC countries reported on enabling environment expenditure totaling 3.7 million USD, representing only 2% of total HIV expenditure. Critical enablers include programmes implemented by (or in partnership with) affected communities, monitoring the response and addressing legal and social barriers to access HIV services.

Streamline services

Many countries in the region have made significant strides in the integration of HIV and tuberculosis services. Progress is slower in integrating HIV services within sexual and reproductive health settings — a critical challenge for countries with concentrated epidemics. Further integration of health and community systems is essential in SAARC countries to ensure scale-up, particularly of HIV testing and counselling, as well as treatment services for increased coverage and impact.

Regional experience shows that across all key populations at higher risk, projects initiated, managed and implemented by communities involved and supported by government have the most credibility, trust and success. Consequently, to improve access and enable sustainability, HIV services need to be decentralized, empowering communities to take a greater role in service delivery.

South Asia is at a pivotal juncture

Across the region, there are impressive examples of successful approaches in prevention, treatment, care and support and multiple regional and national political commitments — many of them visionary, ambitious and showing results.

However, to sustain gains and translate commitments into concrete and lasting action, the region needs to embrace innovation and effective investment strategies that will move the AIDS response to the next level. Long-term progress will therefore depend on ensuring that HIV continues to feature prominently within the region's future health and development agenda, specifically in post 2015 sustainable development goals.

9 Note: All HIV spending data presented in this report excludes India, Bhutan and Maldives.

Seven recommendations to help end the AIDS epidemic by 2030

1. **Power of data:** Information is vital for SAARC countries to turn the epidemic around. Countries need to collect sub-national, gender and age disaggregated programme-monitoring data using established guidelines to analyzeand assess progress. This can better inform appropriately designed and focused HIV programmes at the regional, sub-national and sub-population levels.

2. **Greater focus:** Renewed focus on geographical areas of highest burden such as big cities and hot spots with safe city initiatives and also key populations at higher risk, include cross border migration, will drive progress. Programmes must be rights-based if key populations are to access them in a timely manner. It must be responsive to the needs and experiences of key populations and be provided in safe and non-judgmental settings.

3. **Simplified HIV testing and counselling strategies:** Only when people know their HIV status can they access treatment, care, and prevention services. HIV testing should be done with rapid testing methodology with same day results delivery. Testing can be normalized within health care settings and community-based HIV testing and counselling. Continuum of care, treatment and rights literacy must be introduced and scaled up.

4. **Maximizing the benefits of antiretroviral treatment:** Initiating antiretroviral therapy earlier is vital for successful treatment. Antiretroviral treatment regimens must be simplified as a matter of urgency. Reducing the number of regimens will also help simplify procurement and supply systems, ultimately leading to greater efficiencies. Ensuring affordable treatment is critical and TRIPS flexibilities need to be more widely utilized.

5. **Reduce stigma, discrimination:** Investment in programmes to create enabling environments for accessing HIV services is absolutely crucial to scale up HIV prevention and treatment effectively and sustainably. Countries that have progressed in strengthening human rights and gender equality report greater progress in other targets using the existing human rights programming guidelines

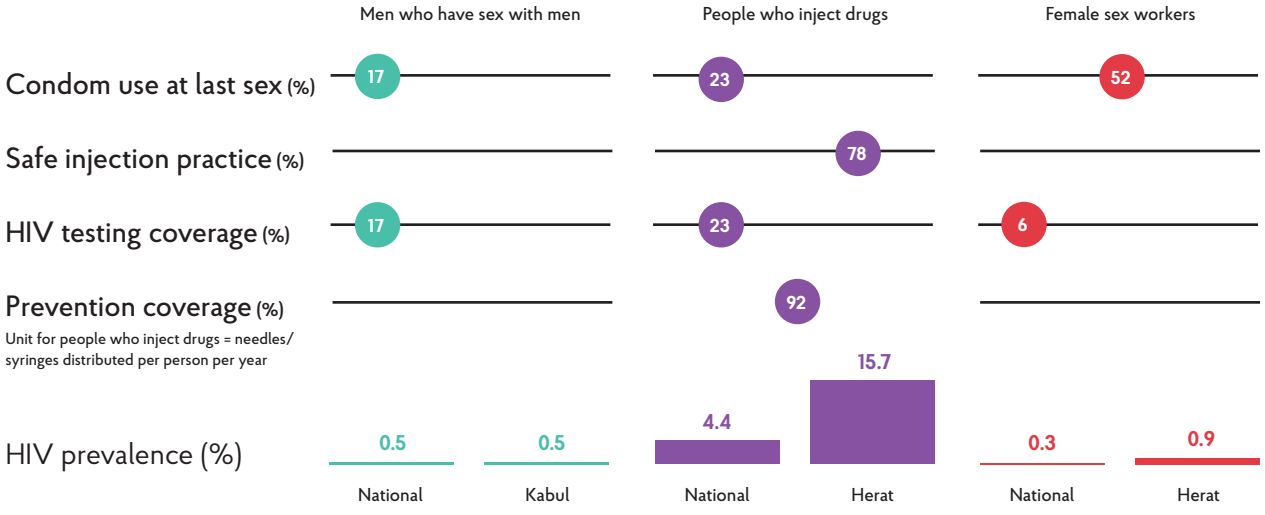
6. **Communities at the centre:** Often the best examples of effective HIV testing, prevention, treatment and care programmes are led and implemented by communities. The meaningful involvement of key populations in the design, implementation, monitoring, evaluation and delivery of HIV services is the key to success.

7. **Smart investments, maximum return:** The next generation of HIV investments in South Asia must focus on increased domestic financing, national ownership of the response and smarter investments in strategies that will maximize returns. A number of actions can be initiated through an improved investment focus, ranging from better integration to greater efficiencies.

Country profiles

Afghanistan

People living with HIV	4500	Low estimate	1700	Trend ↑
		High estimate	17 000	
Women living with HIV	1500	Low estimate	<1000	
		High estimate	6000	
Children living with HIV	<500	Low estimate	<100	
		High estimate	<1000	
New HIV infections	<1000	Low estimate	<1000	Trend <>
		High estimate	6000	
Pregnant women who received ARVs for PMTCT	2%	Low estimate	1%	Pregnant women who received ARVs for PMTCT 4
		High estimate	7%	
ART coverage (people receiving ART as proportion of PLHIV)	5%	Low estimate	1%	People receiving ART 211
		High estimate	13%	
AIDS-related deaths	<500	Low estimate	<200	Trend <>
		High estimate	<1100	



Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report. **Behavioural data:** www.aidsinfoonline.org. **Prevention coverage and HIV testing coverage:** www.aidsinfoonline.org. **HIV prevalence (National):** www.aidsinfoonline.org. **IV prevalence (Sub-national):** Integrated Biological and Behavioural Survey Report 2012. **AIDS spending:** www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2013

245,000 USD

4.6%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men and transgender people
- Criminalization of people who use drugs
- Criminalization of sex work

HIV-related restrictions on entry, stay and residence

- No

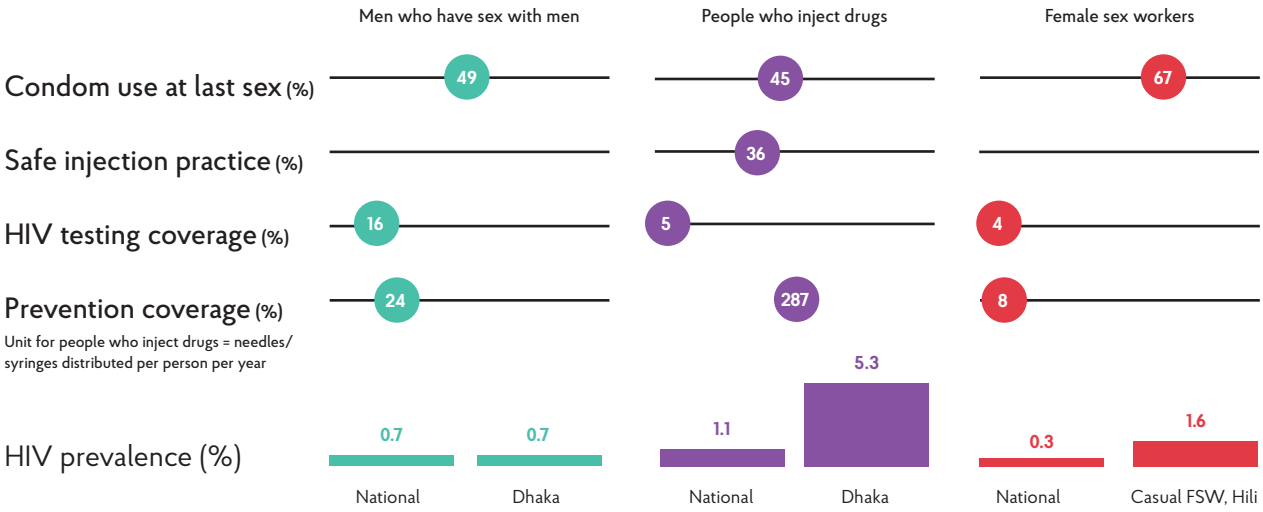
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

Bangladesh

People living with HIV	9500	Low estimate	4100	Trend ↑
		High estimate	97 000	
Women living with HIV	3300	Low estimate	1400	
		High estimate	36 000	
Children living with HIV	<500	Low estimate	<200	
		High estimate	2100	
New HIV infections	1300	Low estimate	<500	Trend <>
		High estimate	27 000	
Pregnant women who received ARVs for PMTCT	13%	Low estimate	1%	Pregnant women who received ARVs for PMTCT 18
		High estimate	33%	
ART coverage (people receiving ART as proportion of PLHIV)	11%	Low estimate	1%	People receiving ART 1083
		High estimate	26%	
AIDS-related deaths	<500	Low estimate	<200	Trend <>
		High estimate	2100	



Sources: **HIV infection estimates and treatment:** 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report. **Behavioural data:** www.aidsinfoonline.org. **Prevention coverage:** www.aidsinfoonline.org. **AIDS spending:** www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2013

3 470 437 USD

16.4%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men and transgender
- Criminalization of people who use drugs
- Criminalization of sex work
- Public order offences, against sex workers
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

- No

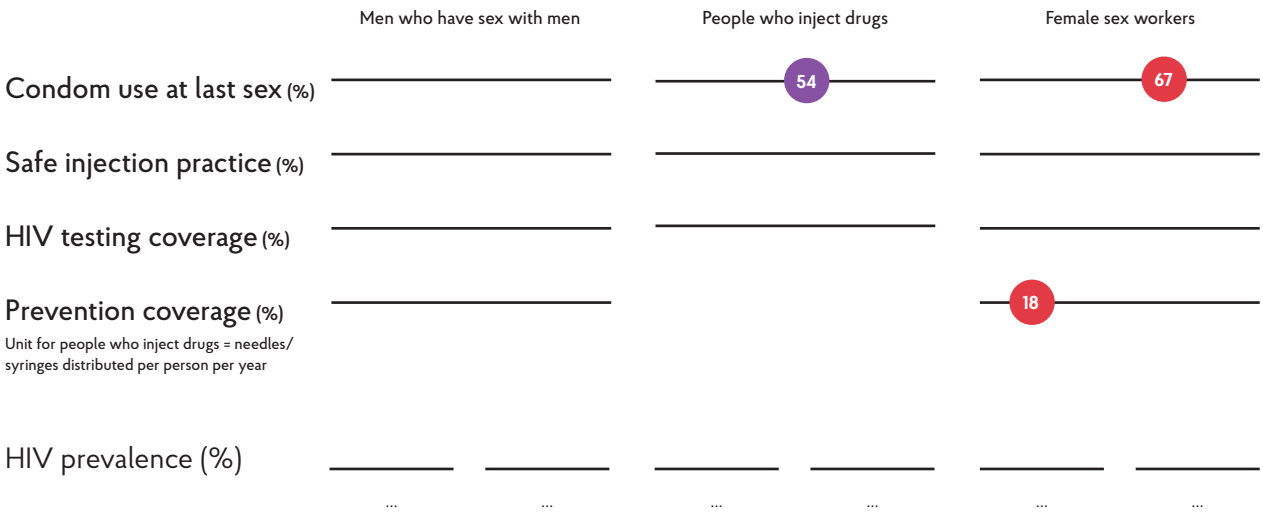
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

20%

Bhutan

People living with HIV	<1000	Low estimate	<500	Trend <>
		High estimate	2100	
Women living with HIV	<500	Low estimate	<200	
		High estimate	<1000	
Children living with HIV	...	Low estimate	...	
		High estimate	...	
New HIV infections	<100	Low estimate	<100	Trend <>
		High estimate	<500	
Pregnant women who received ARVs for PMTCT	...	Low estimate	1%	Pregnant women who received ARVs for PMTCT ...
		High estimate	33%	
ART coverage (people receiving ART as proportion of PLHIV)	...	Low estimate	...	People receiving ART 120
		High estimate	...	
AIDS-related deaths	<100	Low estimate	<100	Trend <>
		High estimate	<100	



Unit for people who inject drugs = needles/ syringes distributed per person per year

Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report. Behavioural data: www.aidsinfoonline.org. **Prevention coverage and HIV testing coverage:** www.aidsinfoonline.org. **HIV prevalence (National):** www.aidsinfoonline.org. **HIV prevalence (Sub-national):** HIV Sentinel Surveillance Survey Report 2011. **AIDS spending:** www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2013

●●●

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men and transgender
- Criminalization of people who use drugs
- Criminalization of sex work
- Public order offences, against sex workers
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

- No

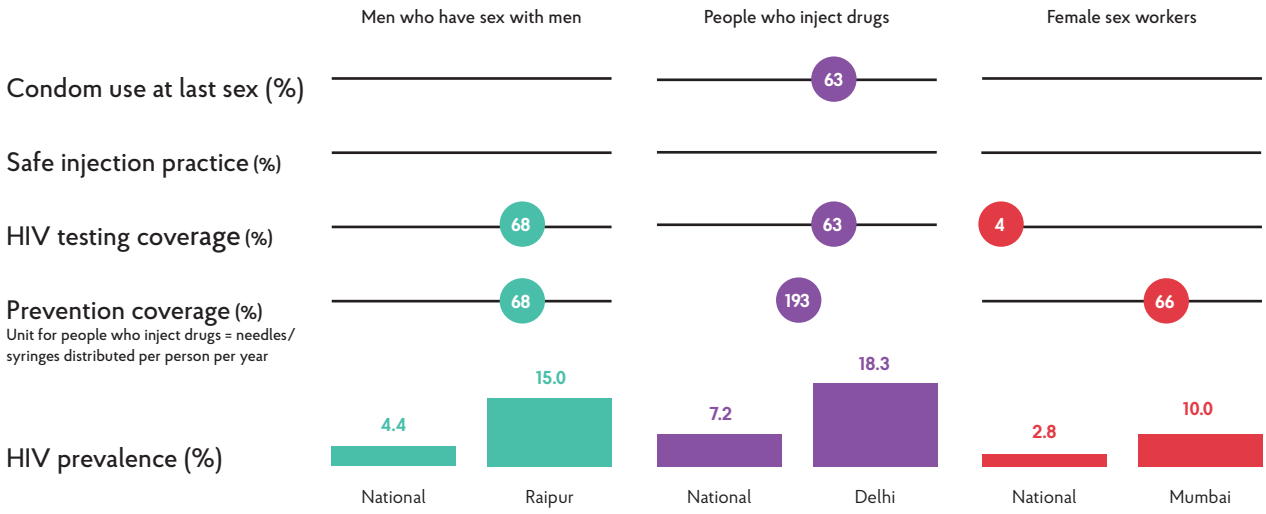
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No Stigma Index conducted

India

People living with HIV	2 100 000	Low estimate	1 700 000	Trend ↓
		High estimate	2 700 000	
Women living with HIV	750 000	Low estimate	600 000	
		High estimate	970 000	
Children living with HIV	140 000	Low estimate	110 000	
		High estimate	170 000	
New HIV infections	130 000	Low estimate	80 000	Trend ↓
		High estimate	250 000	
Pregnant women who received ARVs for PMTCT	18%	Low estimate	12%	Pregnant women who received ARVs for PMTCT 6155
		High estimate	24%	
ART coverage (people receiving ART as proportion of PLHIV)	36%	Low estimate	12%	People receiving ART 747175
		High estimate	24%	
AIDS-related deaths	130 000	Low estimate	93 000	Trend ↓
		High estimate	160 000	



Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report. **Testing coverage & PWID safe injection practice:** www.aidsinfoonline.org; **HIV prevalence (National):** www.aidsinfoonline.org; **HIV prevalence (subnational):** Biological and Behavioural Survey on HIV and AIDS - 2008 (BSS 2008). *BSS 2008 Data for Male (the capital city); condom use data is for consistent condom use. **HIV spending:** www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2013

29 623 913 USD

10.4%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of people who use drugs
- Anti-trafficking law (enforcement against sex workers, including compulsory detention of sex workers for rescue/ rehabilitation)
- Public order offences against sex workers, men who have sex with men and transgender

HIV-related restrictions on entry, stay and residence

- No

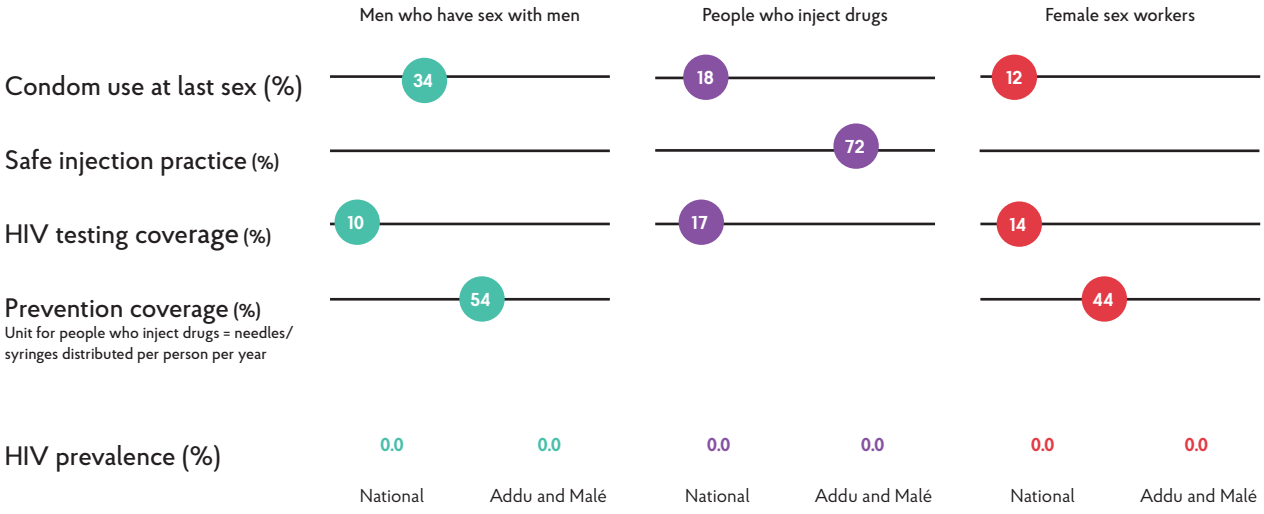
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

No data (pilot only)

Maldives

People living with HIV	<100	Low estimate	<100	Trend <>
		High estimate	<100	
Women living with HIV	<100	Low estimate	<100	
		High estimate	<100	
Children living with HIV	...	Low estimate	...	
		High estimate	...	
New HIV infections	<100	Low estimate	<100	Trend <>
		High estimate	<100	
Pregnant women who received ARVs for PMTCT	...	Low estimate	...	Pregnant women who received ARVs for PMTCT ...
		High estimate	...	
ART coverage (people receiving ART as proportion of PLHIV)	19%	Low estimate	14%	People receiving ART 5
		High estimate	24%	
AIDS-related deaths	<100	Low estimate	<100	Trend <>
		High estimate	<100	



Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds 1990-2013; 2. UNAIDS. (2014). The Gap Report. **Prevention coverage:** www.aidsinfoonline.org **HIV prevalence (National):** www.aidsinfoonline.org **HIV prevalence (Sub-national):** HIV Sentinel Surveillance Survey Report 2010-11. *Programme data from Computerised Management Information System(CMIS) and HRG Estimation report. **HIV spending:** www.aidsinfoonline.org

Funding

Domestic spending from public sources

...

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Criminalization of sex work

Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

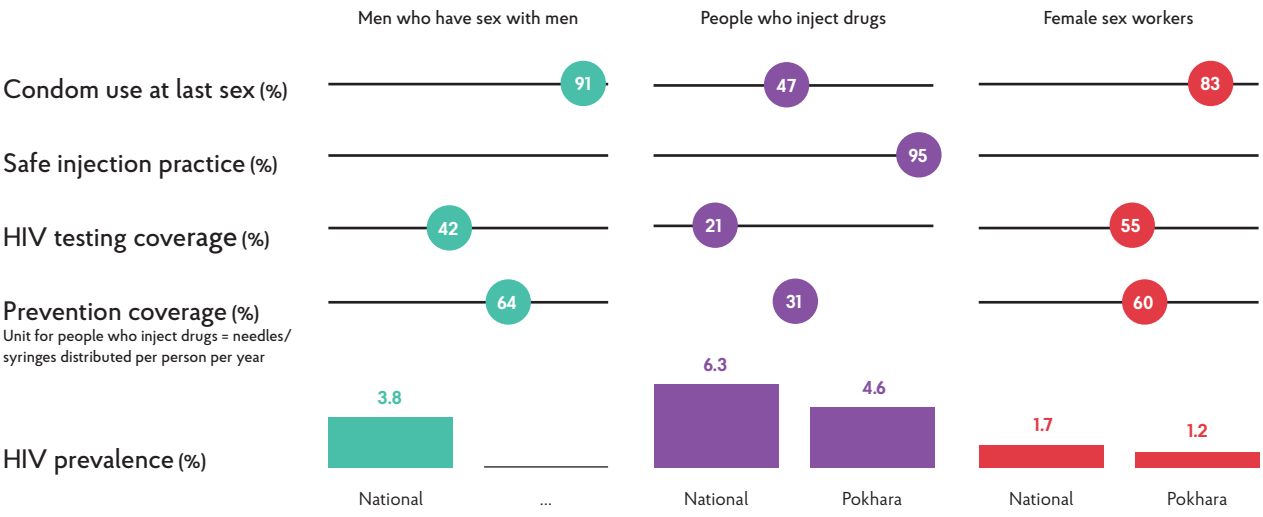
No Stigma index study

HIV-related restrictions on entry, stay and residence

- No

Nepal

People living with HIV	**39 000**	Low estimate 31 000 High estimate 52 000	Trend ↓
Women living with HIV	**7900**	Low estimate 6500 High estimate 10 000	
Children living with HIV	**1900**	Low estimate 1500 High estimate 2500	
New HIV infections	**1300**	Low estimate <1000 High estimate 2400	Trend ↓
Pregnant women who received ARVs for PMTCT	**27%**	Low estimate 19% High estimate 36%	Pregnant women who received ARVs for PMTCT **120**
ART coverage (people receiving ART as proportion of PLHIV)	**23%**	Low estimate 17% High estimate 36%	People receiving ART **8866**
AIDS-related deaths	**3300**	Low estimate 2500 High estimate 4600	Trend ↓



Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report. **Behavioural data**: www.aidsinfoonline.org. **Prevention coverage and HIV testing coverage**: www.aidsinfoonline.org. **HIV prevalence (National)**: www.aidsinfoonline.org. **HIV prevalence (Sub-national)**: Integrated Biological and Behavioural Survey Report. *MSW data is reported. **AIDS spending**: www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2009

265 416 USD

1.3%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalisation of people who use drugs
- Public order offences, against sex workers (including transgender sex workers)
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

- No

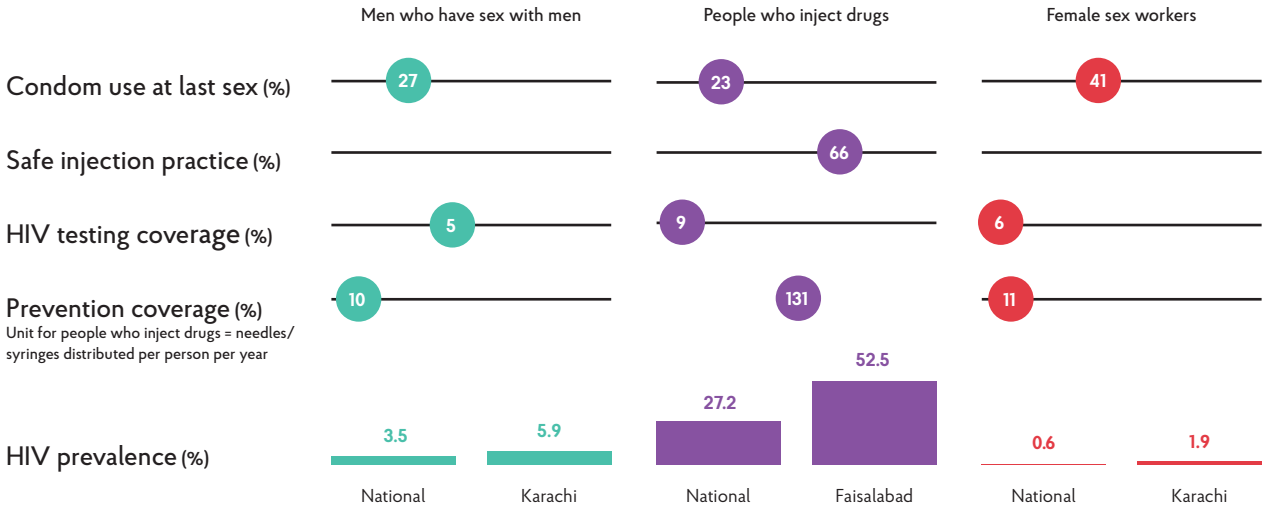
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

11%

Pakistan

People living with HIV	68 000	Low estimate	41 000	Trend ↑
		High estimate	130 000	
Women living with HIV	19 000	Low estimate	12 000	
		High estimate	36 000	
Children living with HIV	1600	Low estimate	1100	
		High estimate	2900	
New HIV infections	14 000	Low estimate	7000	Trend ↑
		High estimate	33 000	
Pregnant women who received ARVs for PMTCT	9%	Low estimate	5%	Pregnant women who received ARVs for PMTCT 126
		High estimate	14%	
ART coverage (people receiving ART as proportion of PLHIV)	6%	Low estimate	3%	People receiving ART 4391
		High estimate	11%	
AIDS-related deaths	2200	Low estimate	1300	Trend ↑
		High estimate	4000	



Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report. **Behavioural data**: www.aidsinfoonline.org. **Prevention coverage and HIV testing coverage**: www.aidsinfoonline.org. **HIV prevalence (National)**: www.aidsinfoonline.org. **HIV prevalence (Sub-national)**: Integrated Biological and Behavioural Survey Reports. *data for Kathmandu Valley is reported as national data. **AIDS spending**: www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2013

3 631 968 USD

36.3%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Criminalization of some drug-related activities
- Criminalization of sex work

HIV-related restrictions on entry, stay and residence

- No

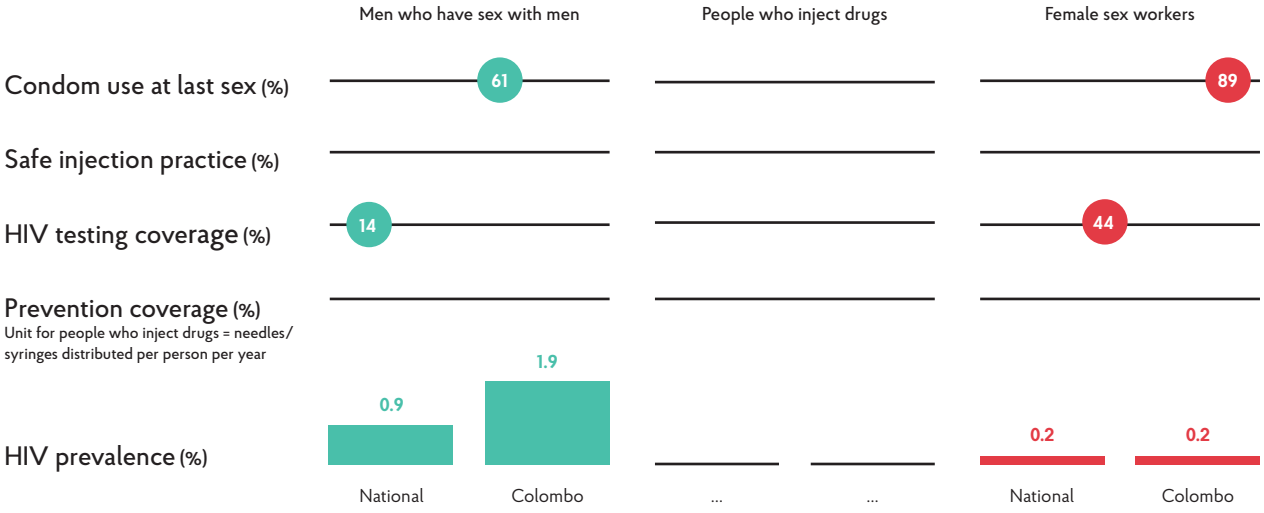
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

20%

Sri Lanka

People living with HIV	2900	Low estimate	1800	Trend ↑
		High estimate	3500	
Women living with HIV	<1000	Low estimate	<1000	
		High estimate	1700	
Children living with HIV	...	Low estimate	...	
		High estimate	...	
New HIV infections	<500	Low estimate	<500	Trend <>
		High estimate	<1000	
Pregnant women who received ARVs for PMTCT	...	Low estimate	...	Pregnant women who received ARVs for PMTCT ...
		High estimate	...	
ART coverage (people receiving ART as proportion of PLHIV)	18%	Low estimate	10%	People receiving ART 492
		High estimate	29%	
AIDS-related deaths	<100	Low estimate	<100	Trend <>
		High estimate	<500	



Sources: HIV infection estimates and treatment: 1. UNAIDS. (2014). HIV estimates with bounds_1990-2013; 2. UNAIDS. (2014). The Gap Report.
Behavioural data: www.aidsinfoonline.org. HIV testing coverage: www.aidsinfoonline.org. **HIV prevalence (National):** www.aidsinfoonline.org.
HIV prevalence (Sub-national): HIV Sentinel Surveillance Survey Report 2011. **AIDS spending:** www.aidsinfoonline.org

Funding

Domestic spending from public sources, 2010

2 277 906 USD

52.8%

Stigma and discrimination

Laws identified as barriers to HIV response in National Commitments and Policy Instrument (NCPI) 2012

- Criminalization of men who have sex with men
- Punitive laws relating to drug use (compulsory treatment)
- Criminalization of sex work
- Public order offences, against sex workers
- Laws and policies preventing some HIV service provision in closed settings

HIV-related restrictions on entry, stay and residence

- No

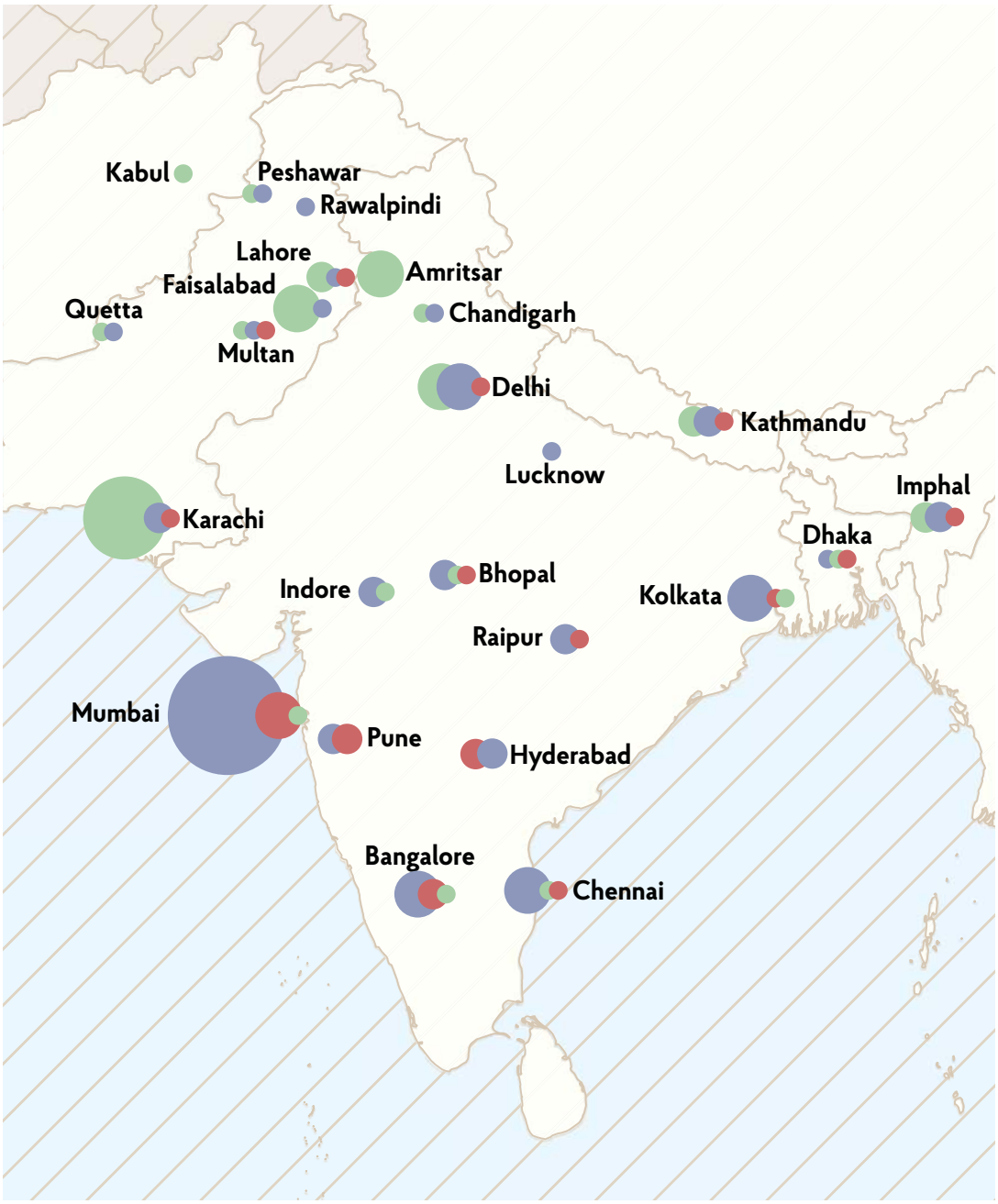
Stigma Index

Percentage of people living with HIV who avoided going to a local clinic when needed to in past 12 months because of HIV status

30%

Annex

Estimated HIV infections among key populations in cities in Asia and the Pacific



Men who have sex with men, including male sex workers

People who inject drugs

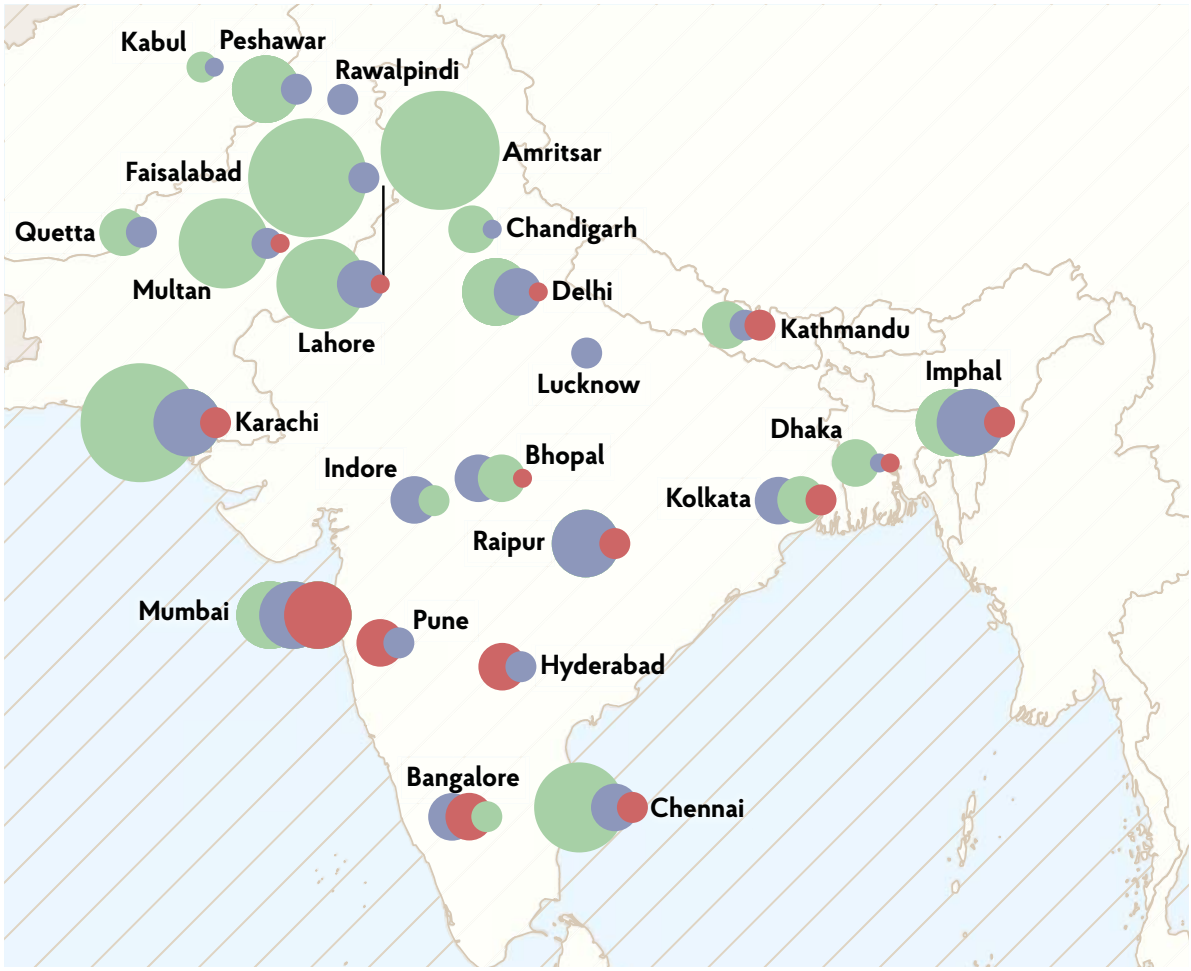
Female sex workers

Key populations HIV burden

No data available | <500 | 501 to 1500 | 1501 to 5000 | 5001 to 10 000 | 10 001 to 25 000

Calculated by www.aidsdatahub.org based on latest available data between 2009 and 2013 on HIV prevalence from national surveillance and other published survey results, and population size estimates from national reports or information from partners.
* Pakistan data for hijra sex workers. MSM: Men who have Sex with Men; MSW: Male Sex Workers; PWID: People Who Inject Drugs; FSW: Female Sex Workers

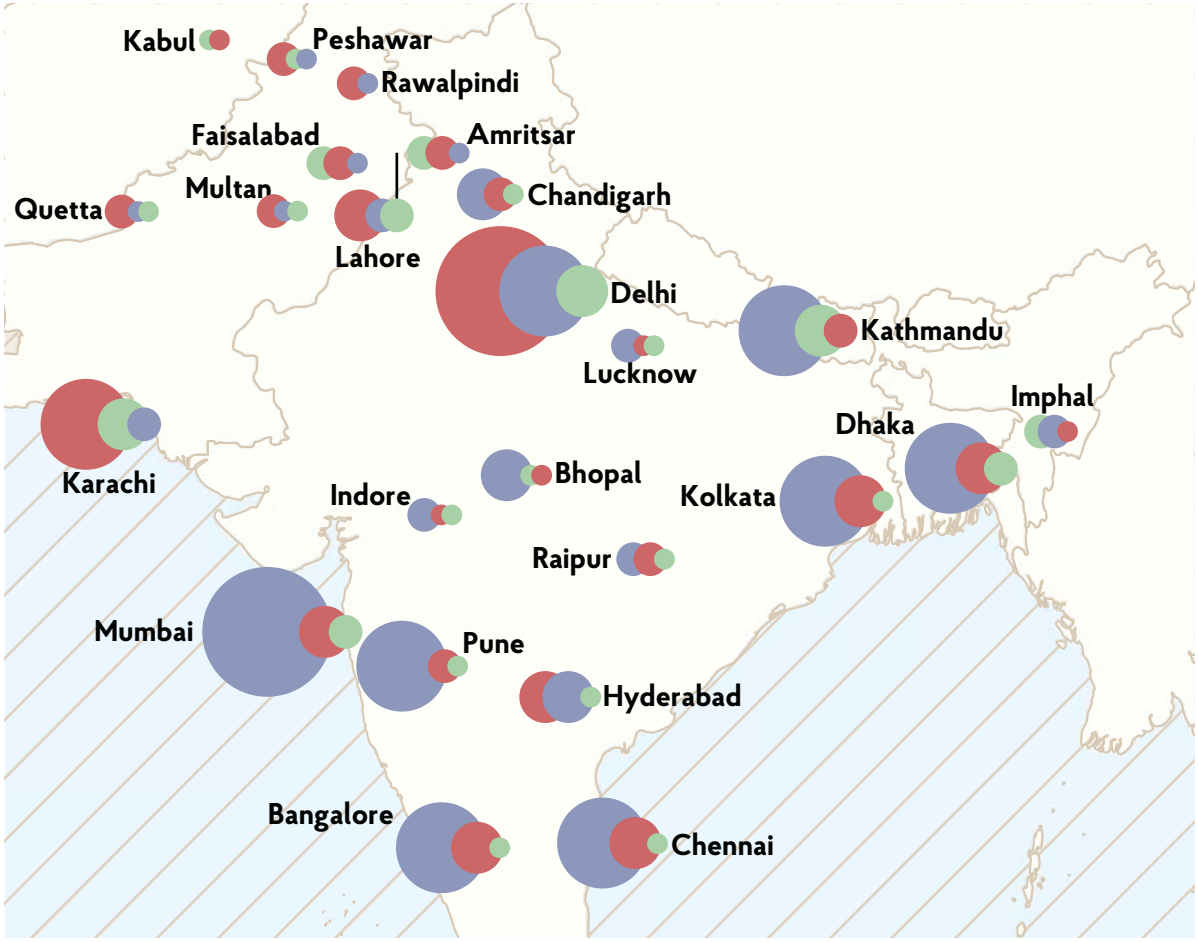
HIV prevalence among key populations in cities in Asia and the Pacific



		HIV prevalence (%)		
Country	Cites/Areas	MSM (incl. MSW)	PWID	FSW
Afghanistan	Kabul	0.4	2.5	0
Bangladesh	Dhaka	0.7	5.3	0.5
India	Amritsar		45.8	0
	Bangalore	8.4	2	6
	Bhopal	8.5	5.5	0.4
	Chandigarh	0.4	7.2	0
	Chennai	5.1	27.2	1.6
	Delhi	5.3	18.3	0.7
	Hyderabad	4		7.2
	Imphal	10.5	13.2	2.8
	Indore	7.4	2.5	
	Kolkata	9.6	7.8	1.6
	Lucknow	3.2		0
	Mumbai	12.4	14.2	10
	Pune	3.6		8.2
	Raipur	15		4.5
Nepal	Kathmandu	3.8	6.3	1.7
Pakistan*	Faisalabad	3.9	52.5	0
	Karachi	12	42.2	1.9
	Lahore	5.2	30.8	0.5
	Multan	1.1	24.9	0.3
	Peshawar	1.1	20	0
	Quetta	2.7	7.1	0
	Rawalpindi	4.2		0

Prepared by www.aidsdatahub.org based on latest available data between 2009 and 2013 from national HIV sentinel surveillance surveys, integrated biological and behavioural surveys, and other published survey results.
* Pakistan data for hijra sex workers.
MSM: Men who have Sex with Men; MSW: Male Sex Workers; PWID: People Who Inject Drugs; FSW: Female Sex Workers

Key population size estimates in cities in Asia and the Pacific



Men who have sex with men, including male sex workers

People who inject drugs

Female sex workers

Key populations size estimates

No data available | ≤ 2500 | 2501 to 10 000 | 10 001 to 25 000 | 25 001 to 50 000 | > 50 000

		Key population size estimates		
Country	Cites/Areas	MSM (incl. MSW)	PWID	FSW
Afghanistan	Kabul		1,251	898
Bangladesh	Dhaka	35,355	4,181	14,387
India	Amritsar	2,450	5,350	3,440
	Bangalore	43,000	2,442	21,000
	Bhopal	14,960	1,400	1,000
	Chandigarh	25,000	1,671	3,750
	Chennai	35,000	1,117	11,777
	Delhi	35,800	17,700	64,000
	Hyderabad	17,000	610	20,395
	Imphal	7,500	9,800	1,500
	Indore	8,130	40	2,108
	Kolkata	28,400	1,036	19,473
	Lucknow	10,000	400	600
	Mumbai	103,000	1,600	23,000
	Pune	36,000	200	6,300
	Raipur	10,000	100	2,600
Nepal	Kathmandu	29,010	20,941	3,685
Pakistan*	Faisalabad	1,613	7,907	4,846
	Karachi	9,069	16,544	25,399
	Lahore	3,643	3,596	23,766
	Multan	2,266	870	5,308
	Peshawar	456	1,850	3,317
	Quetta	1,147	626	3,710
	Rawalpindi	490		3,635

Prepared by www.aidsdatahub.org based on latest available data between 2009 and 2013 from national key population size estimation reports and information from in-country partners on accepted size estimates. Population size estimates are based on national definitions of key populations at higher risk, and MSM includes male sex workers. For Indian cities, MSM size estimates for Targeted Interventions have been adjusted to be comparable to definitions used for the estimates of MSM in other countries. * Pakistan data for hijra sex workers.


SAARC