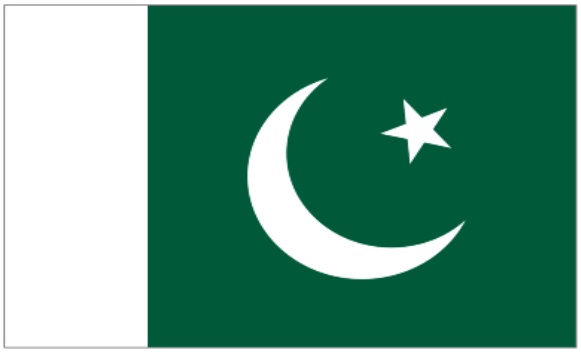
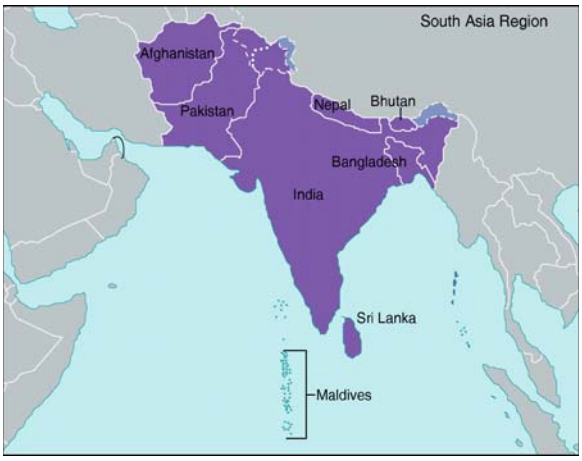
HIV/AIDS in Pakistan

THE WORLD BANK **August 2006**





The World Bank in South Asia

Afghanistan
Bangladesh
Bhutan
India
Maldives
Nepal
Pakistan
Sri Lanka

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Pakistan still has a window of opportunity to act decisively to prevent the spread of HIV. Although the estimated HIV burden is still low—around 0.1 percent of the adult population - there has been an outbreak of HIV among injecting drug users (IDUs) in Sindh. Without vigorous and sustained action, Pakistan runs the risk of experiencing the rapid increase in HIV among vulnerable groups seen elsewhere.

STATE OF THE EPIDEMIC

According to UNAIDS estimates, about 85,000 people, or 0.1 percent of the adult population in Pakistan, are infected with HIV. Officially reported cases are, however, much lower. As of September 2004, only some 300 cases of AIDS and another 2,300 cases of HIV infection were reported to the National AIDS Control Program. As in many countries, underreporting is due mainly to the social stigma attached to the infection, limited surveillance and voluntary counseling and testing systems, as well as the lack of knowledge among the general population and health practitioners. Although overall HIV prevalence is low in Pakistan, there is growing evidence of substantial high risk groups which could contribute to local concentrated epidemics.

The combination of high levels of risk behavior and limited knowledge about H among injecting drug users and sex workers could lead to the rapid spread of HIV. Evidence from a baseline STI survey of high risk groups in Lahore and Karachi conducted from March-July 2004 indicated a concentrated epidemic among IDUs and men who have sex with men (MSM) in Karachi. The survey found 23 percent of the 402 IDUs and four percent of 409 MSMs sampled were HIV positive. There were alarmingly high syphilis rates among Hijras in Karachi (60%) and Lahore (33%). The survey also found very low condom use among these groups, particularly among MSM and low use of sterile injecting equipment among IDUs. More recent data from Karachi confirms these trends and indicates a slight increase in prevalence of IDUs (27%), and in MSMs (7%) and for the first time some female sex workers (FSWs) have also tested positive. Preliminary results of a survey of selected cities in Punjab conducted in May 2005 found HIV prevalence among IDUs in the range of 2.5 percent to 11 percent.

RISK FACTORS

There are serious risk factors that put Pakistan in danger of facing a rapid spread of the epidemic if immediate and vigorous action is not taken:

Outbreaks Among Injecting Drug Users (IDUs): The number of drug dependent people in Pakistan is estimated to be about 500,000, of whom an estimated 60,000 inject drugs. An outbreak of HIV was discovered among injecting drug users in Larkana, Sindh, where, out of 170 people tested, more than 20 were found HIV positive. In Karachi, a 2004 survey of Sexually Transmitted Infections among high risk groups found that more than one in five IDUs was infected with HIV. These represent the first documented epidemics of HIV in well-defined vulnerable populations in Pakistan. They serve as confirmation of the threat that HIV poses to Pakistan and validate the premise of the country's recent Enhanced HIV/AIDS Program.

HIV Infection Among Men who have Sex with Men (MSM): Lahore had an estimated 38,000 MSM in 2002. The MSM community is heterogeneous and includes Hijras (biological males who are usually fully castrated), Zenanas (transvestites who usually dress as women) and masseurs. Many sell sex and have multiple sexual partners. The 2004 STI survey found that 4 percent of MSMs in Karachi were infected with HIV, as were 2 percent of the Hijras in the city. Syphillis rates were also high with 38 percent of MSMs and 60 percent of Hijras in Karachi infected with the disease.

There are significant structural and socioeconomic factors which put South Asia at risk for a full-blown AIDS epidemic.

More than 35 percent of the population lives below the poverty line;

Low levels of literacy;

Porous borders;

Rural to urban and intrastate migration of male populations;

Trafficking of women and girls into prostitution;

High stigma related to sex and sexuality;

Structured commercial sex and casual sex with non-regular partners;

Male resistance to condom use;

High prevalence of sexually transmitted infections (STIs);

Low status of women, leading to an inability to negotiate safe sex.

HIV/AIDS is a challenge that goes beyond the health sector. What is needed is the strategic involvement of all sectors – poverty reduction, education, transport and roads, urban and rural sectors, gender, social development and public health.

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Unsafe Practices among Sex Workers: Commercial sex is prevalent in major cities and on truck routes. Behavioral and mapping studies in three large cities found a CSW population of 100,000 with limited understanding of safe sexual practices. Furthermore, sex workers often lack the power to negotiate safe sex or seek treatment for STIs. Recent findings indicate that although HIV prevalence remains below 1 percent, female sex workers (FSWs) and their clients report low condom use. Less than half the FSWs in Lahore and about a quarter in Karachi had used condoms with their last regular client.

Inadequate Blood Transfusion Screening and High Level of Professional Donors: It is estimated that 40 percent of the 1.5 million annual blood transfusions in Pakistan are not screened for HIV. In 1998, the AIDS Surveillance Center in Karachi conducted a study of professional blood donors—people who are typically very poor, often drug users, who give blood for money. The study found that 20 percent were infected with Hepatitis C, 10 percent with Hepatitis B, and 1 percent with HIV. About 20 percent of the transfused blood comes from professional donors.

Large Numbers of Migrants and Refugees: Large numbers of workers leave their villages to seek work in larger cities, in the armed forces, or on industrial sites. A significant number (around four million) are employed overseas. Away from their homes for extended periods of time, they may be at increased risk for exposure to HIV/AIDS.

Unsafe Medical Injection Practices: Pakistan has a high rate of medical injections - around 4.5 per capita per year. Studies indicate that 94 percent of injections are administered with used injection equipment. Use of unsterilized needles at medical facilities is also widespread. According to WHO estimates, unsafe injections account for 62 percent of Hepatitis B, 84 percent of Hepatitis C, and 3 percent of new HIV cases.

Low Levels of Literacy and Education: Efforts to increase awareness about HIV among the general population are hampered by low literacy levels and cultural influences. In 2001, the illiteracy rate of Pakistani women over 15 years old was 71 percent.

Vulnerability Due to Social and Economic Disadvantages: Restrictions on women's and girls' mobility limits access to information and preventive and support services. Young people are vulnerable to influence by peers, unemployment frustrations, and the availability of drugs. In addition, some groups of young men are especially vulnerable due to the sexual services they provide, notably in the transport sector. Both men and women from impoverished households may be forced into the sex industry for income.

NATIONAL RESPONSE TO HIV/AIDS

Government. Pakistan's Federal Ministry of Health initiated a National AIDS Prevention and Control Program (NACP) in 1987. In its early stages, the program was focused on diagnosis of cases that came to hospitals, but progressively began to shift toward a community focus. Its objectives are the prevention of HIV transmission, safe blood transfusions, reduction of STI transmission, establishment of surveillance, training of health staff, research and behavioral studies, and development of program management. The NACP has been included as part of the government's general health program, with support from various external donors.

As the government has indicated in the recent scaling up of its response to HIV/AIDS, more needs to be done. A special focus on reducing the exposure of high-risk groups is urgently required. Improving skills, building capacities, strengthening advocacy, and increasing participation is needed not only in the area of health, but in several sectors, including education, labor, law and order, etc. In early 2001, the Government of Pakistan, through a broad consultative process, developed a national HIV/AIDS Strategic Framework that sets out the strategies and priorities for effective control of the epidemic.

Non-Governmental Organizations (NGOs). At least 54 NGOs are involved in HIV/AIDS public awareness and in the care and support of persons living with HIV/AIDS. These NGOs also work on education and prevention interventions targeting sex workers, truck drivers, and other high-risk groups. NGOs serve as members of the Provincial HIV/AIDS Consortium, which has been set up in all four of Pakistan's provinces to coordinate HIV/AIDS prevention and control activities. Although NGOs are active in HIV/AIDS prevention activities, it is believed that they are reaching less than 5 percent of the vulnerable population.

Donors. UNAIDS has established a Theme Group and a Technical Working Group on HIV/AIDS to coordinate the response of United Nations Agencies and to provide assistance to the government in the strategic development of activities. The theme group includes UNAIDS, WHO, UNICEF, UNFPA, UNDP, UNDCP, UNESCO, ILO, the World Bank, national and provincial program managers, and representatives of nongovernmental organizations.

ISSUES AND CHALLENGES: PRIORITY AREAS

Vulnerable and High-risk Groups

- Expand knowledge, access, and coverage of vulnerable populations—particularly in large cities—to a package of high impact services, through combined efforts of the government and NGOs.
- Implement harm-reduction initiatives for IDUs and safe sex practices for sex workers.
- Make effective and affordable STI services available for high-risk groups and the general population.

General Awareness and Behavioral Change

- Undertake behavioral change communications with the following behavioral objectives: (i) use of condoms with non-regular sexual partners; (ii) use of STI treatment services when symptoms are present and knowledge of the link between STIs and HIV; (iii) use of sterile syringes for all injections; (iv) reduction in the number of injections received; (v) voluntary blood donation (particularly among the age group 18 to 30); (vi) use of blood for transfusion only if it has been screened for HIV; and (vii) display of tolerant and caring behaviors toward people living with HIV/AIDS and members of vulnerable populations.
- Increase interventions among youth, police, soldiers, and migrant laborers.

Blood and Blood Product Safety

· Ensure mandatory screening of blood and blood products in the public and private sectors for all major blood-borne infections.
· Conduct education campaigns to promote voluntary blood donation.
· Develop Quality Assurance Systems for public and private blood banks to ensure that all blood is properly screened for HIV and Hepatitis B.

Surveillance and Research

· Strengthen and expand the surveillance and monitoring system.
· Implement a second-generation HIV surveillance that tracks sero-prevalence and changes in HIV-related behaviors, including the spread of STIs and HIV, sexual attitudes and behaviors, and healthcare-seeking behaviors related to STIs.

Building Management Capacity

· Continue to build management capacity within provincial programs and local NGOs to ensure evidence-based program implementation.
· Identify gaps in existing programs and continue phased expansion of interventions.

WORLD BANK RESPONSE

The World Bank is the largest financer of HIV/AIDS programs in Pakistan. It assisted the government's HIV/AIDS efforts through funding the second Social Action Program (1998-2003). In addition, the World Bank is working with the government and other development partners (CIDA, DFID, USAID, UN Agencies) to support the government's program through the HIV/AIDS Prevention Project. The Bank is providing US$37.1 million, 75 percent of which is a no-interest credit and 25 percent of which is grant money. This project is helping to scale up existing activities, ensuring that the program focuses on interventions that will do the most to interrupt transmission of HIV and make sure that interventions take full advantage of international experience to date.

The implementation of the enhanced program is making encouraging progress with expansion of coverage of intravenous drugs users program in Punjab; awarding service delivery contracts for sex workers and jail inmates in Sindh and Punjab; and commencement of development of second-generation surveillance system. Significant implementation challenges remain, including addressing basic administrative and financial management; slow progress in awarding next phase of service delivery contracts, and building capacity at provincial level. An important emerging concern is the limited in-country capacity for scaling up interventions for high risk populations and the urgent need for technical assistance to contracted NGOs, particularly for programs with MSMs and sex workers.

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