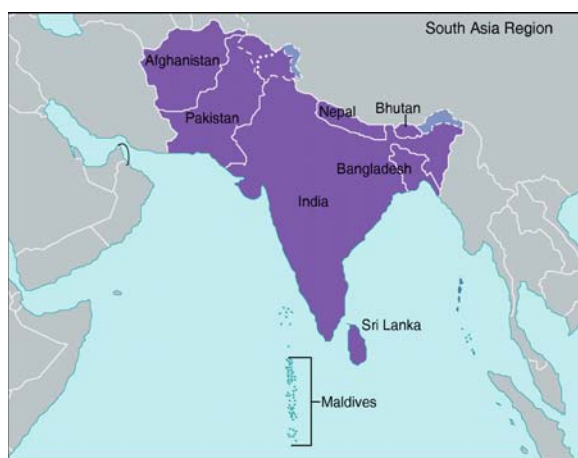


HIV/AIDS in Pakistan

THE WORLD BANK

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The World Bank in South Asia

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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—the country is facing a concentrated epidemic among injecting drug users (IDUs) with HIV prevalence above 5 percent among IDUs in three of the four provinces. Given linkages between IDUs and other high-risk populations including male and female sex workers, Pakistan needs to scale up targeted intervention urgently to prevent rapid increase in HIV among vulnerable groups.

STATE OF THE EPIDEMIC

According to UNAIDS estimates, about 85,000 people are living with HIV in Pakistan. Officially reported cases are, however, much lower. As in many countries, underreporting is due mainly to the social stigma attached to HIV, limited surveillance and voluntary counseling and testing systems, and the lack of knowledge among the general population and health practitioners.

Although overall HIV prevalence is low in Pakistan, there is growing evidence of local concentrated epidemics among IDUs in major cities across the country. The combination of high levels of risk behavior and limited knowledge about HIV among injecting drug users and sex workers could lead to the rapid spread of HIV.

RISK FACTORS

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

Concentrated Epidemic among Injecting Drug Users (IDUs): The number of drug dependent people in Pakistan is estimated to be about 500,000, of whom an estimated 100,000 inject drugs. In 2006, HIV prevalence rates among IDUs ranged between 10 to 50 percent across Quetta, Faisalabad, Hyderabad, Karachi, and Sargodha. The majority of these IDUs were either married or sexually active. The common risk factor for the majority of infected drug users was that they used non-sterile injecting equipment, and awareness of HIV transmission routes was relatively low. Here it is worth noting that safe injection practices are more prevalent in cities such as Lahore and Peshawar where targeted interventions have been in place over a longer period.

HIV among Male Sex Workers and Transgenders:

Surveillance data for 2006 point to a local concentrated epidemic among MSWs and Hijras in Larkana and Karachi in the Sindh province while prevalence elsewhere is still below 5 percent. Behavioral surveillance data for 2005 indicates very low levels of condom use among MSWs and transgenders across all cities surveyed. One in four of the male sex workers said they also bought or sold sex to women. Such high-risk behavior must be addressed in order to limit the further spread of HIV in and beyond those sexual networks.

Unsafe Practices among Female Sex Workers:

Commercial sex is prevalent in major cities and on truck routes. Behavioral and mapping studies in three large cities found a sex worker population of 100,000 with limited understanding of safe sexual practices. Condom use is still low during commercial sex encounters although consistent condom use is more prevalent in Karachi and Lahore where targeted interventions were initiated in 2004. Only 4

percent of male sex workers and less than 1 percent of the hijras in a Karachi study said they used a condom the last time they had sex with a man. Furthermore, sex workers often lack the power to negotiate safe sex or seek treatment for STIs. High levels of sexually transmitted infections indicate widespread sexual risk taking.

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. 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 4 million) are employed overseas. Away from their homes for extended periods of time, they may be at increased risk for exposure to HIV.

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 2006, female literacy was estimated at 42 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,

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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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 it 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, more needs to be done. For examples, focus on reducing the exposure of high-risk groups is urgently required as is increasing the service coverage of key populations (injecting drug users, female sex workers, men who have sex with men, and prison inmates). 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. The government is finalizing the new National Strategic Framework (2007-2011) and the national and provincial action plans.

A draft national AIDS policy and HIV and AIDS Law (both recommending the formation of a National AIDS Council) have been prepared by the National AIDS Control Programme and will be presented to the national cabinet and parliament. Approval of the policy and law would be an important step towards the multisectoral dimension of the national response.

Nongovernmental 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 15 percent of the vulnerable population.

Donors. There is 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 STD 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 towards 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 financier 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 expanding coverage of injecting drug users program in Punjab; implementation of service delivery packages for male and female sex workers in Sindh, Punjab, and NWFP; initiation of mass media campaigns; and establishment of a second-generation surveillance system. Significant implementation challenges remain, including addressing basic administrative and financial management and building capacity at the provincial level. The most important issue relates to mobilizing resources and capacity for scaling up services to high-risk populations. Current interventions barely cover 15 percent of these groups.

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Pakistan
Mr. Shahzad Sharjeel
☎ 92-51- 227-9641
✉ ssharjeel@worldbank.org

Washington, DC
Mr. Erik Nora
☎ 1-202-458-4735
✉ enora@worldbank.org

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