



HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	177 million (mid-2010)
Estimated Population Living with HIV/AIDS**	96,000 [69,000–150,000] (end 2007)
Adult HIV Prevalence**	<0.1% [0.1–0.2%] (end 2007)
HIV Prevalence in Most-at-Risk Populations***	IDUs: 20.8% (2009) MSW: 0.9% (2009) FSW: 0.97% (2009)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy****	6% (end 2009)

*U.S. Census Bureau **UNAIDS ***UNGASS ****WHO/UNAIDS/UNICEF *Towards Universal Access*, 2010

With an adult HIV prevalence rate of less than 0.1 percent, Pakistan is a low-prevalence country that faces a concentrated epidemic among some key populations. The country is at high risk for an HIV/AIDS epidemic due to the presence of several socioeconomic conditions conducive to the spread of HIV, including poverty, low levels of education, and high unemployment, which lead to increased exposure to the disease through temporary migration to higher-prevalence countries. The epidemic has also recently expanded from urban centers to more rural towns and communities. For about a decade after Pakistan's first case of HIV was reported in 1987, the majority of new infections were among men who had been exposed to the disease while abroad. By 1999, approximately three-fourths of reported HIV

infections occurred in migrant workers returning from the Arab Gulf states. Since then, HIV/AIDS infections have markedly increased among other most-at-risk populations (MARPs), including injecting drug users (IDUs), commercial sex workers (CSWs), and prison inmates. The Joint United Nations Program on HIV/AIDS (UNAIDS) estimated in 2007 that 96,000 Pakistanis were HIV positive. The initial IDU epidemic was followed by epidemics in other associated MARPs, with a time lag of two to three years between shifts from one group to another.

Among reported infections, heterosexual sex is the primary mode of transmission (accounting for 67 percent of infections), followed by contaminated blood and blood products (18 percent), homosexual or bisexual sex (6 percent), injecting drug use (4 percent), and mother-to-child transmission (1.3 percent), according to UNAIDS. However, research shows an alarming spike in HIV prevalence in urban IDUs, with an overall seroprevalence of 20.8 percent nationally, according to the 2010 United Nations General Assembly Special Session (UNGASS) report. Prevalence among IDUs has nearly doubled since 2005, increasing at an alarming rate. Detection of a 2003 infection outbreak among IDUs in Larkana provided the first evidence of a concentrated epidemic among high-risk populations, and continued surveillance has indicated HIV prevalence in some urban IDU populations has reached 51 percent.

Among IDUs, risky behaviors increase the likelihood of transmission both among IDUs and to other populations. In a 2009 national surveillance survey, only 11.8 percent of IDUs had been tested for HIV and knew their results. In the 2010 UNGASS report, 77.3 percent of IDUs reported the use of sterile injecting equipment at last injection. The percentage of IDUs 25 years and younger who used a condom at last sexual encounter increased from 13 percent in 2007 to 29.2 percent in 2009 and increased from 22.7 to 31.2 percent in IDUs over 25 years.

HIV prevalence is lower among other MARPs but continues to rise, according to HIV surveillance conducted by the National AIDS Control Program (NACP) from 2005 to 2009. Overall prevalence among female sex workers (FSWs) varies between cities; in 2009, a survey across major urban areas found a prevalence of 0.97 percent. Prevalence was 0.9 percent among male sex workers (MSWs) and 6.1 percent among *hijra* (transgender) sex workers (HSWs) (UNGASS, 2010). FSWs were more likely than MSWs and HSWs to use condoms, with 43.3 percent of FSWs using a condom at last encounter compared to 33.1 percent of MSWs and HSWs. Lack of knowledge, unsafe practices, and high mobility are the likely drivers of an increasing number of cases over the past decade and the spread to rural areas.

High levels of interaction between IDUs and CSWs, coupled with low levels of condom use and HIV/AIDS knowledge among persons belonging to these high-risk groups put Pakistan in danger of a broader HIV/AIDS epidemic. Condom use is low among those IDUs accessing the services of sex workers, although it has been

increasing in the past decade; 17.2 percent of IDUs had purchased sex from a woman, and 13.2 percent had paid for sex with a man. Less than 16 percent of IDUs and sex workers have been tested for HIV and know their results and are at high risk of spreading the virus to their spouses or partners. In Punjab, 15 percent of the wives and partners of IDUs tested HIV positive, according to the 2010 UNGASS report, compared to less than 0.1 percent of the general population. Outreach programs have expanded efforts to reach more MARPs, and the proportion of the IDU population reached with prevention programs has increased from 16 percent in 2007 to 53.8 percent in 2009.

Pakistan is also a key destination for trafficked girls under 16 years of age, especially from Bangladesh and Nepal. Although data on HIV prevalence among trafficked women and girls are limited, studies show persons belonging to this group are highly vulnerable to infection because they are frequently placed in situations where they cannot negotiate condom use, can be forced to endure multiple sex partners, and are often subjected to violence.

Other factors that increase Pakistan's vulnerability to the epidemic include risky sexual practices among a large portion of the country's men who have sex with men (MSM); inadequate blood transfusion screening and a high number of professional blood donors; a sizable migrant and refugee population; unsafe medical injection practices; limited awareness and knowledge of reproductive health issues; social stigmas about HIV/AIDS; and gender inequalities. Migration is a particular concern; as of 2010, 80 percent of the reported cases of HIV in the Northwest province were migration related. Migrants are frequently socially isolated when they leave to find work and have limited health information, often visiting CSWs in their time away from home.

According to the World Health Organization (WHO), Pakistan is one of the world's high burden countries for tuberculosis (TB), with 231 new cases per 100,000 population in 2008. HIV infects 1.8 percent of adults with new TB cases, and HIV-TB co-infection complicates the treatment and care for both diseases.

National Response

Pakistan's Ministry of Health established the NACP in 1988. Initially focused on developing laboratory services, NACP has taken the lead in restructuring and streamlining health service management to strengthen the quality and delivery of care at the federal and provincial levels. NACP also conducts public awareness campaigns; disseminates information materials; organizes workshops and other educational events; develops guidance for improving counseling and care and support, clinical management, surveillance, and blood safety; and oversees research to measure intervention effectiveness. NACP also drafted a national AIDS policy and an HIV/AIDS law that recommended the formation of a national AIDS council.

Drafting policy documents that regularly incorporate sexually transmitted infections (STIs) and HIV as priority issues, the Government of Pakistan has consistently shown its commitment to fighting the spread of HIV/AIDS through multiple strategic plans and frameworks. In 2003, the Government implemented the Enhanced NACP, a five-year program targeting populations most at

risk. Pakistan's Medium-Term Development Framework for 2005–2010, includes among its goals the halving of HIV/AIDS prevalence in MARPs and pregnant women. The 2009 National Health Policy also includes HIV/AIDS as a priority area, with specific emphasis on programs for MARPs.

The new National Strategic Framework for 2007–2012 (NSF II) expands on the previous National Strategic Framework (2002–2006); broadens the scope of HIV/AIDS control efforts in the country to include women, children, and young adults; and stresses the provision of support groups for the spouses and children of key populations, particularly IDUs. The core strategies of NSF II include creating an enabling environment, strengthening the institutional framework for responding to HIV, building local and national capacities, and scaling up program delivery. Specific actions to achieve these goals have included shifting focus to the mapping of high-risk groups and increasing behavioral surveillance; assessing knowledge and attitudes about HIV; creating targeted behavior change communication strategies and implementing a media campaign; and providing care and support to people living with HIV/AIDS (PLWHA).

Service coverage of key populations (IDUs, CSWs, MSM, and prison inmates) in Pakistan is still very low, covering less than 15 percent of MSWs and HSWs and only 40 percent of IDUs, for example. This is well below the minimum needed to contain the epidemic. A public-private partnership between the Government of Pakistan and a consortium of nongovernmental organizations (NGOs) has improved coverage of MARPs recently. The



NGOs typically provide services to marginalized MARPs, often in rural areas, and act as a bridge between PLWHA and support/advocacy organizations. Due to their presence in the local communities and knowledge of the needs of the population, they have been effective promoters of prevention activities and access to treatment. The Government has also successfully implemented public needle exchange programs and selected harm reduction activities and other special services for at-risk populations, but these programs are not reaching the numbers needed to curb the epidemic.

USAID Support

Through the U.S. Agency for International Development (USAID), Pakistan received \$2 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in Pakistan are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative to support partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

USAID resumed its presence in Pakistan in July 2002 after a seven-year hiatus. Its initial activities included support of health sector reform to improve service coverage, responsiveness, quality, and efficiency. From February 2006 until 2009, USAID implemented and completed the Pakistan HIV and AIDS Prevention and Care Project (PHAPCP), a three-year, \$2.7 million project designed to reduce the transmission of HIV/AIDS. During its three years, PHAPCP worked in the cities of Rawalpindi, Lahore, Multan, Karachi, Larkana, Turbat, and Peshawar, thus bringing HIV/AIDS interventions to all four of Pakistan's provinces. In all seven cities, PHAPCP funded local NGOs to raise awareness of HIV prevention among at-risk groups, extended home-based care to PLWHA, and formed a network of groups representing HIV-infected and -affected individuals to advocate for better treatment and to educate the public. PHAPCP's successes in 2006 included informing 120,000 at-risk people about HIV prevention and providing care to 72 HIV-positive individuals and their 1,300 family members through local NGOs.

In 2007, PHAPCP opened confidential HIV/AIDS testing facilities in Karachi, Lahore, Rawalpindi, Multan, and Peshawar. In Turbat, PHAPCP also provided medical and emotional support for those infected and affected by HIV/AIDS. Assessments of PHAPCP programs, conducted in the first quarter of 2009, reaffirmed their success in building on previous HIV programs, with particular success with the MSM populations at project sites. Condom use in MSM increased from 4 percent at baseline (2006) to 29 percent (2009); the percentage of MSM with comprehensive knowledge of HIV and STIs increased from 29 percent (2006) to 66 percent (2009).

In 2009, USAID-supported peer education outreach programs reached 13,637 members of the 14,000 target population. Voluntary counseling and testing services reached 1,184 individuals through USAID-supported clinics, and 935 PLWHA and their families received care and support services.

Important Links and Contacts

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USAID's HIV/AIDS Web site for Pakistan:

http://www.usaid.gov/our_work/global_health/aids/Countries/asia/pakistan.html.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.

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