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HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	165 million (mid-2007)
Estimated Population Living with HIV/AIDS**	85,000 [46,000-210,000] (end 2005)
Adult HIV Prevalence**	0.1% [0.1-0.2](end 2005)
HIV Prevalence in Most-At-Risk Populations***	IDUs: 26% (Karachi), 12% (Sargodha), 9.5% (Faisalabad), 24% (Quetta), 8% (Larkana) (mid 2005) Sex Workers: 2% (Karachi), <1% (Lahore & Rawalpindi)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy****	<1% (end 2006)

*US Census Bureau **UNAIDS ***WHO/UNAIDS/UNICEF Towards Universal Access, April 2007

With an HIV prevalence rate of 0.1 percent, Pakistan faces a concentrated epidemic among some key populations, and the country is at high risk for an HIV/AIDS epidemic. Several socioeconomic conditions conducive to the spread of HIV exist in Pakistan, including poverty, low levels of education, and high unemployment, which lead to increased exposure to the disease via migration to higher prevalence countries. 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 are increasingly being found among injecting drug users (IDUs), commercial sex workers (CSWs), and prison inmates. As of September 2005, the Government of Pakistan reported 3,073 people living with HIV/AIDS (PLWHA); however, UNAIDS estimated in 2005 that 85,000 Pakistanis were HIV-positive. According to UNAIDS, the country fits the stereotype of the typical Asian Epidemic Model scenario, where the number of new infections grows rapidly in a late-developing epidemic.

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. The percentage of HIV infections among Karachi IDUs increased drastically between January 2003 and March 2005 from 0.4 percent to 26 percent, according to a study commissioned by Pakistan's National AIDS Control Program (NACP). In mid-2005, HIV prevalence among IDUs was 12 percent in Sargodha, 9.5 percent in Faisalabad, 24 percent in Quetta, and 8 percent in Larkana. A study among IDUs in Karachi and Rawalpindi found only about half knew HIV could be transmitted through sharing of unclean needles. The Ministry of Health found that 48 percent of IDUs in Karachi and 82 percent in Lahore had used non-sterile syringes in the week before a 2004 survey. Twenty-one percent of IDUs in Karachi and 51 percent in Lahore had injected in another city during the previous year. HIV prevalence is considerably lower among other groups at risk of infection. Among female sex workers (FSWs) in Karachi, HIV prevalence was 2 percent, while it was below 1 percent in Lahore and Rawalpindi. Lack of knowledge, unsafe practices, and high mobility are the likely drivers of this phenomenon.

High levels of interaction between IDUs and CSWs and 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. More than 20 percent of FSWs in Karachi and Lahore have sold sex to IDUs, according to the Ministry of Health. The ministry also found that one-third of IDUs in Lahore have purchased sex from a woman (11 percent of them used condoms consistently), and almost one-quarter have paid for sex with a man (5 percent of them used condoms consistently). A 2006 survey cited by UNAIDS found that less than 20 percent of FSWs and only 5 percent of male sex workers in Karachi and Rawalpindi had used condoms in the preceding month.

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 that persons belonging to this group are highly vulnerable to infection because they are often placed in situations where they cannot negotiate condom use, are forced to endure multiple sex partners, and are 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 level 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.

Pakistan has a high tuberculosis (TB) burden, with 82 new cases per 100,000 people in 2005, according to the World Health Organization. HIV infects only 0.6 percent of adults with TB. However, increased rates of HIV-TB co-infection would complicate treatment and care for both diseases.

National Response

Pakistan's Ministry of Health established the NACP in 1988. Initially focused on developing laboratory services, the program 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 informational materials; organizes workshops and other educational events; develops guidance for improving counseling, care and support, clinical management, surveillance, and blood safety; and oversees research to measure intervention effectiveness. The NACP also drafted a national AIDS policy and an HIV/AIDS law that recommend 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. For example, in 2003 the government implemented the Enhanced NACP, a five-year program targeting populations most at risk. Pakistan's Medium Term Development Framework, 2005–2010, includes among its goals the halving of HIV/AIDS prevalence in most-at-risk populations (MARPs) and pregnant women. The new National Strategic Framework, 2007–2011, broadens the scope of HIV/AIDS control efforts in the country to include women, children, and young adults and stresses the provision of a support group for the spouses and children of key populations, particularly IDUs. It expands upon the National Strategic Framework 2002–2006 and includes the previous plan's nine goals:

- Ensuring an effective, well-coordinated, and sustainable multisectoral HIV/AIDS response;
- Decreasing infection rates among MARPs;
- Reducing youth vulnerability to HIV/AIDS;
- Expanding the knowledge base to improve planning, implementation and evaluation of interventions;
- Lowering the prevalence and preventing the transmission of STIs;
- Increasing the general public's awareness of HIV/AIDS;
- Enhancing blood and blood product safety;
- Preventing HIV transmission in health care settings; and
- Improving quality life of HIV-infected and -affected people through better care and support programs.

However, service coverage of key populations (IDUs, FSWs, MSM, and prison inmates) in Pakistan is still very low – well below the minimum needed to contain the epidemic.

In 2004, NACP received a second-round grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria to enhance the health impact of public and private health services among populations vulnerable to HIV/AIDS, tuberculosis, and malaria infection. The U.S. Government provides one-third of the Global Fund's contributions.

USAID Support

Through the U.S. Agency for International Development (USAID), Pakistan in fiscal year 2007 received $1.5 million for essential HIV/AIDS programs and services. USAID programs in Pakistan are implemented in partnership with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The Emergency Plan is the largest commitment ever by any nation for an international health initiative dedicated to a single disease – a five-year, $15 billion, multifaceted approach to combating the disease in more than 114 countries around the world. To date, the U.S. has committed $18.8 billion to the fight against the global HIV/AIDS pandemic, exceeding its original commitment of $15 billion over five years.

USAID returned to Pakistan July 2002. Its initial activities included support of health sector reform in Pakistan to improve service coverage, responsiveness, quality and efficiency. In February 2006, USAID implemented 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 two years, PHAPCP worked in the cities of Rawalpindi, Lahore, Multan, Karachi, Larkana, Turbat, and Peshawar, thus bringing HIV/AIDS interventions to all four provinces. In all seven cities, PHAPCP funded local nongovernmental organizations (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 better treatment and 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 via local NGOs.

In 2007, the PHAPCP opened confidential HIV/AIDS testing facilitates in Karachi, Lahore, Rawalpindi, Multan, and Peshawar. In Turbat, PHAPCP is also providing medical and emotional support for those infected and affected by HIV/AIDS.

Important Links and Contacts

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USAID HIV/AIDS Web site for Pakistan: *http://www.usaid.gov/our_work/global_health/aids/Countries/ane/pakistan.html*

For more information, see *http://www.usaid.gov/our_work/global_health/aids*

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