

Pakistan

Country Review September 2011

PAKISTAN AT A GLANCE

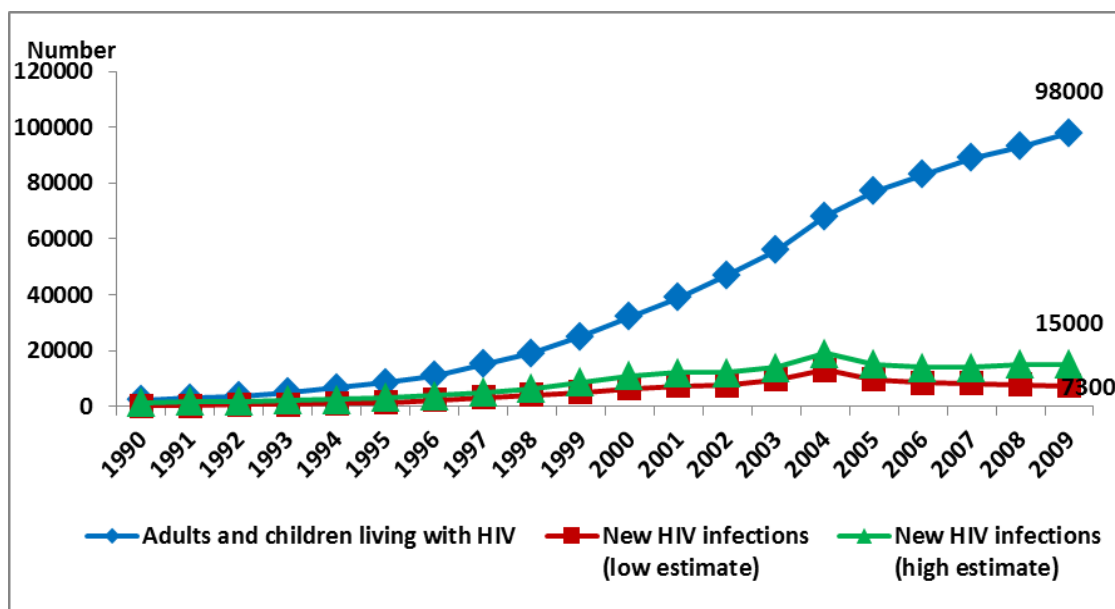
Total population (thousands)	173,591(2010) ¹
Annual population growth rate	2.1% (2005-2010) ¹
Population aged 15-49 (thousands)	90,329 (2010) ²
Percentage of population in urban areas	36% (2007) ³
Crude birth rate (births per 1,000 population)	27 (2007) ⁴
Under-5 mortality rate (per 1,000 live births)	97 (2006) ⁵
Human development index (HDI) – Rank/Value	136/0.551 (2005) ⁶
Life expectancy at birth (years)	63 (2006) ⁶
Adult literacy rate	50% (2006) ⁶
Ratio of girls to boys in primary and secondary education (%)	82 (2009) ⁴
GDP per capita (PPP, \$US)	2,370 (2005) ⁶
Per capita total health expenditure (Int.\$)	49 (2005) ⁵



HIV EPIDEMIOLOGY AND TRENDS

The first case of AIDS in a Pakistan citizen was reported in 1987 in Lahore. During the late 1980s and 1990s, it became evident that an increasing number of Pakistanis, mostly men, were becoming infected with HIV while living or travelling abroad^{7, 8}. In 2009, the estimated the number of people living with HIV in Pakistan stood at 98,000 [79,000-120,000] (Fig. 1), of which 28,000 [23,000-35,000] were women⁹. These are substantially higher numbers from 2001 when an estimated 38,000 [32,000-48,000] adults and children were living with HIV. On a more positive note, overall prevalence remained at less than 0.1% of the population in 2009¹⁰.

Figure 1: Estimated number of people living with HIV, low and high estimates of new HIV infections, 1990-2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

Surveillance systems¹⁰

- Three rounds of Integrated Biological and Behavioural Surveys (IBBS) carried out across the country, Round III completed in 2008 and a special round for FSWs in 2009
- Monitoring and evaluation of the national program by implementation units at the provincial and national level
- Special studies and research with a particular focus on injecting drug practices
- Financial monitoring of national response
- AIDS case reporting system
- Demographic Health Surveys (DHS), most recent carried out in 2007

WHO IS AT RISK OF HIV IN PAKISTAN?

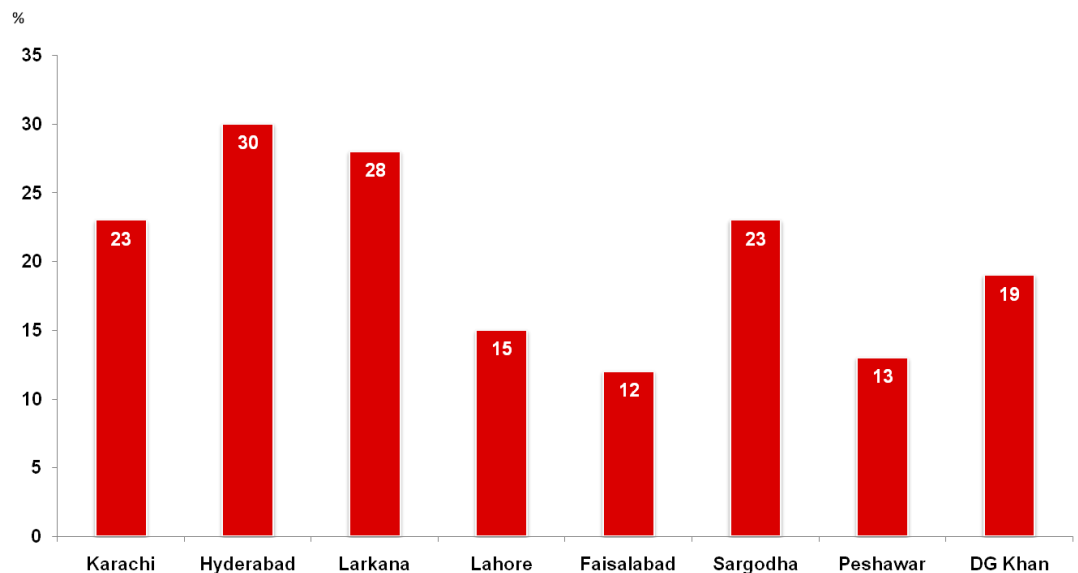
Recent surveillance results indicate that the epidemic is present and consistently increasing among key affected populations. In particular, Pakistan is facing a concentrated epidemic among injecting drug users (IDUs) and Hijra sex workers (HSWs), both of which have prevalence above 5%¹⁰.

Injecting Drug Users

Mapping exercises in 2007 found that IDUs are the second largest key affected population in Pakistan, with an overall estimate of 31,555 from 12 major cities at 7,728 mapped locations¹¹. Extrapolation using estimation models estimate a total of 91,000 IDUs nationwide¹⁰. According to the 2008 IBBS, HIV prevalence among IDUs was 20.8% (averaged over eight major cities)¹². This represents an increase from 15.8% in 2007¹¹ and 10.8% in 2005¹³. Prevalence among IDUs in 2008 was found to be as high as 30% and 27% in Hyderabad and Larkana, respectively (Fig. 2)¹².

A 2009 assessment of HIV prevalence among IDUs was carried out in the four cities (n=1,206)¹⁴. Overall, HIV prevalence was 26%. HIV prevalence was 52% in Mandi Bahauddin, 23% in Rawalpindi, 21% in Sheikhpura and 8% in Gujranwala.

Figure 2: HIV prevalence among IDUs in selected cities, 2008



Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/AIDS Surveillance Project, IBBS round III, 2008, cited in UNGASS Country Progress Report, 2010

Table 1 shows selected characteristics of IDUs in 2008 – in particular, the mean age at first injecting drug use, the average number of years of injecting and the average number of injections per day across survey sites.

Table 1: Selected characteristics of injecting drug use, 2008

	Mean age at first injecting drug use	Average years of injecting drug use	Average number of injections per day
Dera Ghazi Khan	28	3	2
Peshawar	27	2	2
Lahore	29	6	3
Sargodha	28	4	3
Faisalabad	29	5	3
Larkana	29	5	2
Hyderabad	31	7	1
Karachi	27	5	1
Total	29	5	2

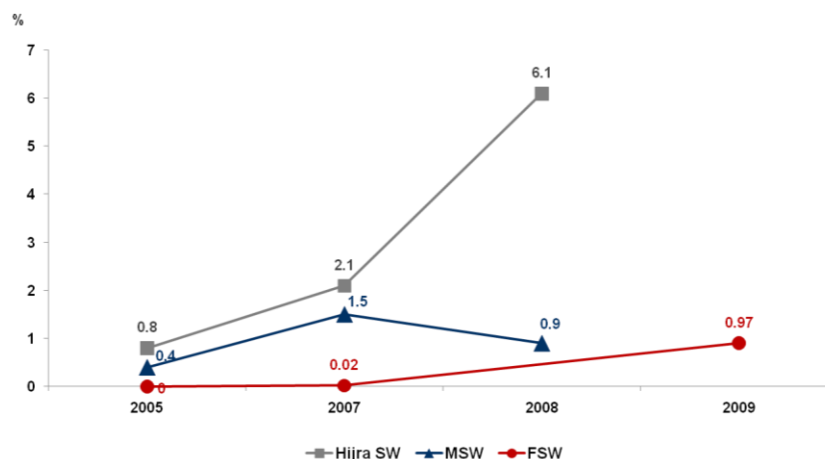
Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/AIDS Surveillance Project, HIV Second Generation Surveillance in Pakistan, IBBS round III, 2008

Female sex workers, male sex workers and hijra sex workers

The 2007 mapping exercises found that FSWs are the largest key affected population, with an overall estimate of 49,037 from the 12 major cities and mapped locations¹¹. In addition, 19,320 MSWs and 14,725 HSWs were mapped¹¹. Extrapolation using estimation models for national level provided estimates of 136,000 FSWs, 63,000 MSWs and 43,000 HSWs¹⁰.

Rounds 1 and 2 of the IBBS found HIV prevalence to be very low among FSWs, 0% and 0.02%, respectively^{11: 13}. As a result, FSWs were dropped as a population sampled in Round 3 of the IBBS. In 2009, a special IBBS round was conducted among FSWs, which found that HIV prevalence was 0.97%¹⁵ (Fig. 3). In 2008, HIV prevalence was 0.9% among MSWs and 6.1% among HSWs (Fig. 3)¹². The 2008 IBBS combined MSWs with HSWs as one surveillance group. Among them, HIV prevalence was found to be 3.1% among those younger than 25 years of age as compared to 4% among those aged 25 and above¹².

Figure 3: Trends of HIV prevalence among sex worker populations, 2005 – 2009



Source: Prepared by www.aidsdatahub.org based on HIV/AIDS Surveillance Project, IBBS round I, II, III and special round for FSW, NACP, MOH, Pakistan, 2005 – 2009

Table 2 shows HIV prevalence among FSWs, MSWs and HSWs in surveyed cities in 2008. Notably, prevalence was as high as 2% and 3.1% among FSWs and MSWs, respectively, in Karachi and reached 27.6% among HSWs in Larkana.

Table 2: HIV prevalence (%) among female sex workers, male sex workers and hijra sex workers in selected cities, 2008 and 2009

	FSWs (2009)	MSWs (2008)	HSWs (2008)
Karachi	2	3.1	3.6
Lahore	1.0	1	2.5
Hyderabad	0	0	0
Larkana	0.6	0.5	27.6
Peshawar	-	0	1.2
Faisalabad	0.8	0	2.5
Sargodha	1.2	-	-

Sources: Prepared by www.aidsdatahub.org based on HIV/ AIDS Surveillance Project, IBBS round I, II, III and special round for FSW, NACP, MOH, Pakistan, 2005 - 2009

The average number of clients per day was 4 for FSWs in 2009, and 2 and 3 for MSWs and HSWs, respectively in 2008¹⁶. The mean age of initiation into sex work was young among both MSWs and HSWs, at 16 years of age. Furthermore, MSWs spent a mean of 6 years in sex work, half that spent by HSWs (12 years)¹².

Men who have sex with men

There is little documentation about the extent to which men engage in sexual activity with other men in Pakistan, largely due to socio-cultural barriers. The 2008 UNGASS report documented HIV prevalence as 1.95% among MSM⁸. As a result, much of the data presented below relates to men who have sex with men only to the extent that male sex workers are a surveillance group.

Vulnerable populations: Urban men, migrants and spouses of key affected populations

In 2007, the National AIDS Control Program – with funding from DFID – commissioned a study of urban men to measure reproductive tract infections, STI prevalence and sexual behaviours in key affected populations, as well as in men comprising the intermediate-risk group, and in women representing the low-risk groups¹⁷. The study was carried out in 6 “major urban” cities: Karachi, Lahore, Quetta, Peshawar, Rawalpindi and Faisalabad. Nearly all of the respondents (2,396 out of 2,400) agreed to provide blood samples, of which 4% tested positive for one of the five STIs. Results showed the following prevalence rates: syphilis – 1.3%; HIV – 0.1%; HSV-2 – 3.4%; gonorrhoea – 0.8 %; and chlamydia – 0%. The individual collective prevalence of all infections by all five organisms was 4%, with the highest prevalence in Karachi (9%) followed by Lahore (5%), Faisalabad (4%) Quetta (4%), Rawalpindi (3%) and Peshawar (2%).

Another vulnerable group in Pakistan worth mentioning are migrants (i.e. returnees and deportees) as a substantial number of HIV/AIDS cases reported to the health services across provinces have been and continue to be among returning migrant workers as well as among their spouses and children. A compelling example is the 88 HIV positive cases (n=246 from the general population) detected in a rural locality in Gujrat district of the Punjab province in mid-2008; the subsequent outbreak investigation found the sample population to include a large number of ex-migrant workers¹⁰.

A recent study which highlights the vulnerability of the wives of IDUs found that up to 15% of the wives of HIV positive IDUs were already infected. Eighty percent reported not having used a condom in their last sexual act with their husbands and approximately half had never heard of HIV or AIDS¹⁸.

Truck drivers

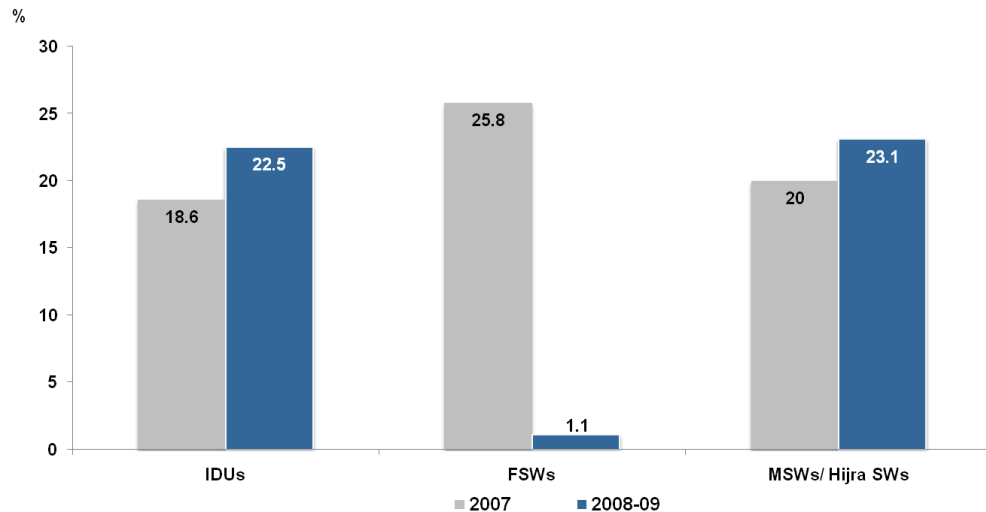
There are estimated 200,000 truckers nationwide¹⁹. Truck drivers are thought to be at an increased risk of acquiring and transmitting HIV from unprotected sex with sex workers or casual partners during their prolonged absences from home²⁰. In 2005, a national study of reproductive tract & sexually transmitted infections among key populations found that HIV prevalence was 1% of surveyed truck drivers in Lahore and 0% among those in Karachi²¹. Thirty percent of truck drivers in Karachi reported visiting FSWs in the last month. This figure was 22% among truck drivers in Lahore, among whom 30% reported having had STI symptoms in the last year.

VULNERABILITY, KNOWLEDGE & RISK BEHAVIOURS

Knowledge about HIV

Generally a low level of HIV knowledge was observed in each of the key affected populations. In 2008, only 22.5% of IDUs and 23.1% of MSWs/HSWs had comprehensive knowledge of HIV – that is, were able to both correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions¹². This figure was significantly lower among FSWs – at 1.1% in 2009¹⁵. While these figures among IDUs and MSWs/HSWs represent a slight increase from the 2007 IBBS, a significant decrease is noted among FSWs (Fig. 4). This can be attributed to the fact that, in the 2009 IBBS round for FSWs, all five questions establishing comprehensive knowledge were asked whereas in the previous IBBS round only 4 questions were asked. ‘Can having sex with only one faithful uninfected partner reduce HIV transmission risk?’ was asked in 2009, and yielded a low number of correct responses¹⁶.

Figure 4: Percentage of key affected populations with comprehensive HIV knowledge, 2007 vs 2008-09



Sources: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/AIDS Surveillance Project, IBBS round II, III and special round for FSW, cited in UNGASS Country Progress Report, 2010

In terms of specific knowledge about HIV prevention among IDUs, 44% knew that a condom can prevent HIV transmission in 2008 (ranging from 16% in Dera Ghazi Khan to 69% in Karachi)¹². Meanwhile, 79% knew that using clean needles/syringes can prevent HIV transmission (ranging from 43% in Dera Ghazi Khan to 95% in Faisalabad)¹². In a 2009 rapid assessment of IDUs in the four cities, only 29% of all respondents had heard of HIV¹⁴. Among the 29%, less than half (45%) knew how HIV is transmitted. Specifically, only 15% knew that HIV can be transmitted through sharing of contaminated and used syringes.

MSWs and HSWs showed variable knowledge about condom use as a means of prevention against HIV transmission across survey sites. Overall, 62% of MSWs had this knowledge in 2008 (ranging from only 33% in Peshawar to 82% in Larkana) together with 66% of HSWs (ranging from 15% in Hyderabad to 95% in Larkana)¹².

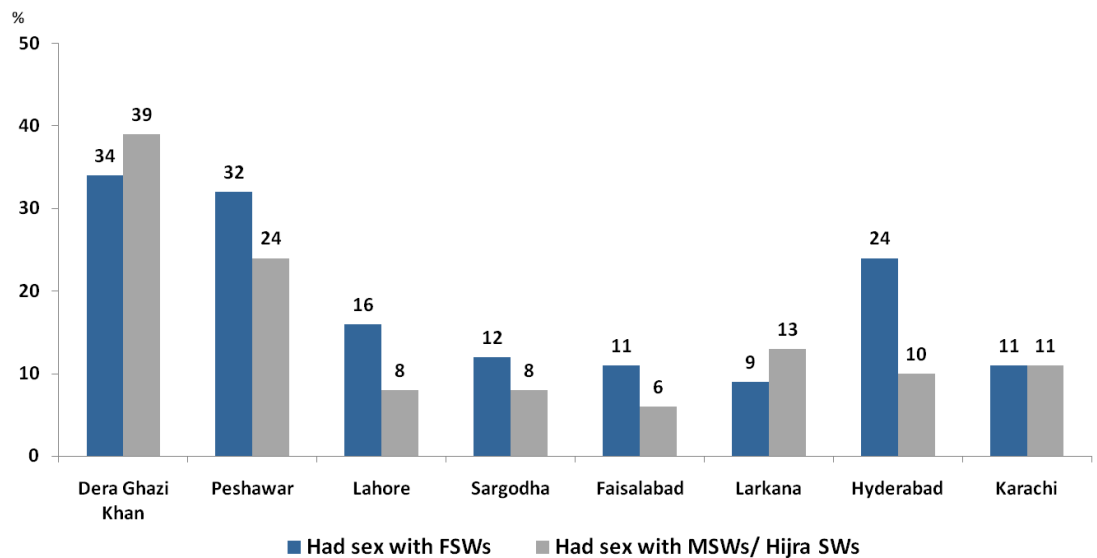
According to the 2007 study of urban men mentioned earlier, almost 90% of the 2,400 respondents in all six cities had heard of the term 'HIV/AIDS'. Misconceptions about how HIV is spread exist; a high proportion of the respondents mentioned that HIV infection could be spread through the sharing of food (25%), clothing (24%), bedding (25%), and toilets (24%) with an infected person. Sixteen percent mentioned that shaking hands with an infected person could lead to transmission¹⁷.

Earlier findings from a 2005 knowledge, attitude and practices study among young people aged 13-19 in the general population (n=3,087) found low levels of knowledge about HIV transmission²². In particular, only 16% and 14% of females in Peshawar and Karachi, respectively, knew that HIV can be transmitted through sexual contact. Among males, this figure was 21% in Peshawar and 19% in Karachi.

Condom use

Among IDUs surveyed in the 2008 IBBS, 39% were sexually active with a regular female partner in the last six months, and only 34% used a condom during their last sexual contact¹². Figure 5 shows the percentage of IDUs having had sex with various types of sex workers in the last six months with a range across survey sites. Notably, commercial sex was highest in Dera Ghazi Khan, where 34% of IDUs reported having had sex with a FSW and 39% had sex with a MSW/HSW in the last six months¹². And yet condom use at last sex with sex worker was low among IDUs – at 31% with a FSW in 2008 (up from 21% in 2006-2007 and 17% in 2005) and 14% with a MSW/HSW (compared to 13% in both previous rounds)¹².

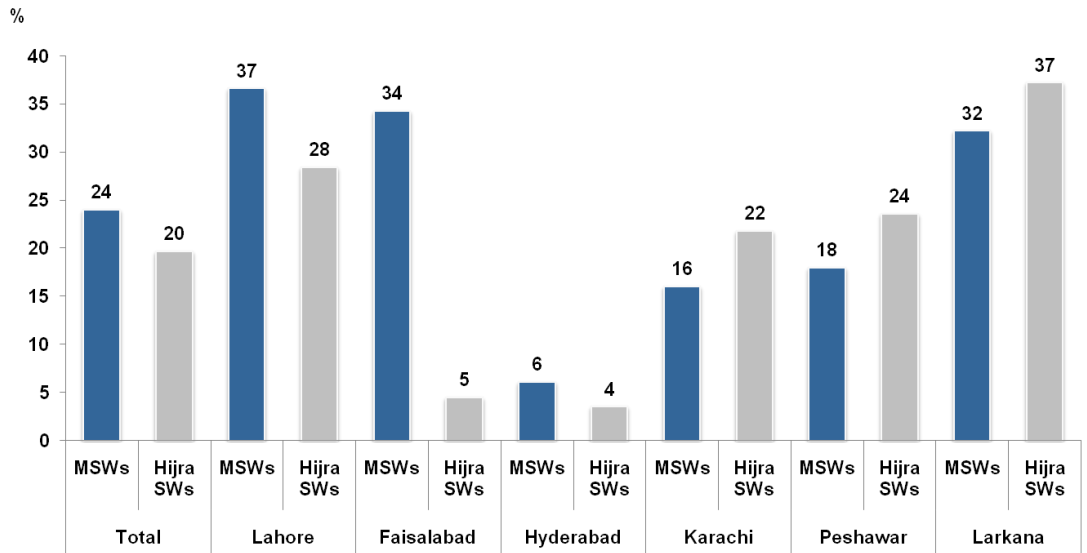
Figure 5: Percentage of IDUs having had sex with SWs in last six months by city, 2008



Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/AIDS Surveillance Project, HIV Second Generation Surveillance in Pakistan, IBBS round III, 2008

In the 2009 IBBS, approximately half of the FSWs under the age of 25 reported using a condom with their last client, while 40% of those above 25 reported the same¹⁵. Condom use by MSWs and HSWs with their most recent client increased from 22% in 2006/7 to 33% in 2008¹⁰. MSWs and HSWs reporting always using a condom with their clients in the last month was widely variable across survey sites in 2008 (Fig. 6). Notably, only 4% and 5% of HSWs in Hyderabad and Faisalabad, respectively, reported such consistent condom usage¹².

Figure 6: Percentage of male sex workers and hijra sex workers who reported always using a condom with their clients in the last month by city, 2008



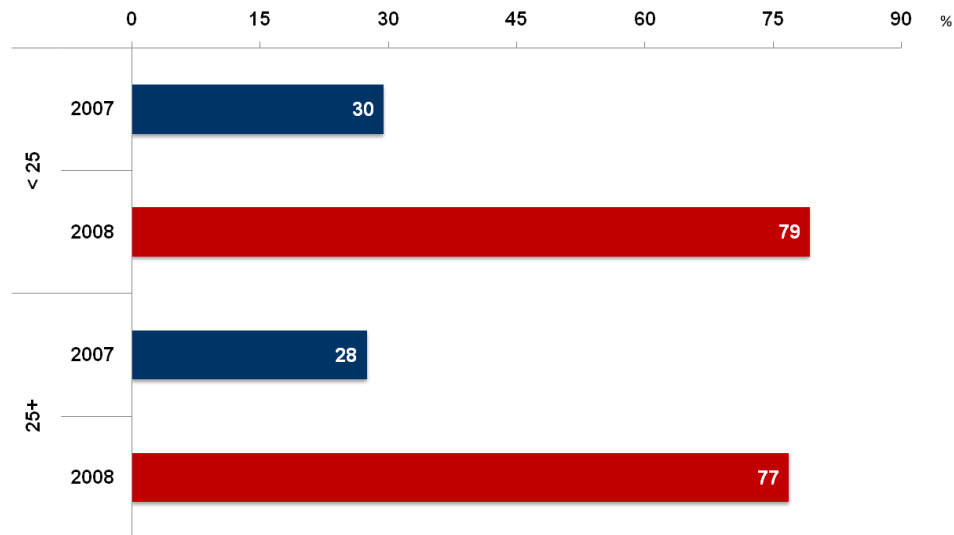
Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/AIDS Surveillance Project, HIV Second Generation Surveillance in Pakistan, IBBS round III, 2008

As mentioned above, truck drivers are a group at risk of HIV infection in Pakistan. In 2005, it was found that 32.3% and 21.5% of truck drivers in Karachi and Lahore, respectively, who reported having had sex with a FSW in the last year – only 1.7% in Karachi and 7% in Lahore reported using a condom the last time they had sex with a FSW²¹.

Sharing of injecting equipment

Overall in 2008, 77% of IDUs reported using sterile injecting equipment the last time they injected¹². While the percentage of IDUs who reported using sterile injecting equipment the last time they injected increased markedly from 2007 to 2008 (Fig. 7), unsafe injecting drug use is widely practiced by IDUs. In 2008, 48% of IDUs always used a new syringe for injecting in the last month (ranging from as low as 21% in Larkana to 74% in Faisalabad¹²). Moreover, many IDUs report either passing a used syringe onto some else (18%), or using a syringe that was passed to them by someone else (23%) and 61% reported being injected by a 'professional injector/street doctor' within the past one month¹².

Figure 7: Percentage of IDUs who reported using sterile injecting equipment at the last time they injected by age group, 2007 vs 2008



Sources: Prepared by www.aidsdatahub.org based on Pakistan, UNAIDS, UNGASS Country Report, 2008; Pakistan, IBBS, National Report Round III, 2008, cited in UNGASS Country Progress Report, 2010

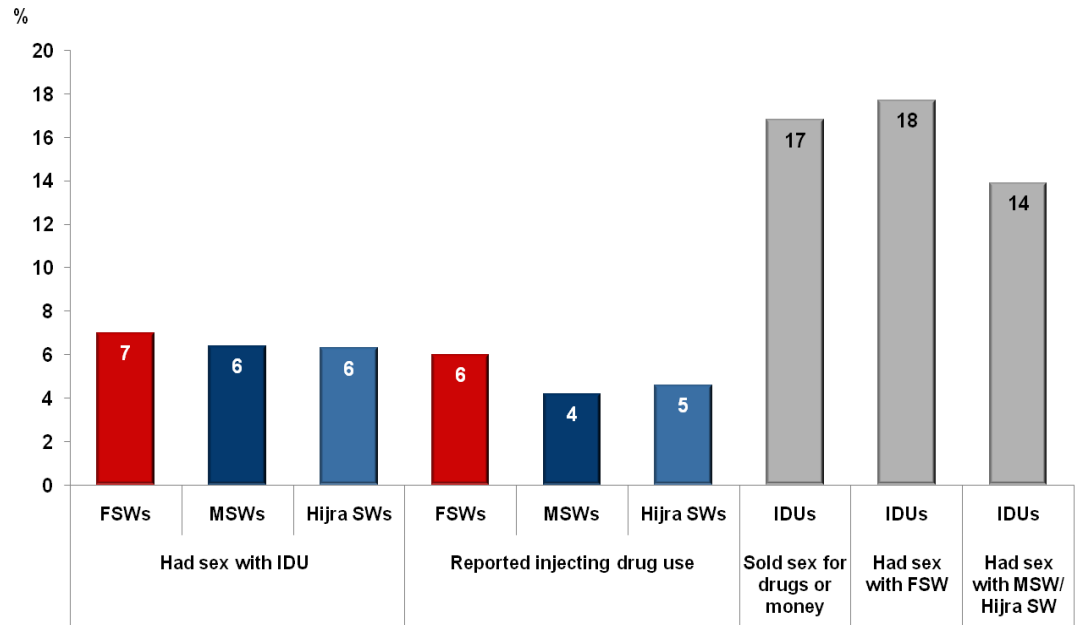
In a 2009 rapid assessment of IDUs in the four cities of Mandi Bahauddin, Rawalpindi, Gujranwala and Sheikhupura, 70% shared used syringes¹⁴. The percentage who never shared used syringes was 31% in Mandi Bahauddin, 30% in Rawalpindi, 47% in Gujranwala and 21% in Sheikhupura. In cities where HIV prevention services and Needle Syringe Exchange Programs were in place, sharing was much lower and over 88% reported having used a new syringe in their last injection.

Overlapping risk behaviours

Key affected populations in Pakistan have overlapping risk behaviours: sexual networking occurs among sex workers and IDUs, while sex workers also inject drugs and IDUs also sell sex. Figure 8 shows these interactions between IDUs, FSWs, HSWs and MSWs reported in IBBS Rounds 2 and 3.

The cities of Lahore and Larkana show especially high levels of networking among key affected populations. Overall, 6% of FSWs reported injecting drug use in the past six months in 2009, while 4% of MSWs and 5% of HSWs reported injecting drug use in the past six months in 2008¹⁶. This figure was as high as 7% and 8% among MSWs in Lahore and Larkana, respectively and 24% among HSWs in Larkana¹². Seven percent of FSWs reported having sex with an IDU in the past six months in 2009, while 6% of both MSWs and HSWs reported the same in 2008¹⁶. This figure was as high as 13% among MSWs in Lahore and 22% among HSWs in Larkana¹².

Figure 8: Percentage of key affected populations with overlapping risk behaviours in past six months, 2008-2009



Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/AIDS Surveillance Project, HIV Second Generation Surveillance in Pakistan, IBBS round III, 2008 and special round for FSW, 2009, cited in UNGASS Country Progress Report, 2010

SOCIO-ECONOMIC IMPACTS OF THE HIV EPIDEMIC

A study in early 2007 showed a low impact of the HIV epidemic on demographic indicators in Pakistan. Accordingly, in the absence of a comprehensive antiretroviral therapy (ART) program, life expectancy is projected to decline by 0.2% by 2015. Also in 2015, the crude death rate is expected to increase by 0.1% due to AIDS²³.

NATIONAL RESPONSE

Law and policy related issues

Pakistan has a number of criminal laws that make key affected populations hard to identify, monitor and reach with HIV prevention programmes. The Penal Code, Section 377, criminalizes male-to-male sex as “carnal intercourse against the order of nature” with the punishment of imprisonment with the possibility of fines²⁴. Sharia law also carries heavy penalties for homosexuality – of imprisonment for 2-10 years or for life, or of 100 lashes or stoning to death (depending on whether the person is married or not)²⁵. Sex work is also illegal²⁶ and Section 9 of the Control of Narcotics Substances Act 1997 allow for the death penalty for drug offences²⁷.

In 2009, the Supreme Court of Pakistan ruled that hijras are entitled to complete citizenship rights under the Constitution¹⁰. This recognition allows hijras to now access the services of state social welfare departments and financial support programs¹⁰.

The *HIV/AIDS Safety and Control Bill 2009* has been accepted by Parliament for review¹⁰. Key principles of legislation include public awareness on HIV prevention among the general population as well as equitable access to prevention, treatment, care and support services by PLHIV and key affected populations without stigma or discrimination.

Governance

The national response to the HIV epidemic in Pakistan is characterized by three major phases according to the UNGASS 2010 report - the early phase of the Government response (1987-2003), and the second phase of the response (2003-2007), and the most recent (2007-2012)¹⁰. Each phase is briefly described as follows:

Early phase of the Government Response (1987 – 2003)

- Established the National AIDS Control Program (NACP) in 1988;
- The Federal Committee on AIDS (FCA) defined broad policy guidelines for AIDS control in Pakistan;
- The AIDS prevention and control program started in August 1987 and developed further in mid-1990s;
- Incorporated HIV/STI as a priority issues in national policy documents: National Policy for Development and Empowerment of Women, the Population Policy of Pakistan, Reproductive Health Services Package (1999); the National Health Policy (2001); Poverty Reduction Strategy Papers (2003);
- First National Strategic Framework for HIV & AIDS (2002-2006) outlined broad strategies and priorities for effective control of the epidemic, with increased focus on working with vulnerable populations;
- Based on the Framework, developed an Enhanced HIV & AIDS Control Program with a focus on provision of HIV preventive services and information to high risk groups;
- Established surveillance and diagnosis centre;
- Implemented laboratory-based AIDS prevention activities.

Second phase of the Government Response (2003-2007)

- New Enhanced Program for HIV & AIDS prevention and control (2003 – 2008) renewed focus on mapping core high-risk groups, expanding interventions among the general population, reducing HIV and STI transmission through improved blood safety, and capacity development and program management;
- Developed five centres of excellence to provide treatment of opportunistic infections and hospitalized care;
- Formulated the National Plan of Action (2003-2008), Medium Term Development Framework (2005-2010), National AIDS Policy (2005);
- Formulated ordinances on safe blood transfusion services for ensuring blood safety.

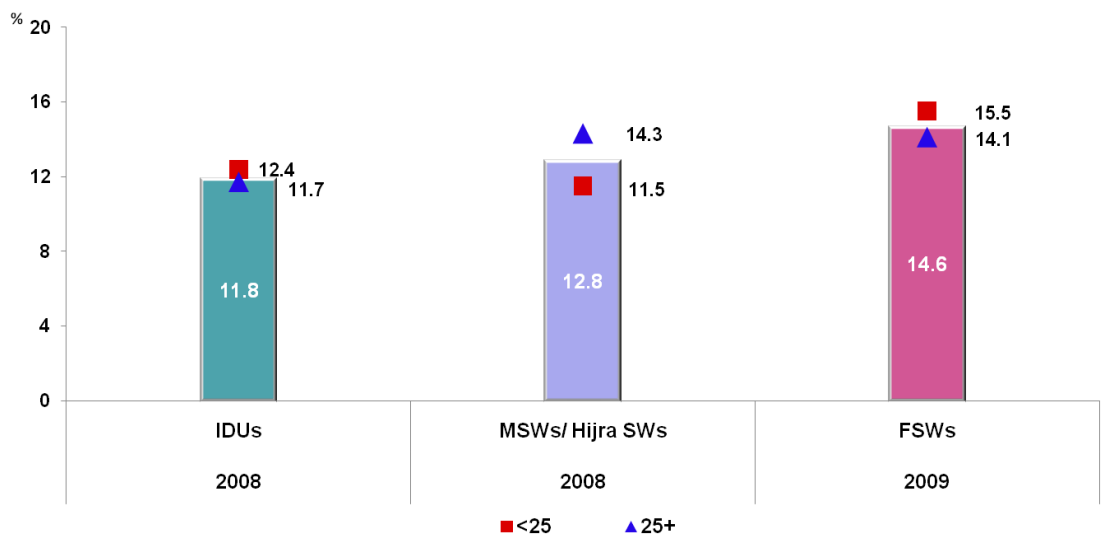
Third phase of the Government Response (2007-2012)

- Developed the Second National Strategic Framework (2008-2012) with core strategies as follows: creating an enabling environment; strengthening the institutional framework; building up the right capacity; and scaling up program delivery;
- Inclusion of HIV/AIDS as a priority area in the National Health Policy 2009 with IDUs, MSWs, FSWs and HSWs mentioned as the key affected populations.

Prevention Programmes

In 2009, 13 facilities were reported to be providing HIV testing and counselling²⁸. Figure 9 shows the percentage distributions of key affected populations who were tested for HIV in the past 12 months and who knew their results in 2008-2009. Levels of HIV testing increased since previous reports, but remain very low for all groups (less than 16%). Overall, 14.6% of FSWs were tested and knew their results in 2009 – up from 4.9% reported in 2007¹⁰. In 2008, 12.8% of MSWs/HSWs received testing and knew their results (up from 6.8% in 2007) together with 11.8% of IDUs (up from 8.7% in 2007)¹⁶. In 2007, it was also reported that only 3.5% of MSWs younger than 25 years of age were tested and knew their results, compared to 5.5% of their older counterparts⁸. A 2007-2008 cross sectional study of sex workers and IDUs in Peshawar and Abbotabad (n=153) found that only 27% had ever heard about voluntary counselling and testing²⁹.

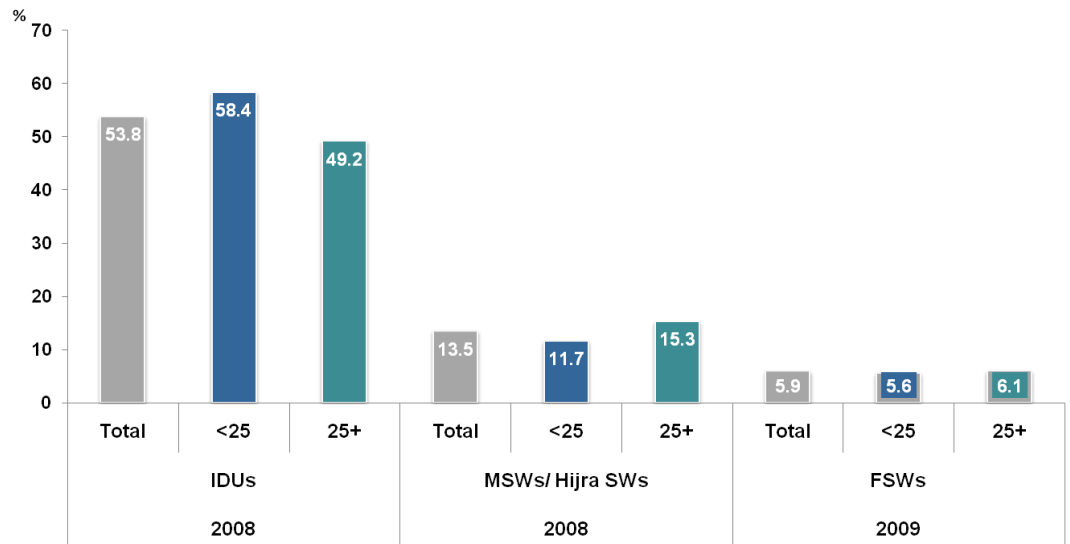
Figure 9: Percentage of key affected populations who received HIV testing in the last 12 months and knew the results by age group, 2008-2009



Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/ AIDS Surveillance Project, IBBS round III, 2008 and special round for FSW, 2009, cited in UNGASS Country Progress Report, 2010

Among key affected populations in 2008-2009, IDUs have by far the highest coverage of prevention services (nearly 54%), followed by MSWs/HSWs (13.5%) and FSWs (5.9%) (Fig. 10)¹⁶. This data indicates improved programme reach since previous IBBS rounds: from 15.5% among IDUs, 5.4% among MSWs/HSWs and 1.7% among FSWs in 2007⁸. However, survey questions have changed over time. Most recently, IDUs, MSWs and HSWs were asked if they had ever contacted any program in the area whereas previous Rounds asked if they had ever contacted a government-run program. Similarly, the 2009 IBBS among FSWs asked if they had contacted a programme in the last 12 months, as opposed to the previous question as to whether they had ever contacted a programme¹⁰.

Figure 10: Percentage of key affected populations reached with HIV prevention programmes by age group, 2008-2009

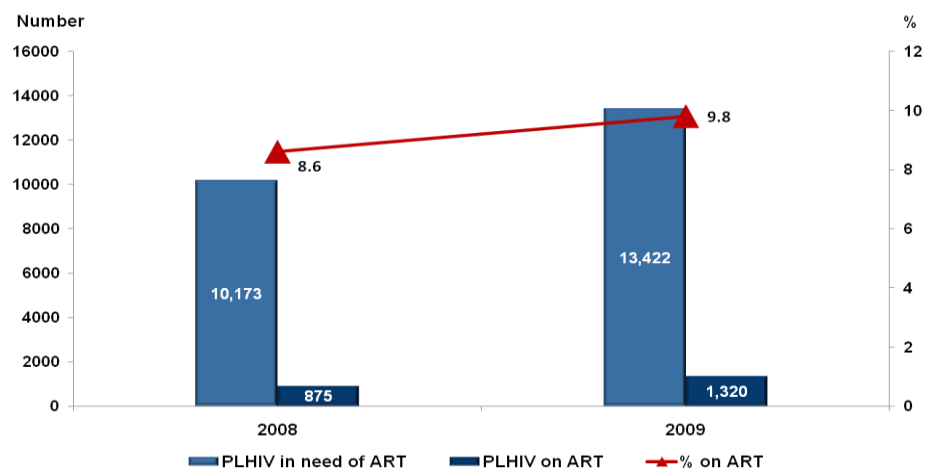


Source: Prepared by www.aidsdatahub.org based on Pakistan, NACP, MOH, HIV/ AIDS Surveillance Project, IBBS round III, 2008 and special round for FSW, 2009, cited in UNGASS Country Progress Report, 2010

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

The percentage of adults and children with advanced HIV receiving ART remains low, but has risen from 7.4% in 2007 to 8.6% in 2008 and to 9.8% in 2009. This 2009 figure represents 1,320 people living with HIV receiving ART versus the 13,422 people needing ART (Fig. 11)³⁰.

Figure 11: Status of ART coverage among PLHIV, 2008 vs 2009



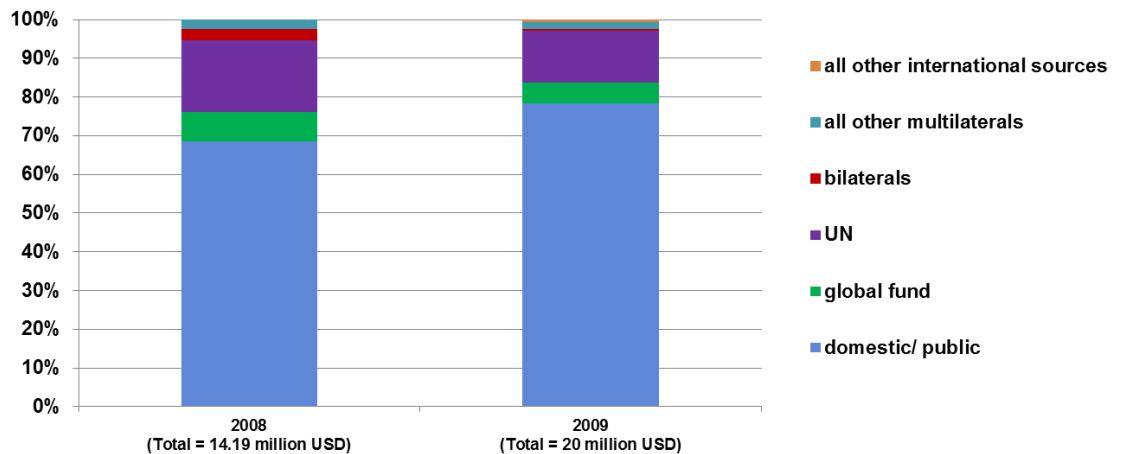
Source: Prepared by www.aidsdatahub.org based on Pakistan, UNGASS Country Progress Reports 2008 and 2010

In 2009, less than 1% of pregnant women were tested for HIV¹⁰. Only 0.4% of HIV infected pregnant women received ARVs to reduce the risk of mother-child transmission (up from 0.2% in 2008) while 1% of infants born to HIV infected women received any antiretroviral prophylaxis for prevention of mother-to-child transmission^{10,28}. Corresponding to this low coverage of antenatal care, model estimates (i.e. EPP and Spectrum) project that 28.9% of infants born to HIV-infected mothers were themselves infected as of 2009¹⁰.

ECONOMICS OF AIDS

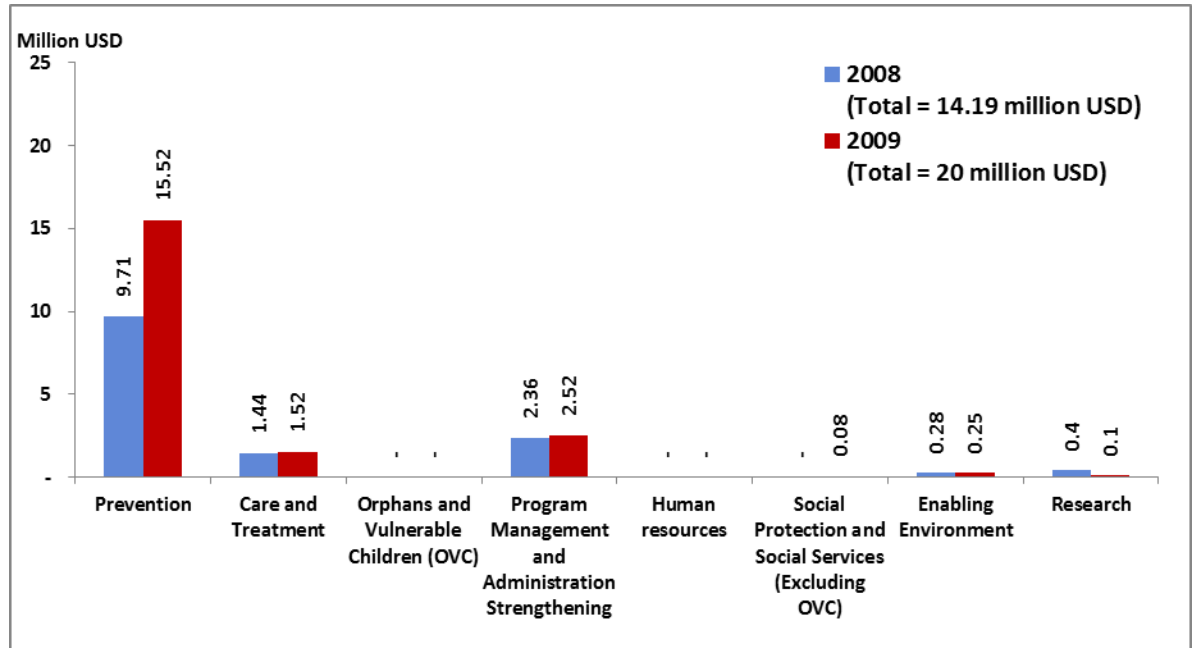
During 2009, expenditures on HIV and AIDS totalled US\$ 20 million, increasing from US\$ 14.2 million in 2008⁹. The amount of national funds spent by governments from domestic sources was US\$ 15.7 million (78.4% of the total share, figure 12a)⁹. Figure 12b shows the amount of AIDS spending by category, with prevention-related activities having been allocated the largest share (78%), followed by programme management (13%) and care and treatment (8%)⁹. Of the US\$ 15.5 million dollars spent on prevention in 2009, 39% was allocated towards harm reduction programmes for IDUs, 5% went towards prevention programmes for MSM and 9% to prevention programmes for sex workers and their clients⁹.

Figure 12a: % distribution of total HIV expenditures by financing source, 2008 - 2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

Figure 12b: Amount of total HIV expenditures by major spending category, 2008-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

References

- ¹UN Statistics Division. (2010). Demographic and Social Statistics. Retrieved 10 January 2011 from <http://unstats.un.org/unsd/demographic/products/socind/population.htm>
- ²UN Population Division. (2011). World Population Prospects, the 2010 Revision. Retrieved 10 January 2011 from <http://esa.un.org/unpd/wpp/Excel-Data/population.htm>
- ³UNFPA. (2010). *State of World Population 2010*.
- ⁴World Bank. World Development Indicators & Global Development Finance. Retrieved 10 January 2011 from <http://databank.worldbank.org/ddp/home.do?Step=12&id=4&CNO=2>
- ⁵WHO. (2010). *World Health Statistics 2010*.
- ⁶UNDP. (2010). *Human Development Report 2010*. Retrieved 10 January 2011 from <http://hdr.undp.org/en/reports/global/hdr2010/chapters/en/>
- ⁷Khawaja, Z. A., Gibney, L., Ahmed, A. J., & Vermund, S. H. (1997). HIV/AIDS and Its Risk Factors in Pakistan. *AIDS*, 11, 843-848.
- ⁸National AIDS Control Program. (2007). *UNGASS Country Progress Report: Pakistan*. Islamabad: Ministry of Health.
- ⁹UNAIDS. (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic*.
- ¹⁰National AIDS Control Program. (2010). *UNGASS Country Progress Report: Pakistan*. Islamabad: Ministry of Health.

- ¹¹National AIDS Control Program and Canada-Pakistan HIV/AIDS Surveillance Project. (2007). *HIV Second Generation Surveillance in Pakistan: National Report- Round II*
- ¹²National AIDS Control Program Pakistan, Canada-Pakistan HIV/AIDS Surveillance Project, & Canadian International Development Agency. (2008). *HIV Second Generation Surveillance in Pakistan: National Report Round III*
- ¹³National AIDS Control Program, Canada-Pakistan HIV/AIDS Surveillance Project, & Canadian International Development Agency. (2005). *HIV Second Surveillance in Pakistan - National Report Round 1.*
- ¹⁴Nai Zindagi. (2009). *Rapid Situation Assessments of HIV Prevalence and Risk Factors among People Injecting Drugs in Four Cities of the Punjab.*
- ¹⁵UN. (2002). *Statement on HIV/AIDS in Pakistan*
- ¹⁶WHO. (2003). *Update on WHO in DPR Korea.*
- ¹⁷Mir, A. M., Reichenbach, L., Wajid, A., & Khan, M. (2008). *Study of Sexually Transmitted Infections among Urban Men in Pakistan: Identifying the Bridging Population:* National AIDS Control Programme, Population Council and DFID.
- ¹⁸Nai Zindagi. (2008). *The Hidden Truth: A Study of HIV Vulnerability, Risk Factors and Prevalence among Men Injecting Drugs and their Wives:* Punjab AIDS Control Program and UNAIDS.
- ¹⁹UNICEF. (2006). *Maldives: UNICEF HIV and AIDS Programming Country Profile 2006.*
- ²⁰Khan, A. A., & Khan, A. (2010). *The HIV Epidemic in Pakistan.*
- ²¹National AIDS Control Program, FHI, & DFID. (2005). *National Study of Reproductive Tract and Sexually Transmitted Infections: Survey of High Risk Group in Lahore and Karachi, 2005.*
- ²²National AIDS Control Program. (2005). *Report on Knowledge, Attitude and Practices Study Conducted in Peshawar and Karachi.*
- ²³McLeod R. (2007). *The Economic Costs of Inaction – Curbing the Asian HIV/AIDS Epidemic, Draft Version:* Asian Development Bank and UNAIDS.
- ²⁴As cited by International Lesbian and Gay Association (ILGA), *State-sponsored Homophobia: A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults.* ILGA, April 2007.
- ²⁵UNESCO. (2010). *Education Sector Response to HIV, Drugs and Sexuality in Indonesia*
- ²⁶Global Network of People Living with HIV, International Harm Reduction Association, ilga, IPPF, et al. (2010). *Making The Law Work for The HIV Response: A Snapshot of Selected Laws that Support or Block Universal Access to HIV prevention, Treatment, Care and Support.*
- ²⁷Patrick, G., & Lines, R. (2010). *The Death Penalty for Drug Offences Global Overview:* International Harm Reduction Association.
- ²⁸WHO, UNAIDS, & UNICEF. (2010). *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector.*
- ²⁹Afridi, N. K., Khan, S., & Fatima, S. (2010). Factors affecting accessibility and acceptability of Voluntary Counselling and Testing among High Risk Group (HRG) for Human Immunodeficiency Virus (HIV) in NWFP Pakistan. *Journal Pakistan Medical Association*, 60(4), 265-269.
- ³⁰National AIDS Control Program. *UNGASS Country Progress Reports 2008 and 2010: Pakistan.* Islamabad: Ministry of Health.