



PAKISTAN

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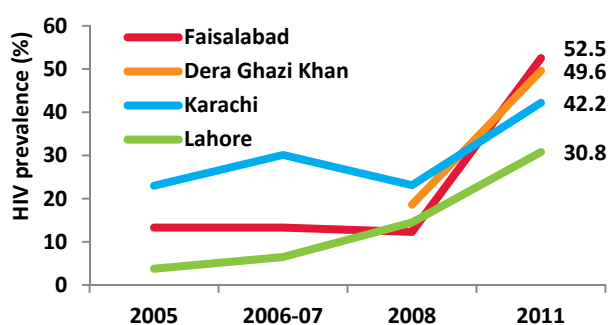
Fast facts 2012		Trend
People living with HIV ¹	87 000 [50 000-160 000]	↑
Women living with HIV ¹	24 000 [14 000-44 000]	↑
Young women living with HIV ¹	5 200	↑
Young men living with HIV ¹	6 900	↑
New HIV infections ¹	19 000 [8 700-39 000]	↑
People receiving ART (2013) ²	3 281 (3 211 adults, 70 children)	↑
AIDS deaths ¹	3 500 [2 100 - 6 600]	↑

1) UNAIDS Report on the Global AIDS Epidemic 2013; 2) ART Treatment Centres

The epidemic

- Although the overall adult HIV prevalence in Pakistan remains low at <0.1% (<0.1-0.2), there has been a substantial expansion of the HIV epidemic in recent years. Between 2001 and 2012, Pakistan has seen an eight-fold increase in new HIV infections with an estimated 87 000 people living with HIV and 3 500 AIDS-related deaths in 2012 (UNAIDS Report on the Global AIDS Epidemic 2013).
- Pakistan has followed the epidemic pattern typically seen elsewhere in Asia, i.e., shifting from low HIV prevalence to high prevalence concentrated among certain key populations at higher risk. The first indigenous HIV case was detected in 1987, more cases started being reported in the 1990s (mostly among returning work migrants and their families), and then suddenly in 2003 high levels of HIV were detected among people who inject drugs in Karachi (23%) and Larkana (9.7%) in Sindh.
- Rising epidemics among people who inject drugs (PWID) have continued unabated, with estimated national HIV prevalence at 27.2% in 2011, an increase from 11% in 2005. Recent Integrated Biological and Behavioral Surveillance (IBBS) indicates high levels of HIV among PWID in several key cities: 52.5% in Faisalabad, 49.6% in Dera Ghazi Khan, 46.2% in Gujrat, 42.2% in Karachi and 31% in Lahore (IBBS 2011).

Figure 1: Rapidly expanding HIV epidemic among PWID in cities, 2005-2011



Source: National Study of Reproductive Tract and Sexually Transmitted Infections, Lahore and Karachi, 2005, and HIV Second Generation Surveillance in Pakistan - National Report Rounds I to IV, National AIDS Control Program, Pakistan.

- Notably, the HIV prevalence among young PWID (34%) is higher than among older cohorts of PWID (25%) aged more than 25 years (IBBS 2011).
- High HIV prevalence levels are also detected among hijra sex workers (HSW) in Larkana (15%) and Karachi (12%) – much higher than the estimated national prevalence of 5.2% in 2011 - and among male sex workers (MSW) in Karachi (6%) (IBBS 2011). HIV among men who have sex with men who are not sex workers has not been measured.
- HIV prevalence remains low (<1%) among female sex workers (FSW) through the four rounds of IBBS conducted between 2005 and 2011.



Risk behaviours

- All key populations reported low levels of condom use at last sex: 23% among PWID, 32% among male and hijra sex workers, and 41% among female sex workers. Young key populations used condoms even less than their older counterparts (IBBS 2011).
- Safe injecting practices are still low among PWID; only 28% of surveyed PWID in Lahore reported consistent use of sterile injecting equipment during the past month (IBBS 2011).
- Overlapping risk behaviours among key populations and risks of onward transmission to their intimate partners are also causes for concern. For instance, 15% of PWID sold sex in the last six months; 17% of FSW in Multan, 9% of HSW in Larkana and 7% of MSW in Quetta injected drugs in last six months; and 40% MSW reported they had paid for sex with females in the past month and 16% of them were married (IBBS 2011).
- The recent Demographic and Health Survey (2012-2013) found that 27% of ever-married women had experienced domestic physical violence by their male intimate partners in the past 12 months.

Governance

- The National AIDS Control Programme (NACP) was established in 1986-87 and the programme was brought under the multi-donor financed Social Action Programme in 1994.
- As part of the implementation of the 18th Amendment to the Constitution of Pakistan, the Ministry of Health was fully devolved to provincial levels by June 2011. NACP was initially placed under the Ministry of Inter-Provincial Coordination and then moved under the Ministry of National Health Services Regulation and Coordination. The programme is now implemented through federal and provincial implementation units.
- The National Strategic Framework-II (NSF-II) completed its five year timeframe in December 2011. *Provincial AIDS Strategies 2012-16* with costed action plans are now in place in all four provinces of Pakistan.

Response

- Less than 10% of female, male and hijra sex workers were reached with HIV prevention programmes in 2011; coverage is also low among people who inject drugs with less than 100 needles and syringes distributed per PWID per year in 2012. (IBBS 2011 and UNAIDS Report on the Global AIDS Epidemic 2013)
- Less than 30% of key populations know their HIV status. HIV testing coverage is particularly low among FSW at 16%, followed by PWID and male and hijra sex workers at 25% and 28%, respectively (IBBS 2011).
- HIV treatment, care and support facilities are available through 18 treatment centres, 5 pediatric AIDS centres, 11 Prevention of Parent-To-Child Transmission (PPTCT) sites, and 16 Voluntary Confidential Counselling and Testing (VCCT) centres. The majority of treatment, care and support facilities are confined to key cities (www.nacp.gov.pk).
- Under grants made available through the Global Fund Round 9, 11 Community Home Based Care (CHBC) sites have been established.
- By the end of 2013, 3 281 people (3 211 adults and 70 children) were on antiretroviral treatment (ART), a three-fold increase from 2009. However, the pace of ART initiation has slowed down - only 33 eligible PLHIV per month in 2012-2013 were started on treatment, whereas it was 40-45 eligible PLHIV per month in 2011. (ART Treatment Centres)
- The number of HIV-positive pregnant women who received ART in Pakistan has increased more than two times since 2012 and 126 HIV-positive pregnant women were provided maternal triple ARV prophylaxis (option B) in 2013. (Country programme data reported in online GARPR 2014)



- A national mid-term review of Pakistan's progress towards meeting the 10 targets and elimination commitments endorsed through the UN 2011 Political Declaration was conducted in 2013 with participation of national, United Nations, and civil society partners. Though some targets were assessed to be on track, targets for reducing sexual transmission, eliminating new HIV infections among children, access to ART, closing the resource gap, eliminating gender inequalities, and eliminating stigma and discrimination are not on track.
- In March 2014, a consultation on the draft *HIV Bill* was held with participation of various stakeholders and the draft *HIV Bill* is to be presented to the National Assembly Standing Committee. The proposed bill aims to halt the spread of HIV among key and vulnerable populations, to protect against discrimination, and to provide care, support, and treatment of people living with HIV. (www.nacp.gov.pk)

AIDS response financing

- Only 2.5% of GDP is spent on annual health expenditures, of which a low 0.05% is allocated for HIV responses.
- The overall investment on HIV is still low—an estimated total of US\$ 13 million in 2010, of which 37% of expenditure on HIV and AIDS was financed by the Government of Pakistan (GARPR 2013).
- An estimated US\$ 5.6 million was spent on prevention. Pakistan has the distinction in the region of spending the highest proportion on HIV prevention programmes for key populations (83%). Furthermore, over half of the key populations' prevention spending was domestically financed, which is 5 times higher than the regional average of 11%. (www.aidsinfoonline.org)

Stigma and legal barriers

- The Stigma Index Report in 2009-10 showed that 33% of surveyed people living with HIV were denied health services due to their HIV status.
- Analysis of National Commitments and Policy Instrument (2012) found there are punitive laws relating to sex work, drug-related activities, and same-sex sexual activities between consenting adult males.

Challenges

- Political leadership at national level: The Ministry of Health Services and Coordination at national level is quite new and needs to develop systems for a more effective role in the area of coordination among provinces and provision of normative guidance to the provinces, which are now more independent. While devolution brought increased decentralization of policies, finances, planning and implementation to the provinces, it has yet to bring together multiple government stakeholders to address the HIV response beyond a planning level.
- Transformation: There are funding, systemic and governance barriers to be overcome for the massive increase in coverage, continuity and effectiveness of HIV service provision to be undertaken in 2014-15. At present it is difficult to even measure progress as there has not been any surveillance conducted since 2011. There is a need for a massive scale-up in HIV testing of key populations so that more people become aware of their status and nobody is left behind.
- Social change: Institutionalizing partnership between emerging community groups, civil society and public sector is necessary to effectively deliver appropriate Harm Reduction services (including OST), VCT, PMTCT, ART, and Continuum of Care. Several factors are hindering an enabling environment for the response and need to be addressed. In a socially conservative culture with an epidemic concentrated among marginalized and criminalised populations, a rights-based approach is critical so that those most in need are able to access services without barriers due to stigma and discrimination.