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Research Briefing

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HIV in Pakistan

Preventing a future epidemic in most-at-risk groups

KEY POINTS

- Current HIV prevalence is generally low but STI levels are high in some at-risk groups.
- Violence, abuse and discrimination are commonly experienced by sex workers and injecting drug users, and can increase the likelihood of infection.
- A future HIV epidemic is likely to be concentrated in those with highest levels of STIs and the highest levels of abuse – transgender sex workers.
- Five key interventions are recommended to stem the transmission of HIV/STIs in Pakistan.
- Interventions targeted at transgender sex workers will have little support among society, and will be difficult for the government and public sector to implement, but they could be implemented successfully by NGOs, with donor funding and support.
- For interventions to be successful and sustainable, the underlying vulnerabilities and environment faced by all of the most-at-risk groups must be addressed. Interventions must recognize, protect and promote the human rights of all individuals.

Non-therapeutic drug use, prostitution and homosexuality are illegal in Pakistan and carry severe penalties. Yet Pakistan has one of the highest rates of injecting drug-use in the world, and commercial sex work (by women, men and transgenders) is widespread. Very low levels of HIV/AIDS awareness and condom use, together with high-risk sexual behaviours in these vulnerable groups, make it a potentially high-risk country for HIV spread. Indeed there are signs that this may have begun, with high levels of HIV found among injecting drug users in Karachi in 2007.

National survey on HIV and STIs

The National AIDS Control Programme (NACP) commissioned a study to investigate the extent of STI and HIV epidemics among populations at risk through selling sex or through injecting drugs. The study also looked at associated behaviours including risk taking and protection from risk in these groups.

Surveys were conducted in 2007 in Rawalpindi in Punjab and Abbottabad in North West Frontier Province. They focused on female sex workers (FSW; 533 in total), male and transgender sex workers (MTSW; 917 in total), and injecting drug users (IDUs; 404 in total). MTSW were divided into three groups:

- ***khusra*** (transgender, biological males who dress mostly as women; some having gender re-assignment through hormones or surgery);
- ***khotki*** (biological males who dress publicly as men but have a 'female soul' and feminised traits); and
- ***bantha*** (biological males with a male identity).

Prevalence of infections

MTSW were more likely to have infections than the FSW. No cases of HIV were found in Abbottabad, and only a few MTSW in Rawalpindi were HIV positive. Over half of khusra, 14% of khotki, and less than 10% of all other groups had herpes. Current syphilis infections

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were mainly found among the khusra. Almost half in Rawalpindi had active syphilis, and 22.5% (57/253) in the same city had rectal gonorrhoea or Chlamydia.

Khusra who reported using condoms at last anal sex, and khusra who had correct knowledge about HIV risk reduction, had lower levels of infection – evidence that risks can be reduced among these sex worker groups.

In Rawalpindi, 2.6% of IDUs were HIV positive, with no cases in Abbottabad. Prevalence of acute STIs was similar in both cities, at 7.6%. Lifetime infections were significantly higher in Rawalpindi (13.6%) than in Abbottabad (5.9%).

Although condom use among FSW was higher than among MTSW, women reported the lowest levels of condom use with their clients – i.e. husbands and regular non-paying partners were more likely to use a condom.

Violence and abuse

Violence was commonly experienced by all groups. Key perpetrators included partners, clients, neighbours and the police. Sexual and physical abuse by police among bantha and khotki, and client violence among khusra, increased the odds of infection.

All sex worker groups were exploited by police, who played on their fear of exposure or raids to negotiate bribes of money or free sex. IDUs were the most powerless group, with no wealth, little autonomy and therefore little possibility of placating the police. They often had to surrender drugs or equipment to the police or pay a bribe.

More than a quarter of khusra had been raped by police in the last year.

All groups felt that their rights to function as part of a family and to respect in society were widely violated.

Barriers to care

Fear of ill-treatment and exposure constituted a major barrier to accessing health care for all groups – although experiences of rudeness, humiliation or abuse were reported by only a minority of individuals, mainly at public sector facilities. Private providers were said to generally treat individuals better than in the public sector, because the service was paid for. Traditional healers or friends were the preferred source of care.

IDUs, with little disposable income, rarely sought private care except when family or friends helped them access private detox centres. Twenty percent of IDUs had used detox services, where they faced considerable abuse, and sometimes outright brutality and humiliation (beatings, head/eyebrow shaving, being chained up).

Few FSW or MTSW had ever had an HIV test, although between a quarter and two-fifths of these groups had sought care from allopathic providers in the last year.

Social and sexual networks

Social networks were important across all groups. FSW were afforded some level of protection by living with their families. For khusra, some protection was usually found within the dairas or other social networks.

Sexual and social interactions between groups means human rights abuses experienced by one high-risk group can increase HIV-risk both for them and for other groups.

All groups were linked by sexual and social networks. Clients were shared between male and female sex workers. IDUs pimped for sex workers as well as using them. Only small numbers of sex workers had ever injected drugs, but IDUs were relatively common as clients, partners or husbands.

The policy context

AIDS is perceived by a range of stakeholders as occupying an exaggerated position on the country's development and health agendas – a position perceived as externally imposed. Pakistan is a low-income country. Health outcomes in general are relatively poor; gender inequality is entrenched; violence and unrest are commonplace – all factors which may facilitate the spread of HIV.

HIV legislation (the prevention and treatment act) was drafted in 2006, but has been held up in the Ministry of Law. A National HIV and AIDS Policy was finalized in 2007 but has yet to be approved by the Ministry of Health. A key aim of the draft policy is to 'provide and maintain an enabling environment for HIV and AIDS prevention and care programs and services'. A National HIV and AIDS Strategic Framework 2007-2012 has also been drafted.

Non-governmental organisations (NGOs) play a key role in health care provision to sex workers and drug users, but there are few strong civil society advocacy organisations involved in HIV issues.

Projections of HIV evolution in male and transgender sex workers

HIV and STI (Chlamydia trachomatis and Herpes simplex virus 2) infection transmission in the three intermixing populations of MTSW (bantha, khotki and khusra) and their clients was simulated using a mathematical model. Plausible scenarios for the evolution of HIV and STI prevalence were investigated in the absence and presence of simulated condom- and treatment-based interventions.

Despite current low HIV prevalence, the model found potential for substantial increase in prevalence over time in these populations. Model projections suggest a peak prevalence of 30–50% in khusra, the most at-risk group. Prompt interventions potentially can rapidly interrupt rising prevalence levels. Targeted interventions which comprise both STI treatment and condom use are most likely to prove effective.

Implications for policy

While current HIV levels are low, the mathematical modelling clearly indicates the need to act to avert a much larger epidemic in future, particularly among groups most at risk. Encouragingly, there is evidence, among khotki and khusra, that risk reduction strategies (such as condom promotion and awareness raising) are effective at preventing infection.

Successful interventions have been implemented in the south Asian region (e.g. Calcutta in India), with programmes addressing not only the immediate risk environments, but also the wider context. This success has been realised partly through utilising existing social and professional networks to increase knowledge, promote empowerment and enable those at risk to insist on safer sex.

Based on the study findings, we recommend five priority interventions.

1) Needle and syringe exchange programmes for injecting drug users

These programmes are technically and administratively simple, address a widely acknowledged problem and face no strong opposition. Programmes are delivered through contracted NGOs. Successful harm reduction interventions are already provided in some cities by NGOs, but scaling up will present challenges.

Ministries other than the MOH will need to be engaged with, and ideally local ex-user champions can be found to act as advocates. NGO staff will need to develop trust with law-enforcement agencies and local community leaders.

2) Comprehensive sexual health care for male and transgender sex workers

Although the mathematical model suggests that male, and particularly transgender, sex workers will play a central role in the future of the HIV epidemic in Pakistan, informants believed that provision of effective interventions for them - e.g. distribution of condoms and lubricants, treatment of STIs, voluntary testing and counselling for HIV - will be far from straightforward.

MTSW are highly stigmatized. Allocation of government funding to services for them will likely face strong opposition. Donor support will therefore be required.

Interventions for MTSW are likely to have least resonance with society of the five interventions we propose, will be difficult to explain to the public, and will likely face opposition from powerful groups and individuals. MTSW are not organised politically to demand recognition or services. As yet, no prominent champion has emerged to raise awareness.

While the above MTSW interventions are technically simple, delivering them and ensuring their uptake will be complex. Few men and transgenders selling sex currently seek care in the public sector due to stigma. It may therefore be more effective to use public (or donor) funds to ensure they receive high quality and effective care at their currently preferred sources.

3) Sexual and reproductive health care for female sex workers

This intervention will require significant levels of increased government funding, but it does address a relatively widely acknowledged problem and is based on strong evidence. However, it will not resonate widely with society. Opposition to the delivery of services at public sector facilities is anticipated from frontline staff, but this could be overcome with monetary incentives.

The draft HIV policy promotes the integration of HIV services into existing programmes, in part to avoid 'unnecessary and unsustainable HIV-specific services', but it does not refer explicitly to FSW.

4) Targeted behaviour change communication for most-at-risk groups

This intervention is highly evidence-based, easy to explain, and supported by powerful and committed stakeholders (including one or more donors according to our informants). The draft national policy aspires to ensure that 'All persons will be provided with access to the information and support they need to protect themselves against HIV infection'.

Use of explicit information is problematic due to prevailing social norms, but opposition will be mitigated by targeting at specific at-risk groups out of mainstream view. The intervention is complicated in terms of the number of organisations and administrative layers involved, and there are concerns that NGOs may lack capacity to deliver it at sufficiently high quality.

5) Addressing stigma and discrimination, and protecting human rights

Addressing the human rights abuses and stigma suffered by these groups will require quite major changes for the national AIDS response, but will require few additional resources. The issues involved are quite widely acknowledged and informants felt this intervention would resonate more with social values than the others.

The draft HIV policy recognises the potential increased risk that uniformed personnel face, and proposes that this is addressed through targeted programmes. Success will likely depend upon getting them to understand their own personal risk, as opposed to protecting and promoting the rights of vulnerable populations.

Implementation

The feasibility of implementation of four of the interventions is improved by their being delivered by contracted NGOs. This obviates potential problems in mobilising public sector providers to meet the needs of these communities and creates domestic interest groups to demand the financing of these interventions. This approach raises questions around sustainability, works against integration, perpetuates the treatment of MTSW, FSW and IDU as 'other', and is possibly stigmatising, but it may also forge increasing solidarity and lead to a political identity, as it has elsewhere.

Recommendations

For the Government

1) While Pakistan has signed the International Covenant on Civil and Political Rights (ICCPR) and the Convention Against Torture (CAT), it has not ratified them. This should be done.

2) While the International Covenant on Economic, Social and Cultural Rights (ICESCR) has been ratified, enshrining the right to health, during a Universal Periodic Review (of progress on human rights) in May 2008, Pakistan publicly stated that there would be exceptions to its commitments – including the decriminalisation of non-marital consensual sex and adultery. This works against the recognition and protection of human rights in the vulnerable groups highlighted here.

3) In setting the age of consent for HIV testing at 18 years, the draft national HIV policy excludes some of the most vulnerable of the at-risk population, who report age at first sex around 13-14 years on average. Further, the policy makes no explicit mention of homosexuality or male and transgendered sex workers.

4) It is important that the government both understands and acts to:

   a) support interventions to improve access to and quality of services for the most-at-risk groups,

   b) address cultural and social stigma, essential for promoting dignity and autonomy, and

   c) openly acknowledge the role of police in increasing HIV-risk and work with them to reduce this risk.

For Donors

1) Donor support for scaled-up delivery of the priority interventions will be required. We recognize that this can be a double-edged sword as external leadership can undermine national ownership, domestic accountability and sustainability. Nonetheless, addressing the HIV epidemic is of global concern, and if local leadership is not forthcoming, it is not clear what the alternatives are.

2) The development of constituencies among the highly stigmatised groups needs to be supported, in order to build their capacity to demand government accountability for delivery of the interventions. Well-connected champions can prove invaluable here, such as the leadership of Nai Zindagi (a local NGO) in rolling out interventions for IDUs.

3) Despite a lack of outright opposition to the interventions and a good evidence-base at the disposal of government, support for the reforms is rather fragile. Advocacy coalitions need to be formed and supported, over the longer term, to deepen and widen demand and support for the interventions.

- An HIV and further STI epidemic in Pakistan is not inevitable. The proposed interventions are known to be effective in reducing HIV/STI risks and improving sexual health.
- The protection of human rights needs to be an integral part of a multi-sector response to HIV/AIDS. Only by working at both legal and programme levels to protect the rights of, and minimise discrimination against, groups vulnerable to HIV can the Government of Pakistan effectively reduce the potential for HIV spread before the epidemic takes hold.

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For further information, please contact Dr Sarah Hawkes at sarah.hawkes@lshtm.ac.uk or see the Programme's website: http://www.lshtm.ac.uk/dfid/aids/Pakistan.htm. This research is presented in more detail in an April 2009 supplement of *Sexually Transmitted Infections* (volume 85, Suppl. 2).