Local and Global response to HIV/AIDS in Pakistan An initial assessment ‘IDUs’

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In African, Middle Eastern, and Asian Muslim societies, as in many other places affected by HIV, the disease first became common among IDUs, [male] homosexuals, [male and female] prostitutes and their clientele before spreading into the wider community.¹

Abstract:

The government of Pakistan has been fighting HIV/AIDS in the country since the establishment of the National AIDS Control Program in 1987. International organizations, such as the Them Group (UNAIDS, WHO, UNICEF, ILO, UNDP, UNDCP, UNESCO, World Bank and UNFPA) have since become involved in the response to the deadly virus. Despite the efforts undertaken by national and international organisations, the latest reports on HIV/AIDS published by UNAIDS are nevertheless very discouraging. Recent figures show that not only do 78.1% of intravenous drug users (IDUs) still reuse syringes, but also, in certain urban areas of Pakistan, HIV infection among IDUs has reached 51% in a span of less than three years. The current needle exchange programmes for IDUs are outdated and need to be revised. This paper applies Global Governance’s theoretical framework in order to examine the collective response of international institutions and NACP of Pakistan to the spread of HIV/AIDS in the country. The paper will study the challenges HIV/AIDS poses, the results achieved and the problems that still persist. The analysis will proceed by examining the official documents of UNAIDS, NACP, WHO, and the World Bank. It will also critically investigate current limited awareness, care, support, treatment and prevention programs applied by NACP, UNAIDS, UNODC, USAID, WHO and World Bank.

Introduction

As compared to its neighbours India and China, Pakistan did not generally suffer from locally acquired cases of HIV for nearly twenty years; however that changed in 2004 when the country experienced its first full-blown HIV outbreak in the remote town of Larkana in the province of Sindh. The outbreak occurred among the city’s intravenous drug users (IDU) community, which indicated that HIV had become a local phenomenon. This was confirmed by further outbreaks all over the country. This research paper examines the spread of HIV/AIDS among the most affected high risk individuals, who function as a bridge between the group itself and the wider population i.e intravenous drug users (IDUs). In the subsequent pages I intend to explain the primary means of transmission and the factors that facilitate the pandemic in the country, the government of Pakistan’s response and an initial assessment of what has been missing in the national programmes to fight HIV/AIDS in country. In addition, this paper will evaluate the strengths and weaknesses of the intervention programmes coordinated by National Aids Control Programme (NACP) of Pakistan and global governance institutions i.e. UNAIDS, UNODC, USAID, WHO and World Bank. Among all seven high-risk groups i.e. men having sex with men (MSM), male sex workers (MSWs), female sex workers (FSWs), cyclical migrant men, truck drivers, prisoners and IDUs, I will only be focusing on intervention programmes coordinated by global governance institutions for IDUs. The reason for this is because IDUs have an enormous potential to spread HIV/AIDS not only to other high-risk groups but also to the general population of the country. In this paper I argue that the current needle exchange programmes for IDUs is outdated and needs to be revised. There is an urgent need for global governance institutions and the government of Pakistan to revise the current response plan.

Background to the spread of HIV/AIDS in Pakistan

The first case of HIV/AIDS in Pakistan was identified in the city of Lahore in 1987. Subsequently in the late eighties and nineties, it was clear that a growing number of Pakistanis, particularly males, were becoming infected with HIV while travelling out of Pakistan or living in a foreign country. These infected men transmitted the infection to their spouses upon returning to Pakistan who in turn passed it on to their children, in some cases. The first case of HIV transmission through breastfeeding in Pakistan came to light in 1993 in the city of Rawalpindi. Cases of HIV/AIDS were reported among a variety of groups in the nineties; these included FSWs, MSWs, MSM, IDUs, prisoners, truck drivers and male cyclical migrants. To a certain degree, the rise in infection rates among these groups has been seen to reflect a similar trend among the general population. According to reports by the government, the number of people infected with HIV/AIDS reached the figure of 1,699 in September 2000. On the other hand, UNAIDS noted a significant increase in the number of HIV/AIDS sufferers as compared to the report by the Pakistani government. In 2006 UNAIDS re-categorized Pakistan as a country with a concentrated epidemic in high-risk

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groups: the country had 85,000 HIV positive adults between the ages of 15-49. \(^3\) 11,000 more cases of HIV were recorded by the World Bank at the end of 2007, pushing the total number to 96,000.\(^4\)

The actual figures are likely to be significantly higher than official reports have shown, and many observers feel that the numbers of reported cases are actually only the “tip of the iceberg”. The official figures for the total number of HIV-positive people in the country are unconfirmed, therefore the data is unreliable.\(^5\) The reason for the inaccuracy of the data is that in developing countries such as Pakistan low reporting rates are widespread.\(^6\) Under-reporting of HIV/AIDS cases in Pakistan also means that many of cases are not even diagnosed at all.\(^7\) On a national level, only 64 cases of AIDS were reported up to the end of 1996 excluding the 59 reported AIDS cases in Sindh province. The sum of 123 AIDS cases in the general population of Pakistan (which was 140 million in 1996) demonstrates the insufficiency of the data and the government’s lack of commitment to providing accurate data.\(^8\)

Even if accurate data is not available, these numbers are still alarming and point to the spread of an epidemic. Dr Faisal Sultan says, “potentially this is a big problem since other countries notably India, have gone from small to big in a very short time.”\(^9\) “We are very weak in terms of surveillance” said Imran Rizvi from the Pakistani AIDS charity Amal. He adds, “I think we are all aware that our health infrastructure is weak and there are issues regarding HIV/AIDS to deal with including, stigma and discrimination which prevent a lot of people coming forward.”\(^10\)

Pakistan’s poor health sector and limited knowledge of HIV/AIDS among medical staff makes it all the more difficult to implement HIV surveillance programmes. In the port city of Karachi, the knowledge of physicians and other healthcare officers in hospitals is a matter of grave concern. Their understanding of sexually transmitted infections (STI) symptoms and treatment of HIV is severely lacking. Physicians in Karachi lack efficiency in offering HIV therapy and counselling to the patients and some medical professionals have misconceptions and prejudices regarding HIV patients. Practicing physicians, nurses and medical students

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8 In the province of Sindh in 1996 0.27% for HIV and 0.05% for AIDS was estimated. For every recorded case of AIDS, five HIV positive individuals, on average, were recorded. The national presented data in 1996 was 0.064%, AA Hyder, OA Khan, MA Memon, and et al., 'Sub-national Response in HIV/AIDS: A case study in AIDS prevention and control from Sindh province, Pakistan' in *Science Direct*, Vol 113, No.1,1999, pp.39-43, p.41


10 A Paul, BBC News, 'Pakistan has launched a big programme to tackle Aids after denying that the country has a problem', Tuesday 18 November, 2003, at [http://news.bbc.co.uk/2/hi/south_asia/3279190.stm](http://news.bbc.co.uk/2/hi/south_asia/3279190.stm) (accessed 02/03/09)
believe that they have the right to deny treatment to HIV infected homosexual men, sex workers and drug users. Presumably medical staff and students have been educated about HIV however there is a possibility that they have received ‘vague’, inconsistent information and invalid knowledge about HIV.11

Cultural aspects of Pakistani society such as morals and religious beliefs also come into play. Medical staff, and indeed the general population, may believe that vulnerable groups should be left to suffer because they acquired HIV from immoral sexual intercourse. In support of this idea, the author of Knowledge and attitudes of Pakistani medical students towards HIV-positive and/or AIDS patients, Farah D Shaikh, states that religion has an impact on education, prevention programmes and treatment of HIV positive individuals. In Islam sex outside marriage and homosexuality is strictly forbidden and is considered morally wrong. People commonly believe that HIV patients have been punished by God for engaging in homosexuality or extra-marital sex.12

Until the 1990s, a majority of Muslim countries and global governance institutions did nothing to provide awareness to high risk groups in Muslim societies. Perhaps this was because a number of Muslim countries strongly believed that adultery, premarital sex, prostitution, homosexuality and intravenous drug usage were not prevalent in Muslim societies. According to the NACP officer “the reason HIV prevalence was lower in Pakistan than in other countries was largely due to our better social and Islamic values.”13 This notion has not changed in the 21st century. Among Muslims and even some non-Muslim people there is a belief that as compared to other religious groups, Muslims are safe from the danger of HIV/AIDS pandemic. This is not sufficient, like other societies of the world, Muslim societies are and can be vulnerable to the pandemic of HIV/AIDS and this carries the risk of a large number of Muslims getting infected by the virus. Pakistan has an opportunity to learn from the experiences of other Muslim countries. Pakistan faces a choice between either accepting the challenge posed by AIDS and its effects in the future or preferably try to preempt the consequences by taking measures now. Opting for the latter would save lives and also spar Pakistan much distress.14

It is true that Pakistan cannot be compared to its neighbour India with an estimated 5 million HIV infected people15 and China, where almost 200 Chinese become infected every day.16 Nonetheless, whilst if the number of infected Pakistanis is not as great as those countries mentioned, Pakistan does have a very serious potential to suffer from the spread of HIV/AIDS. In 2007, 90 percent of blood donations came from “non-voluntary” donors who are known to be IDUs.17 Blood donors in the country accelerate the transmission of

11 FD Shaikh, SA Khan, MW Ross, and et al., p.8
12 FD Shaikh, SA Khan, MW Ross, and et al., ‘Knowledge and attitudes of Pakistani medical students towards HIV-positive and/or AIDS patients’, in Psychology, Health & Medicine, Vol 12, No.1, pp7-17, at http://pdfserv.informaworld.com/614793_729893566_759327050.pdf, p.8 (accessed 7/04/09)
13 Laura and Eberstadt, P.
15 T Barnett, p.301
HIV/AIDS. Estimates suggest that only 40% of the 1.5 million blood transfusions that take place in Pakistan annually are not screened for HIV. Another factor that helps the virus to spread is the low use of contraception in the country. It comes as no surprise that in 1991 the prevalence of modern contraceptive methods was roughly 9%, a figure which indicates rare use of condoms and other barrier methods of contraception which prevent STI. This figure is one of the lowest in the world and in this regard, Pakistan falls far behind its neighbours. The low use of condoms, blood transfusions, high numbers of homosexual men, IDUs getting infected, lack of knowledge among the medical staff, denial, stigmatisation of HIV “economic insecurity, poverty, lack of empowerment, gender inequalities, lack of information and/or commodities for self-protection, all combine to make Pakistani society more vulnerable to an HIV epidemic.”

HIV/AIDS and IDUs

On a global level, injecting drug use has provided a “kick start” to the spread of HIV/AIDS. In the 1990s IDUs were the largest of the HIV/AIDS positive groups in many western countries. In 1992 scholars such as Don C. Des Jarlais were uncertain about where HIV among IDUs would occur in the future. For him it was not clear what factors would facilitate the rapid spread of HIV in the aforementioned group. Analysing data from Pakistan has provided some answers to his concerns. In 1986 Pakistan had a relatively small percentage of drug addicts in the general population: an estimated 1.9 million. However the situation changed in the mid-1990s, when Pakistan experienced a dramatic growth in the number of drug users. According to Tariq Zafar and Salman ul Hasan, the Pakistan Narcotics Control Division has reported that over three million Pakistanis were drug dependent in the 1990s. The report shows that in 2002, the numbers of Pakistani heroin users dropped to 0.5 million. This might not be accurate as Pakistan tends to underestimate the number of drug users and HIV positive people in the country. In 2007 and 2008 a rise in injecting drugs was noted; Arshad Altaf et al, states that in 2007 there were 5 million drug users, 180,000 of whom were injecting drugs, and a high percentage of these IDUs were identified as HIV positive. Although varying data exists on the number of drug users and IDUs, it is believed that by 2002, 1 million Pakistanis

18 (IRIN), ‘Pakistan: Unsafe blood transfusions pose HIV, hepatitis risk’


23 Don C. DES Jarlais,’ p. 347

24 Don C. DES Jarlais,’ p. 348


27 A Arshad , AS Sharaf, NA Zandi, and et at., ‘p.2

28 A Rajabali, S Khan, HJ Warraich, and et at.,’ p.512
were injecting drugs.\textsuperscript{29} IDUs in Pakistan are a major impediment to the prevention of HIV/AIDS.\textsuperscript{30}

A number of surveys carried out in Pakistan in the 1980s and 1990s have suggested that on average the number of drug users increases by 12\% each year.\textsuperscript{31} A study conducted in two different areas of Karachi in 2002 indicated that 80-100\% of addicts were using heroin via injections. Out of a total of 930 IDUs tested between January 2004 and 30\textsuperscript{th} April 2004, 65 IDUs tested HIV positive.\textsuperscript{32} Across the country, a disturbing trend is being seen that shows higher incidences of HIV infection among IDUs. According to the report published by NACP, the occurrence of HIV/AIDS among IDUs increased from 0.4\% in December 2003 to 7.6\% in 2004. The situation was even more severe in the town of Larkana where 27\% of IDUs were shown to be infected with HIV/AIDS.

In the city of Karachi in 2004 one in five IDUs was infected with HIV\textsuperscript{33} and some of these IDUs were as young as fourteen years old.\textsuperscript{34} With the growth in the production of drugs in Afghanistan, which happens to be the one of the largest poppy producers in the world, IDUs are likely to increase, which suggests that the number of HIV/AIDS cases will rise too.\textsuperscript{35} IDUs also have a negative influence on FSWs, who find it harder to protect themselves from HIV/AIDS. In Pakistan, a study carried out by the government in 2004 showed that 3\% of all FSWs interviewed admitted injecting drugs, while 21\% had sex with clients whom they had identified as IDUs.\textsuperscript{36}

HIV/AIDS among IDUs is spreading as a result of needle sharing and unprotected sex. Even though syringes are available and needle exchange programmes exist in some cities of Pakistan, it has been found that drug users still reuse syringes (78.1\%) and inject in groups (73.3\%) in places where needle sharing takes place (50\%). In addition to this, 23.7\% of IDUs regularly used the paid services of professional injectors, also known as street doctors. These ‘doctors’ use equipment that has usually been used on multiple people without adequate sterilisation, further increasing the transmission of HIV.\textsuperscript{37}

\textbf{State’s Response}

With the support of UNAIDS, the NACP of Pakistan was created in 1987-1988, soon after the detection of the first HIV/AIDS case in Pakistan and was based at the National Institute of

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\item \textsuperscript{29} T Zafar, and SUI Hasan, ‘p.121 ; The rate of needle exchange and sharing of needles among IDUs across the country increased after the collapse of Taliban in Afghanistan. Prior to the war in Afghanistan drug addicts were inhaling heroine called “brown sugar” however since 2001 this type of heroine is not accessible in each part of the country therefore majority of addicts have turned to use “white stuff” which only can be injected. More information can be obtained from A Arshad , AS Sharaf , NA Zaidi, and et al.,’ pp.1-6
\item \textsuperscript{30} SA Strathdee, T Zafar, H Brahmbhatt and et al.,’ p.17
\item \textsuperscript{31} F Emmanuel, and M Fatima, ‘Coverage to curb the emerging HIV epidemic among injecting drug users in Pakistan: Delivering prevention services where most needed’, in \textit{International Journal of Drug Policy}, Vol 19, No.1, 2008, p.60
\item \textsuperscript{32} SA Shah, and A Altaf,’ p.290
\item \textsuperscript{33} World Bank, ‘Preventing HIV/AIDS in Pakistan’.
\item \textsuperscript{34} UNICEF, ‘Positive diaries; young people living with HIV and Aids in Pakistan’, at \texttt{http://www.unicef.org/pakistan/Positive_Diaries.pdf}, p.4 (accessed 11/10/08)
\item \textsuperscript{35} MA Rai, HJ Warrach, SH Ali and et at,’p.2
\item \textsuperscript{36} F Emmanuel, and M Fatima,’ p. 61
\item \textsuperscript{37} F Emmanuel, and M Fatima,’ p. 60
\end{itemize}
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Health. NACP’s first programme to be funded by the government was in 1990 which was for three years; the work of NACP was then expanded in 1994 until 1997. At the end of June 1997, the program was extended until 2003 because only a fraction of the funds actually required by NACP, had been provided, i.e. 15 %.\textsuperscript{38} NACP’s accomplishments include the sensitisation of health workers across the country on a range of HIV/AIDS related issues and the setting up and provision of limited funding support to Provincial Implementation Units (PIUs). The provision of HIV/AIDS data in Pakistan has been another feat of the NACP.\textsuperscript{39} The Pakistani government, through the NACP has coordinated efforts to combat the HIV epidemic.\textsuperscript{40} NACP has made a major contribution in raising awareness about HIV/AIDS throughout Pakistan through a large-scale general public awareness campaign in all four provinces. As a part of this campaign, educational materials were made public, different types of workshops and educational events were held and the electronic media was also used for raising awareness. PIUs were in each province and numerous surveillance centres were established all over the country. NACP aims to prevent HIV transmission by ensuring safe blood transfusions, reducing STI transmissions, putting in place surveillance, providing training to health staff, promoting research and behavioural studies and trying to prevent the stigmatisation of HIV sufferers.\textsuperscript{41} NACP comprises a federal programme and five separate provincial programmes working under a National Health Policy. The provincial programmes consist of North-West Frontier Province (NWFP), Sindh, Punjab, Baluchistan and the Azad Jammu and Kashmir AIDS Control Programme. Each of these programmes manages its own activities while still working under the national framework.\textsuperscript{42}

Whereas in the beginning NACP focused on diagnosing cases that had been reported in hospitals, it gradually gained more of a community focus. Abid Atiq, National Programme Officer for UNAIDS (2002) in Islamabad stated, “the government did hold back on tackling the issue due to the nature of the disease as this is an Islamic country,” he added “most of the funding for previous projects run by the authorities came from the government itself, and very little from donors. However, a renewed interest from the international aid community has given the green light for a more comprehensive five-year programme, with a budget of US $47 million to run as of 2003[-2008].”\textsuperscript{43} The government of Pakistan has also included NACP in its general health programme, which has the support of external donors.\textsuperscript{44} In
addition it is effectively working to raise general awareness to reduce risk of infection amongst the general public.\textsuperscript{45}

It is quite surprising to note that Pakistan has no formal HIV/AIDS policy. The country deals with the problem through a National AIDS Country Strategic Framework (NACSF), which was put together in 1999-2000 with the support of, UNAIDS and other development partners as well as civil society organisations and people living with HIV/AIDS (PLWHA).\textsuperscript{46} NACSF recognizes the significance of working towards reducing the risk of transmission of HIV and other blood-borne infections through blood transfusion. Last but not the least, NACSF provides quality care and support to PLWHA (including meeting their medical, social, and sometimes material needs), and ensures a secure environment for all PLWHA and those affected by HIV/AIDS.\textsuperscript{47}

While the government of Pakistan has provided a response to the spread of HIV/AIDS in the country, the number of infected individuals, particularly among IDUs, continues to rise. In Karachi, between early 2004 and March 2005, the proportion of HIV-infected IDUs rose from 1\% to 26\%.\textsuperscript{48} Similarly in 2005-2006 the number of HIV positive cases among IDUs in Lahore increased to 3.3\%.\textsuperscript{49} In certain urban areas of the country, HIV infection among IDUs has reached up to 51\% in a span of less than three years.\textsuperscript{50} An analysis of these figures confirms that “Pakistan can no longer be considered a low-prevalence country since there is now a ‘concentrated epidemic among IDUs, which exists in a number of cities; Karachi (26.5\%), Sukkur (19.6\%), Hyderabad (18.3\%), Faisalabad (13.2\%) and Quetta (9.7\%).”\textsuperscript{51}

HIV/AIDS is not a problem of individual countries, it is a global problem. Its scope in affecting every segment of society and spreading indiscriminately in all groups and societies is one of the characteristics that makes HIV/AIDS a global issue. HIV/AIDS is a global threat that needs a global response. How to respond to this threat is not the sole responsibility of a state or the UNAIDS; a number of national, transnational and international institutions are needed to address this global problem. HIV/AIDS and other potentially dangerous diseases have always been a matter of concern for the UN. In January 2000, Kofi Annan in his address to the United Nations Security Council (UNSC) session on HIV/AIDS stated that, “AIDS is causing socio-economic crises which in turn threaten political stability.”\textsuperscript{52} In addition to this, the UNSC which is usually concerned with security issue had a meeting in 2000 about the problems caused by HIV/AIDS. This shows that HIV/AIDS has been seen as a security threat that needs to be addressed not only on a national level but also on an international level. James Wolfensohn, a former President of the World Bank, in his address to the UNSC said, “if we want to avoid violent conflict, we need a comprehensive, equitable, and inclusive


\textsuperscript{46} ‘Pakistan National Youth Shadow Report 2006’ p.9

\textsuperscript{47} ‘Pakistan National Youth Shadow Report 2006’ p.10


\textsuperscript{51} F Emmanuel, and M Fatima,’ p. 60

\textsuperscript{52} Nk Poku, A Whiteside and B Sandikjaer, Aids and Governance (Ashgate Publishing Limited England, 2007), p.94
Development cannot take place if we do not stop the disease from spreading and weakening societies. The Commission on Global Governance sees HIV/AIDS as “the single greatest threat to continual global development.”

Global Governance and the HIV/AIDS epidemic

The discipline of International Relations has taken a theoretical-based approach in understanding global governance. A majority of theories have tried to explain global governance by offering a “problem-solving” approach, yet there is still no single explanation of the concept. The literature on global governance offers varied meanings for the concept. Global governance is one of the general terms which does not have a very clear meaning. Global governance is not really something which involves a high level of integration; rather it can be seen as a label for a very complex and dissimilar range of activities that result in a limited degree of global coherence. Global governance is also understood as a vibrant and multi-faceted practice of interactive decision-making which is developing on a continuous basis and reacting to changing conditions. According to Rorden Wilkinson, global governance is “the sum of the many ways individuals and institutions, public and private, manage their common affairs. It’s an ongoing process through which conflicting or diverse interest may be accommodated and co-operative action may be taken. It includes formal institutions and regimes empowered to enforce compliance as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest.”

Global governance is also considered to be a “complex of formal and informal institutions, mechanisms, relationships, and processes between and among states, markets, citizens, and organisations-both intergovernmental and nongovernmental-through which collective interests are articulated, rights and obligations are established, and difference are mediated.” Global governance has positive implications for today’s world. It provides order and stability instead of chaos, encourages collaboration instead of conflict; it provides solutions to problems in a reasoning sense.

The global governance environment is multifaceted and pluralistic. Different types of authority have different levels of impact in different regions of the world. Although state governments might continue to be significant as strategic sites, the new institutional structure involves more distributed decision-making with political authority delegated to different levels of governance. The reasoning behind establishing global governance is that it is the only means of dealing with instability and the common risks that everyone faces.

Examples of governance at a local level can be regional, local, society and community-based bodies which regulate and work on community matters. The Pakistani community has a variety of community-based governments and multi-urban formal and informal institutions.
that operate on the basis of regional and state rules. At the international level, governance has been seen as intergovernmental relationships; however it also includes non-state actors such as NGOs, multinational corporations, citizens, institutions and the global capital market. In this paper global governance refers to the collective responses of state authorities, international organisations, environmental agencies, non-governmental organisations (NGOs), international governmental organisations (INGOs), private sector elites, community-based organizations (CBOs) and formal and informal institutions.

Theoretical Framework

HIV/AIDS has been studied from the perspective of a serious threat to state stability, security and development. Scholars have tried to explain this threat by comparing it to the Black Death or the ‘War on Terror’. Nana K. Poku states, “striking similarities between HIV/AIDS and the Black Death can be seen, including the reshaping of the demographic distribution of societies, massive orphanning, labour shortages in agricultural and other select trades, strong challenges to military forces, an abiding shift in spiritual and religious views, fundamental economics transformations, and changes in the concepts of civil society and the roles of the state.”

There is agreement amongst scholars that this local and global response to HIV/AIDS has failed specifically in African countries. Scholars have suggested various reasons for this failure. According to Harto Hakovirta, international organisations have failed to respond to HIV/AIDS in the way they had promised. This, he argues, is because international institutions have not recognised that poverty is one of the main causes for the failure of the state and global responses to HIV/AIDS. He further suggests that there is a problem not only with the way in which aid is distributed between the Global North and the Global South, but also the way in which developing countries are using this aid. Low-income developing countries are struggling to absorb the additional funds they receive from global governance institutions.

The significant raise in global funding has helped in reduce the gap between the resources needed and the ones available for expanding the response to AIDS, but it has not been as successful in reducing the so-called ‘implementation gap’, which is the failure of countries to use available resources in time and in an effective manner. If this situation persists, it is probable that the major donors would decrease their financial commitments which in turn could put the long-term sustainability of the AIDS response at serious risk.

In addition to the mismanagement on the part of the local governments, UNAIDS (as presenting global governance in the fight against HIV/AIDS) in many cases fails to remain neutral and it is unsuccessful in overcoming the division between the Global North and the Global South. Poku argues that global governance lacks appropriate policies to stop the spread of HIV/AIDS in the Global South because “the global figures do not terrify us enough [in the Global North], we do not comprehend their implications, the reality is geographically

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62 Wilkinson, P.26
63 Nk Poku, A Whiteside and B Sandkjaer, p.31
64 H Hakovirta, Six Essays on Global Order and Governance (Turku, Finland: University of Turku, Dept. of Political Science, 2004) p. 88
distant; their implications are distant in time. We do not attend to their implications." Hakovirta points towards a lack of consideration for culture when creating and implementing the response to HIV/AIDS. He argues that the global response needs to be sensitive to local norms and values and should not impose strategies that have a liberal bias. In his words, "it’s impossible to do anything good by intervening into a strange culture and a strange political system."

HIV/AIDS is not recognised as a threat to the security of Pakistan, it has not affected the process of development, nor is it seen as a serious health issue in the country. However HIV/AIDS in Pakistan is still a great cause for concern as the number of cases is rising and it does affect the security, development and stability of the country. Increased drug-abuse among Pakistanis affects the most productive segment of the country’s population; it increases the risk of HIV infection and loss of lives which make the widowed women and orphans vulnerable to the infection. The government of Pakistan and global governance organisations are aware of the problem of IDUs in the country, which is why they have provided service centres for promoting awareness about HIV/AIDS among the IDUs group. In this next part of the study I attempt to analyse how successful these rehabilitation centres have been in reducing the risk of HIV transmission among IDUs.

Programmes for IDUs (Drop-in Centres)

The Asian epidemic model suggests that if the HIV epidemic among IDUs is not controlled: it alone could lead to a 40% increase in the total number of HIV-infected people, even if the other modes of transmission are managed. The needs of the IDUs community of Pakistan have been addressed by UNAIDS, UNDCP, UNDOP, DFID and NACP of Pakistan. These institutions have managed to open rehabilitation centres for IDUs. The Pakistani government’s HIV/AIDS effort was financed by the World Bank through funding of the second Social Action Programme (1998-2003). In total, the World Bank has given US$37.1 million, three-quarters of which was interest-free and one-quarter of which was in the form of a grant. HIV prevention services are helped by the programme in areas such as mass media campaigns, raising awareness in order to reduce stigma, promoting safe blood transfusions, building management and institutional capacity specifically for the most at-risk groups. These targeted intervention programmes have been reasonably successful and have led to the expansion of an IDU programme in Punjab and the implementation of service delivery.

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66 Poku, Whiteside and Sandkjaer, P. 32
67 Hakovirta, 89-90
68 T Barnett, p.301
69 A Rajabali, RS Khan, HJ Warraich, and et at., p.512
70 The Asian Epidemic Model (AEM) has been designed to reflect the primary groups and transmission modes driving HIV transmission in Asia. The user adjusts AEM fitting parameters until HIV prevalence outputs from the model agree with observed epidemiological trends. The AEM resultant projections are closely tied to the epidemiological and behavioural data in the country. In Thailand and Cambodia they have shown good agreement with observed epidemiological trends in surveillance populations and with changes in HIV transmission modes, AIDS cases, male: female ratios over time, and other external validation checks. By varying the input behaviours and STI trends, one can examine the impact of different prevention efforts on the future course of the epidemic. In conclusion, the AEM is a semi-empirical model, which has worked well in Asian settings. It provides a useful tool for policy and programme analysis in Asian countries. Please see T Brown, W Peerapatanapokin 'The Asian Epidemic Model: a process model for exploring HIV policy and programme alternatives in Asia' in Sexually Transmitted Infections, 2004;80(Suppl 1):119-124
71 F Emmanuel, and M Fatima,' p. 60
packages for male and female prostitutes in Sindh, Punjab and NWFP. A reduced level of risky behaviour, mainly among IDUs, suggests that HIV prevention services are bringing about change. However, the limited coverage of the existing intervention programmes must be taken into account, since they cover only 15-20 percent of the most at-risk groups. The most critical area concerns the mobilisation of resources and capacity for increasing the scale of services provided to high-risk populations.

UNODC sponsored the first harm-reduction effort in Karachi in 1993; however it ended in failure and was closed after just three months. Nonetheless, success was achieved with other efforts such as the opening of a drop-in centre in Lahore in 1998 and two drop-in centres in Karachi in 2000. These programmes enjoyed more success thanks to the considerable involvement of stakeholders. The relative success of this programme triggered a broad-based harm reduction project, supported by the UK Department for International Development (DFID) in 2002 as a part of the NACP. The key features of this programme were the running of drop-in centres and mobile harm reduction units that were to provide services to IDUs in all provincial capitals. When the project ended, the AIDS control programmes in each of the provinces assumed responsibility for continuing the harm reduction services and also expanding them to other larger cities. Three of these rehabilitation centre programmes will be presented in this paper.

Nai Zindagi which means ‘New life’ is a non-profit organisation supported by UNAIDS, DFID and UNDCP. Nai Zindagi has been working for and with drug users since 1990. It has opened drop-in centres in Quetta, Peshawar, Lahore and Rawalpindi. The drop-in centre in Quetta has a team of medical staff who provide basic medical care to drug users. The centre also offers “space to relax, tea, food, toilet and bathing facilities.” Of the 82 IDUs surveyed in the Quetta drop-in centre, 52 percent were sharing syringes before coming to the centre. The same syringe had been used up to four times among some of these IDUs. IDUs register themselves in order to get treated; there are greater numbers of IDUs as compared to non-IDUs seeking treatment. Not all the IDUs who come to the drop-in centres can be fully rehabilitated as treatment is costly. IDUs who are at high risk of being infected with HIV ‘donate’ their blood in order to earn money. In the Quetta centre 75 percent of IDUs had donated blood for money.

The AIDS Surveillance Centre in Karachi conducted a survey in 1998 among professional blood donors, the results showed that 20% of the samples were infected with Hepatitis C, 10% had Hepatitis B whereas 1% were infected with HIV. It should be noted that in 2005 one-fifth of all transfused blood originated from professional donors. This figure is not as shocking as the statistics of 2007, when 90 percent of blood donations came from the “non-

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72 World Bank, ‘HIV/AIDS in Pakistan’ p. 3
73 F Emmanuel, and M Fatima,’ p. 62
74 T Zafar, and SUl Hasan,’ p.122
76 I Kuo, SUl Hasan, T Zafar, and et al., P.855
77 T Zafar, and SUl Hasan,’ p.123
78 World Bank, ‘Preventing HIV/AIDS in Pakistan’.
voluntary” donors who were known IDUs. Knowledge of HIV transmission via sharing needles was poor among the 501 drug users of Quetta, none of the drug users questioned were aware that by sharing needles they were in direct danger of contracting the infection. There is a danger that HIV may spread into the heterosexual population of the country as almost half of Quetta’s studied drug users were married and in 2000, 45% of drug users’ wives in Manipur were HIV-positive.

The Lahore drop-in centre which opened in 2001 provides basic healthcare to drug addicts. It has hundreds of recovered drug users. The medical staff and counsellors provide health and education to drug users. The centre also offers condoms, bathing and rooms for drug users to rest. Similar to Quetta’s drop-in centre, this rehabilitation clinic helps mostly male clients since drug usage is a largely ‘male phenomenon’ and women are not expected to be seen in there. However a number of FSWs were also using the centre’s facilities.

‘House of Hope’, a drug rehabilitation centre run by the Marie Adelaide Rehabilitation Programme has been providing services to drug addicts in the rural areas of Sindh province for more than 21 years. In 2002, the programme established a needle exchange or drop-in centre in the Burns Road area of Karachi, known to be home to a large number of addicts. It did so with the assistance of DFID, UNAIDS and UNODC. This centre is better equipped than the aforementioned drop-in centres. The ‘House of Hope’ provides a range of services including syringe exchange, free condoms, treatment of bacterial STIs, abscess dressing, an outpatient clinic, bathing as well as regular counselling and health education to IDUs. The centre also has number of physicians and 10 trained members of staff, all of whom were themselves rehabilitated addicts and who had the appropriate skills for interacting with current addicts.

The UNAIDS and NACP’s joint response

Keeping in mind the fact that sooner or later IDUs may become a bridge between the high-risk groups and the general population UNAIDS, USAID and NACP have addressed this concern by providing awareness, prevention and treatment programmes. Being at the forefront of the global action against HIV/AIDS, UNAIDS in Pakistan is dedicated to an expanded response to the epidemic. At the start it aims to avert the spread of HIV/AIDS, providing care and support for those who are infected and affected by it. Moreover, it would decrease the vulnerability of individuals to HIV/AIDS and alleviate the socio-economic and human impact of the epidemic. Although UNAIDS is committed to a comprehensive response, in the past it focused solely on HIV testing and paid no attention whatsoever to

80 T Zafar, and Shi Hasan,’ p.123
81 T Zafar, and Shi Hasan,’ p.124
82 I Kuo, Shi Hasan, T Zafar, and et al.,’ p.855
83 A Altaf, Sa Shah, NA Zaidi, and et al.,’ p. 2
84 A Altaf, Sa Shah, NA Zaidi, and et al.,’ p. 2
85 A Altaf, Sa Shah, NA Zaidi, and et al.,’ p. 2
86 ‘United Nations Statement on HIV/AIDS in Pakistan’ p.15
87 ‘United Nations Statement on HIV/AIDS in Pakistan’ p.15
the target groups. Nonetheless, the situation changed in 1992 when UNAIDS began to have greater involvement with NGOs and engaged in a mass awareness-raising campaign through the electronic media the year after.\textsuperscript{88}

In association with the UN, the Pakistani government has entered into affiliations with print as well as electronic media associations in order to train journalists on reporting on HIV and AIDS. Also under the partnership, resources centres have been set up allowing journalists access to technical and programmatic information on HIV so that they can report more accurately on the subject. In association with UNICEF, NACP has worked at length with religious leaders in order to sensitize them on issues regarding HIV and AIDS, particularly the stigma associated with it, and to gain their active involvement in the national response to the epidemic. A non-profit registered organisation was launched under the name of the Pakistan Inter-Religious Council on HIV and AIDS (PIRC) and religious leaders in all provinces were trained on the Info-Kit. The PIRC was involved in the production of sample sermons for Friday ‘jumma’ prayers and in conducting training sessions in every district of Pakistan throughout 2007.\textsuperscript{89} The coordination and backing of UNAIDS is essential, without it the Pakistani government would be unable to tackle the threat of HIV/AIDS effectively.\textsuperscript{90}

Launched in February 2006, the Pakistan HIV/AIDS Prevention and Care Project (PHACP), funded by USAID, is a three-year project scheduled to run until January 2009. Its objective is to expand HIV/AIDS prevention and care and to support efforts started under the Implementing AIDS Prevention and Care (IMPACT).\textsuperscript{91} Rawalpindi, Multan, Larkana and Lahore were the first cities where intervention was initiated; it has since been expanded to Karachi, Turbat and Peshawar. Nearly 40,500 individuals, considered to be at a high risk of HIV infection, have been reached by PHAPCP with the ABC prevention approach (Abstain, Be faithful, and correct and consistent use of Condoms are the three major pillars of US President Bush Emergency Plan for AIDS Relief). Diagnosis of STIs and assistance with treatment has also been provided to 1,800 people. Nearly 10,000 more have been reached, due to the recent amalgamation of voluntary counselling and HIV testing services.\textsuperscript{92}

In 2001 up to 100\textsuperscript{93} and in 2004 200\textsuperscript{94} NGOs were involved in HIV/AIDS related activities in Pakistan. However it is estimated that they manage to reach less than five percent of the population susceptible to this epidemic.\textsuperscript{95} The reason why these NGOs are failing to achieve full-scale coverage is because both the NACP and international bodies need to manage resources appropriately and improve their implementation of effective strategies targeting high-risk groups, something to which they had earlier committed.

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\bibitem{93} United Nations Statement on HIV/AIDS in Pakistan, p. 12
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The analysis of the local and global response

Global governance through UNAIDS created NACP of Pakistan which tackles the problem of HIV/AIDS in the country. However, neither global governance nor NACP have achieved a reduction, or in an ideal world, the prevention of the spread of HIV/AIDS among the high risk groups or the general population of the country. HIV/AIDS transmission in Pakistan is speeded up by HIV prevalence among IDUs. Thus the surveillance of Pakistan’s national health sector suggests that “this disease-specific approach is at best outdated and, at worse, doing more harm than good.” This is a well-founded claim since if the current programmes in Pakistan were working effectively Pakistan’s pandemic would have not progressed from a low to a concentrated level. International institutions blame the Pakistani government for its political unwillingness to provide an adequate response to the pandemic.

The government of Pakistan is slow in responding to HIV/AIDS as the response lacks political willingness and effective coordination of programmes. In 2002, the Director General of the WHO, Dr Gro Harlem Brundtland, stated that he believed that national governments should implement better strategies and take action to deter the spread of HIV. According to him, “unless we see national prevention initiatives championed by the highest level of government, the growth in infections can be unstoppable.” Although the political resolve and dedication to the country’s efforts against HIV/AIDS have both been fairly weak in the past, it is now crucial to gain support for a national response against HIV/AIDS at the highest political levels. According to Nana, politics and not medicine hold the key to an effective response. It is obvious that as the HIV/AIDS epidemic evolves in Pakistan, the national response will have to react accordingly. Management and coordination mechanisms, programme plans and ongoing steps must be reviewed on a regular basis. Since there are limited resources for HIV/AIDS, newer and more innovative sources of funding need to be identified and then utilised.

A national response is vital and necessary in addressing HIV/AIDS in Pakistan but what if Pakistani society has still not accepted that HIV/AIDS is a threat? Even though trends are changing rapidly, the age-old stigmas and taboos related to HIV still exist. It is easy to blame the state for the failure of the current programmes, however one needs to realise that it is not the sole responsibility of the state. Global governance institutions are equally responsible for the failure and for those lives being lost as a result of HIV/AIDS. Global governance institutions do not coordinate among each other or with the state. This paper has highlighted that NACP, UNAIDS, UNDCP, DFID and World Bank have managed to open drop-in centres for IDUs. However we have to keep in mind that fighting HIV/AIDS requires more than just delivering condoms and providing limited harm reduction programmes.

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The drop-in centres are not sufficient in terms of providing shelter and needle exchange programmes for the majority of IDUs. These centres hardly meet the needs of IDUs as it does not help them in once they leave the centres. The rehabilitation centres rely hugely on donor funding since charities and donations from the private sector are not yet commonplace in Pakistani society. In spite of the efforts of 200 concerned NGOs and the facilities provided by the rehabilitation centres, the rates of HIV infection among IDUs are increasing dramatically. Drop-in centres decrease the risk of HIV infection among the registered addicts, but they cannot completely prevent HIV infection on their own.

Although a number of IDUs seek treatment, others do not want to commit to these programmes and might drop out at any time. In order to prevent the spread of HIV infection among drug users, programmes should not try to put a complete stop to illicit drug usage. As a matter of fact injecting drugs does not itself transmit HIV, it is the needle sharing that puts the lives of these drug users in danger. Pakistan needs to endeavour to provide “safer injecting programmes”. These could involve giving free injecting equipment at the rehabilitation centres, clinics, pharmacies, and to street IDUs. Beside syringe exchange programmes the organisations involved and NACP should also distribute bleach as it helps to sterilise used needles and decreases the chances for a widespread expansion of illegal market for sterile injection equipment.\(^{101}\)

The drop-in centres should work to provide detoxification programmes as there are very few private clinics that offer such a facility and those that do charge very high prices. Additionally, drug users should be trained to learn skills such as woodwork, electrical or motor vehicle maintenance that they can use once they leave the centre. Time and resources will be wasted unless addicts learn transferable skills: they will be unable to return to the community and will once more turn to heroine or ‘donating’ blood in order to earn money.\(^{102}\)

The overall analysis of HIV/AIDS situation in Pakistan suggests that there is a problem of transparency in the programmes initiated by the Pakistani government and global governance institutions. The amount of information supplied by the state and international organisations is insufficient to be able to evaluate effectively the programmes currently in progress. Initially there is the problem of reliability on the part of UNAIDS. UNAIDS claims that it provides care and support for PLWHA; however it has yet to implement any kind of programme. In addition to this, UNAIDS and NACP has been working on raising people’s awareness through the use of electronic media. In a country where people rarely even have access to print media, this raises questions about the effectiveness of an awareness-raising campaigns conducted via the electronic media.

Secondly, under the global governance framework international organisations and the state are required to provide treatment for PLWHA. However, apart from the WHO, no other international organisation, or even NACP, is providing treatment to PLWHA. Without effective treatment, HIV soon leads to AIDS which, as we know, kills. Furthermore, the current literature on the response of the state and that of international institutions demonstrates that there is no single awareness programme for MSM, truck drivers and cyclical migrant men. This paper has only investigated the spread of HIV/AIDS among IDUs,

\(^{101}\) Don C. DES Jarlais, ‘ pp. 349-350

\(^{102}\) A Altaf, SA. Shah, NA. Zaidi, and et al., ‘ p. 5
however my previous research on the subject indicated that MSM is the second largest high-risk group in the country. HIV/AIDS has been spreading rapidly among these groups. MSM, truck drivers and cyclical migrant men, besides being at high risk of infection, have largely been ignored by the programmes drawn up by the Pakistani government and global governance.

Global institutions such as UNAIDS have an ability to influence the local and national response. For a start, global institutions have always tried to provide strategic ‘support’ in creating HIV/AIDS programmes. According to Wilkinson this would help global actors to build policies and practices which will enable them to act as a group. However, effective global decision-making should be based on decisions taken at a local, national and regional level. As a matter of fact HIV/AIDS needs a collective and long term response, however more than anything else, it needs better allocation of resources and coordination among state and international institutions. No strategy should be dictated to the state organisations such as NACP of Pakistan. One of the failures on the part of NACP is the result of implementing general programmes which have had a better result in other countries. The Pakistani situation should be treated as a unique case since HIV/AIDS is concentrated in the male population of the country, particularly among IDUs, MSM and MSWs.

Conclusion

Taking into consideration the possible limitations and challenges facing the government of Pakistan, it still has the responsibility to protect the nation from HIV/AIDS. The rising level of HIV infection among IDUs highlights the need to fill the gaps in the existing prevention strategy. Figures have shown that effective harm reduction activities have failed to reach a large number of IDUs, which calls for an urgent expansion of these activities if the impending epidemic among IDUs is to be prevented. In addition, it is also imperative that harm reduction activities are integrated into public health as a whole. Surveillance data from Pakistan have shown that harm reduction programmes have had little effect in reducing the spread of HIV/AIDS among IDUs. Although HIV/AIDS and STIs management and treatment are made a part of various government policies and programmes, there is a need for these to be made part of the mainstream programme.

103 Wilkinson, p.27
104 SA Shah and A Altaf, p.290
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