HIV/AIDS: The State of The Nation

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Acquired immunodeficiency syndrome (AIDS) is a hidden epidemic in Pakistan but it has already caused unprecedented devastation in Africa where entire countries are crumbling under its burden. There are over 40 million human immunodeficiency virus (HIV) cases worldwide, of whom 38 million live in the developing world. Less than a million patients receive antiretroviral (ARV) therapy and most of these are in the developed World. Nearly 4 million die from HIV with an additional 5 million new cases world wide annually. In sub-Saharan Africa, which bears the most burden, the median life expectancy has decreased from over 60 to around 30 yrs and is continuing to fall. At this rate we may see many countries in Africa depopulate in our lifetimes. No natural calamity, plague or wars in human history has ever caused a depopulation of countries and continents at this scale - this crisis is unique.

Communicable diseases spread via distinct patterns. They start in a core group with characteristics that allow the disease to establish among them. The disease then spreads to the general population when another subgroup bridges the contact between the core and the general population. The core groups for HIV are usually injection drug users and sex workers while their clients and spouses provide the bridging with the rest of the population.

Data show that both HIV and sexually transmitted diseases are now extant and increasing in Pakistan. The National RTI/ sexually transmitted infections (STI) study[1] showed 23% prevalence of HIV among injection drug users (IDUs) in Karachi and 4% among male sex workers (MSWs). The same study found extensive of needle sharing, overlapping sex/drug use networks, infrequent condom use and scant knowledge of HIV and protective actions. The prevalence of STIs (syphilis: 60%, gonorrhea: 12%) and hepatitis C (87% prevalent among drug users) was found to be high, underscoring the extent of risky needle and sexual behaviors. With approximately 3-4 million heroin users nationwide, of which approximately 180,000 injections[2-3] users, there is much reason for concern. Previous studies The study of STIs in antenatal clinics, 2001, unpublished. have demonstrated similar findings. On the other hand the same RTI/ STI study showed lower comparable prevalence in cities other than Karachi, suggesting that this is an early phase in the epidemic.

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In fact these data confirm that Pakistan still has low overall prevalence with some pockets of higher concentration. In this regard Pakistan is following the typical Asian model (seen in Thailand, Myanmar, Vietnam, Malaysia and parts of China and India) where the epidemic was initially driven by explosive spread among IDUs and sex workers. Risky behaviors and increasing prevalence among differing core groups (male sex workers: 4% in Karachi[1]) suggest that HIV will spread rapidly once it crosses certain key thresholds between population subgroups and that the process may have already begun.

There are currently 2,832 documented HIV cases in Pakistan[5], although the UNAIDS estimates the actual number to be around 80,000 (range: 24,000 to 150,000). Of these 65% are due to heterosexual transmission, 19% to blood borne transmission and 4% to injection drug abuse. Besides IDUs and sex workers, another aspect of the Pakistani epidemic is the Pakistani repatriate who acquired the disease while in the Middle East and was sent back to Pakistan untreated, consistent with the prevalent policy in many of these countries. Currently no estimates are available to enumerate these patients.

Blood-borne transmission remains a key component of the HIV epidemic. At 19% of reported HIV infections, Pakistan's contribution from blood-borne transmission is clearly in excess of the world experience of 5-10%. Only about 60% of the 1.5 million annual transfusions are screened for HIV in Pakistan. The enormity of the situation is further highlighted by findings of 12-20% prevalence of Hepatitis C among various groups including random donors[6].

Treatment of patients with HIV to date has been limited to those who can acquire ARVs privately. In 2003 only about 100 received antiretroviral therapy out of estimated 10,000 individuals who actually needed it[7]. This will change shortly as ARVs imported by the government of Pakistan have arrived and approvals have been granted for further import of generic ARVs from India. Five treatment centers are being set up in the public sector to be followed by similar centers in the private sectors. However the World experience illustrates that HIV care is most successful when ARV therapy complements very strong community based support. In Pakistan, such support networks are in early phases of development and will require considerable strengthening to cope with the current situation. Also much of the community support thus far has focused on procuring ARVs rather than developing actual support networks. This is in contrast to India where early spread of the epidemic forced

support networks to develop before ARVs became available. When ARVs arrived, they were incorporated into the already existing framework of support systems.

The way forward must include development of civil society support systems based on involvement of patients living with HIV/AIDS (PLWHA) and their advocates. Physicians caring for HIV must forge links with these groups to complement aspects of HIV care that are typically not their domain. For most of us this is a paradigm shift since our clinical training did not address these issues (many of these systems operated outside our clinics, being run by governmental and non-governmental organizations). As Pakistan builds its HIV care setup experience of other countries must guide our efforts. This experience emphasizes the importance of support systems and the role of PLWHA in their own care. If we physicians are to lead the way as opinion leaders and advocates for our patients, we must learn and adapt from the world experience.

References

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