## Pakistan

### Country Review  September 2011

### PAKISTAN AT A GLANCE

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (thousands)</td>
<td>173,591 (2010)</td>
</tr>
<tr>
<td>Annual population growth rate</td>
<td>2.1% (2005-2010)</td>
</tr>
<tr>
<td>Percentage of population in urban areas</td>
<td>36% (2007)</td>
</tr>
<tr>
<td>Crude birth rate (births per 1,000 population)</td>
<td>27 (2007)</td>
</tr>
<tr>
<td>Under-5 mortality rate (per 1,000 live births)</td>
<td>97 (2006)</td>
</tr>
<tr>
<td>Human development index (HDI) – Rank/Value</td>
<td>136/0.551 (2005)</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>63 (2006)</td>
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<tr>
<td>Adult literacy rate</td>
<td>50% (2006)</td>
</tr>
<tr>
<td>Ratio of girls to boys in primary and secondary education (%)</td>
<td>82 (2009)</td>
</tr>
<tr>
<td>GDP per capita (PPP, $US)</td>
<td>2,370 (2005)</td>
</tr>
<tr>
<td>Per capita total health expenditure (Int.$)</td>
<td>49 (2005)</td>
</tr>
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</table>
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 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 women\(^9\). 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 2009\(^10\).

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

![Graph showing estimated number of people living with HIV from 1990 to 2009.](source)


Surveillance systems\(^10\):
- 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%.

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 locations. Extrapolation using estimation models estimate a total of 91,000 IDUs nationwide. According to the 2008 IBBS, HIV prevalence among IDUs was 20.8% (averaged over eight major cities). This represents an increase from 15.8% in 2007 and 10.8% in 2005. Prevalence among IDUs in 2008 was found to be as high as 30% and 27% in Hyderabad and Larkana, respectively (Fig. 2).

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

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

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Mean age at first injecting drug use</th>
<th>Average years of injecting drug use</th>
<th>Average number of injections per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dera Ghazi Khan</td>
<td>28</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Peshawar</td>
<td>27</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Lahore</td>
<td>29</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Sargodha</td>
<td>28</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Faisalabad</td>
<td>29</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Larkana</td>
<td>29</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Hyderabad</td>
<td>31</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Karachi</td>
<td>27</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>


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 mapped locations. In addition, 19,320 MSWs and 14,725 HSWs were mapped. Extrapolation using estimation models for national level provided estimates of 136,000 FSWs, 63,000 MSWs and 43,000 HSWs.

Rounds 1 and 2 of the IBBS found HIV prevalence to be very low among FSWs, 0% and 0.02%, respectively. 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%. (Fig. 3). In 2008, HIV prevalence was 0.9% among MSWs and 6.1% among HSWs (Fig. 3). 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 above.

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Karachi</td>
<td>2</td>
<td>3.1</td>
<td>3.6</td>
</tr>
<tr>
<td>Lahore</td>
<td>1.0</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Hyderabad</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Larkana</td>
<td>0.6</td>
<td>0.5</td>
<td>27.6</td>
</tr>
<tr>
<td>Peshawar</td>
<td>-</td>
<td>0</td>
<td>1.2</td>
</tr>
<tr>
<td>Faisalabad</td>
<td>0.8</td>
<td>0</td>
<td>2.5</td>
</tr>
<tr>
<td>Sargodha</td>
<td>1.2</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>


The average number of clients per day was 4 for FSWs in 2009, and 2 and 3 for MSWs and HSWs, respectively in 2008. 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).

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 MSMs. 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 groups. 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%; gonorrhea – 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 workers.\(^\text{10}\)

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 AIDS.\(^\text{16}\)

**Truck drivers**

There are estimated 200,000 truckers nationwide.\(^\text{19}\) 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 home.\(^\text{20}\) 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 Karachi.\(^\text{21}\) 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 misconceptions.\(^\text{12}\) This figure was significantly lower among FSWs – at 1.1% in 2009.\(^\text{15}\) 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 responses.\(^\text{14}\)
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)\textsuperscript{12}. Meanwhile, 79% knew that using clean needles/syringes can prevent HIV transmission (ranging from 43% in Dera Ghazi Khan to 95% in Faisalabad)\textsuperscript{12}. In a 2009 rapid assessment of IDUs in the four cities, only 29% of all respondents had heard of HIV\textsuperscript{14}. 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)\textsuperscript{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 transmission\textsuperscript{12}.

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 transmission\textsuperscript{22}. 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 contact\textsuperscript{12}. Figure 5 shows the percentage of IDUs having had sex with various types of sex workers in the last six month 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 months\textsuperscript{12}. 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)\textsuperscript{12}.

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

[Diagram showing percentages of IDUs having had sex with different types of sex workers in various cities, with Dera Ghazi Khan having the highest percentage of IDUs having had sex with a FSW (34%) and a MSW/HSW (39%).]

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 same\textsuperscript{15}. Condom use by MSWs and HSWs with their most recent client increased from 22% in 2006/7 to 33% in 2008\textsuperscript{19}. 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 usage\textsuperscript{12}. 
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

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 FSW.  

Sharing of injecting equipment

Overall in 2008, 77% of IDUs reported using sterile injecting equipment the last time they injected. 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 Faisalabad). Moreover, many IDUs report either passing a used syringe onto someone 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 month.
In a 2009 rapid assessment of IDUs in the four cities of Mandi Bahauddin, Rawalpindi, Gujranwala and Sheikhupura, 70% shared used syringes. 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 2008. This figure was as high as 7% and 8% among MSWs in Lahore and Larkana, respectively and 24% among HSWs in Larkana. 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 2008. This figure was as high as 13% among MSWs in Lahore and 22% among HSWs in Larkana.
Figure 8: Percentage of key affected populations with overlapping risk behaviours in past six months, 2008-2009


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 AIDS.

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 fines. 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). Sex work is also illegal and Section 9 of the Control of Narcotics Substances Act 1997 allow for the death penalty for drug offences.
In 2009, the Supreme Court of Pakistan ruled that hijras are entitled to complete citizenship rights under the Constitution. This recognition allows hijras to now access the services of state social welfare departments and financial support programs.

The HIV/AIDS Safety and Control Bill 2009 has been accepted by Parliament for review. 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). Each phase is briefly described as follows:

- 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.

- 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.

- 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 counselling. 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 2007. 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). 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 counterparts. 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 testing.

![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](Image)


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). 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 2007. 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 programme.
**Country Reviews September 2011**

**Pakistan**

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

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>&lt;25</th>
<th>25+</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDUs 2008</td>
<td>53.6</td>
<td>58.4</td>
<td>49.2</td>
</tr>
<tr>
<td>MSWs/Hijra SWs 2008</td>
<td>13.5</td>
<td>11.7</td>
<td>15.3</td>
</tr>
<tr>
<td>FSWs 2009</td>
<td>5.9</td>
<td>5.6</td>
<td>8.1</td>
</tr>
</tbody>
</table>


**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).²⁰

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

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLHIV in need of ART</td>
<td>10,173</td>
<td>13,422</td>
</tr>
<tr>
<td>PLHIV on ART</td>
<td>875</td>
<td>1,320</td>
</tr>
<tr>
<td>% on ART</td>
<td>8.6%</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Pakistan, UNGASS Country Progress Reports 2008 and 2010
In 2009, less than 1% of pregnant women were tested for HIV. 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. 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 2009.

**ECONOMICS OF AIDS**

During 2009, expenditures on HIV and AIDS totalled US$ 20 million, increasing from US$ 14.2 million in 2008. The amount of national funds spent by governments from domestic sources was US$ 15.7 million (78.4% of the total share, figure 12a). Figures 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%). 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 clients.

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

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


References


As 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.

UNESCO. (2010). Education Sector Response to HIV, Drugs and Sexuality in Indonesia.


