Pakistan has progressed from low to a concentrated level of human immunodeficiency virus (HIV) epidemic primarily because of consistently high prevalence of infection among injection drug users (IDUs). Following the first outbreak in this group in 2003 the prevalence has steadily increased and reached as high as 31% in 2007 in Karachi. While there are harm reduction programmes with needle/syringe exchange and other services there are still no drug (methadone/buperonorphine) substitution programmes in the country.

Men Who Have Sex with Men (MSM) is a term created to include MSM who do not identify as gay or bisexual. Among them commercial sex workers including male sex workers (MSWs) are those men who indulge in sexual activity with another man for money or financial benefits. Similarly transvestites or hijra sex workers (HSWs) are those who identify themselves as hijras and indulge in sexual activity with another man for money or financial benefits. Findings of subsequent rounds of second generation surveillance conducted in the country suggest that these two groups are emerging as the second highest risk group in Pakistan. Their numbers in four cities of Sindh (Karachi, Hyderabad, Sukkur and Larkana) are estimated to be around 16,000 (MSWs 7,700 and HSWs 8,300). The prevalence of HIV infection has been on the rise among them. In 2004-5 the Karachi Pilot study found prevalence of HIV infection 7% (14/200) and in round 1 of surveillance in 2005-6 in Karachi the infection was found to be 4% (8/200) among MSWs and 1.5% (3/200) among HSWs. In 2006-7 the infection rates had risen to 7.5% in Karachi. In other cities of Sindh for e.g. in Larkana it was found to be 2.5% among MSWs and 14% among HSWs; in Hyderabad 2% (4/200) HSWs were HIV positive. Previous studies have also documented their risk factors in 1999.

In view of the emerging threat Sindh AIDS Control Programme started service delivery packages for prevention and control of HIV infection for MSM in Karachi, Hyderabad and Sukkur in 2006. The clientele of MSW/HSW range from unmarried or married bisexual men, migrant workers and long distance truck drivers living away from home. Condom use among MSW and HSW in paid commercial sex in Sindh has also been quite low (6.7%) while reviewed literature suggest that correct and consistent condom use reduces the risk of sexual transmission of HIV infection by 80-90% and efficacy that exceeds those reported for many of the world's standard vaccines.

It is notable that at least 5-10 percent of all HIV cases worldwide are attributable to sexual transmission between men. In countries in the Asia-Pacific region, HIV prevalence among MSM ranges from 3-17 % (5 to 15 times higher than overall HIV prevalence). Prevention investment targeting MSM has been effective in reducing risk behaviours among MSM.

The experience of working and interacting with this high risk group in Pakistan suggest that it is relatively easier to work with hijras sex workers compared to male sex workers. There are some key hurdles which require mentioning here:

1. Hijras are identifiable and relatively easier to work with however, their leader commonly called guru has to be involved in the process.
2. Because of the stigma attached to MSM it is quite difficult to reach and educate them as they are a hidden group.
3. The society as a whole in Pakistan is not willing to accept the existence of MSM/MSWs and fear of harassment and violence causes difficulty in identifying them.

Prudent measures with appropriate coverage programmes increasing health awareness and promoting condom and lubricant use are needed to improve risky behaviours. The challenge is to achieve the desired behaviour change and practices which can help reduce the transmission of HIV among this vulnerable group.

References
Injury* is one of the leading causes of mortality and disability worldwide. It is a significant public health problem that is often overlooked in the developing world. The burden of non-communicable diseases (including injuries) is continually increasing and currently accounts for nearly half of the global burden of disease among all ages.1 Five million people worldwide lose their lives annually as a result of trauma and injury.2 Globally, among the age range of 15-44 years, the leading causes of fatal injury are traffic collisions, interpersonal violence, self harm, war, drowning, and exposure to fire. Unfortunately, people with lower economic backgrounds are at a higher risk of injury because they often live, work, travel, and go to school in unsafe environments.

National injury statistics in Australia, the Netherlands, New Zealand, Sweden and the USA indicate that for every death, at least 30 times as many people are treated in hospital emergency rooms.3 However, these numbers do not depict the true injury burden in low and middle income countries because of limited data availability in these regions. Low and middle income countries account for 90% of the total burden of injuries4 with the Southeast Asia and Western Pacific regions having the highest number of injury deaths worldwide.5 The effects of injuries and trauma on premature mortality and long-term disability are often over shadowed by the overwhelming burden of infectious disease and malnutrition in low and middle income countries. As a result, a low budget is allotted for injury prevention and safety promotion, and few injury prevention programmes are developed.

Pakistan is the seventh most populous country in the world, with a population of 164 million.6 In the first national injury survey in Pakistan, the yearly overall incidence of injury was found to be 41 injuries for every 1000 persons. The survey identified road traffic injuries (RTIs) as one of the major causal factors for injury. RTIs have a yearly incidence of 15 injuries for every 1000 persons.7 Children injured in RTIs tend to have uneducated mothers when compared to non-injured controls.8 Another major mechanism of injury in Pakistan is that of violence. Violence primarily affects wage earners and can include anything from intimate partner violence (IPV) to war. A study conducted to assess the magnitude of IPV in Pakistan indicated that 44% of women experience lifetime marital physical abuse.9 Reported risk factors for domestic violence against women include low educational status, low empowerment, poverty, the dowry system, and an addiction to alcohol in males. Violence related to war is also a significant problem. A study of blast injuries during the last five years in the city of Karachi reported 58 bomb blasts in this city alone, resulting in 689 injuries and 164 deaths.10

In order to accurately measure the burden of injuries in Pakistan, the problem must be assessed at a national level. A National Action Plan for Non-communicable Disease Prevention, Control and Health Promotion in Pakistan (NAP-NCD) is currently being developed. The plan incorporates the prevention of road traffic crashes (RTC)s, occupational injuries, falls, burns, and all other injuries into a national public health strategic plan.11

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* The standard definition of an ‘injury’ as used by WHO is: Injuries are caused by acute exposure to physical agents such as mechanical energy, heat, electricity, chemicals, or ionising radiation interacting with the body in amounts or at rates that exceed the threshold of human tolerance. In some cases (for example, drowning and frostbite), injuries result from the sudden lack of essential agents such as oxygen or heat.

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