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Editorial

Confronting the HIV/AIDS Epidemic in Khyber Pakhtunkhwa—A Critical Public Health Challenge

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Introduction

The HIV/AIDS epidemic is emerging as a significant public health concern in Khyber Pakhtunkhwa (KPK), Pakistan. The Family Care Centre at Lady Reading Hospital, Peshawar, has registered over 2,000 cases, highlighting the silent yet steady rise of the disease in the region. Affected individuals predominantly belong to high-risk groups, including truck drivers, hotel workers, migrant laborers in the UAE, transgender individuals, intravenous drug users (IVDUs), and thalassemia patients. Alarmingly, the spread of HIV is not confined to these groups; it extends to their families, with spouses and children often becoming victims of the virus, frequently without awareness.[1-3] If swift and decisive action is not taken, this growing epidemic will place an unsustainable burden on KPK's already fragile healthcare system.

Globally, the burden of HIV remains substantial, with approximately 38 million people living with the virus as of 2021 (UNAIDS, 2022). The epidemic disproportionately affects low- and middle-income countries, particularly in sub-Saharan Africa and South Asia. In Pakistan, the estimated number of people living with HIV was around 240,000 in 2022, reflecting an increase in prevalence, particularly among marginalized groups (Pakistan National AIDS Control Program, 2022). According to the UNAIDS Global Report (2023),[1] Pakistan ranks 5th in Asia in terms of HIV prevalence, with a national prevalence of approximately 0.1%. However, certain populations, such as IVDUs and transgender individuals, exhibit significantly higher prevalence rates, with estimates exceeding 30% in some urban centers (Khanani et al., 2019). This escalating trend necessitates urgent action to avert a larger public health crisis.[4]

Several socioeconomic and behavioral factors contribute to the spread of HIV in KPK. Long-distance truck drivers and hotel workers, often separated from their families for extended periods, frequently engage in unprotected sexual activity, significantly increasing their risk. Migrant laborers working in the UAE also face heightened vulnerability due to loneliness and isolation, leading to high-risk behaviors. Among transgender individuals and IVDUs, the situation is dire. These marginalized groups confront not only societal discrimination but also limited access to healthcare and preventive services, exacerbating their vulnerability. A particularly troubling aspect is the high rate of infection among thalassemia patients, who face the risk of HIV transmission through contaminated blood products. Despite improved blood screening protocols, gaps remain, and the consequences for patients reliant on transfusions are devastating. Furthermore, spouses and children of individuals living with HIV often face unknowingly increased exposure to the virus. Women frequently contract the infection from their partners and transmit it to their children during pregnancy or childbirth, particularly in the absence of preventive interventions such as antiretroviral therapy.

The pervasive stigma surrounding HIV in KPK represents a significant barrier to controlling the epidemic.[5] Fear of discrimination leads many individuals to conceal their diagnosis, delaying testing and treatment, and facilitating further transmission. The psychological toll of this stigma is profound, resulting in severe mental health challenges, including depression and anxiety, which can lead to non-compliance with medication and follow-up care.

Addressing the HIV epidemic in KPK requires a comprehensive and multi-sectoral public health

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response. First, the region needs a coordinated surveillance and case tracing system to identify high-risk individuals, ensuring they receive early diagnosis and treatment. Community outreach efforts must be intensified, particularly in rural areas and among migrant populations, where awareness and access to healthcare remain limited. Public education campaigns are critical for raising awareness about HIV transmission and reducing stigma. These initiatives must challenge deep-seated misconceptions, encouraging communities to view HIV not with fear and prejudice but with compassion and a commitment to prevention.

Equally important is the expansion of HIV prevention and treatment programs. Access to antiretroviral therapy (ART) must be scaled up to ensure that all individuals diagnosed with HIV receive appropriate care. Prevention strategies, such as harm reduction programs for IVDUs and safer sex education for high-risk groups, must be prioritized.[6] For pregnant women living with HIV, timely interventions can prevent vertical transmission of the virus, safeguarding both maternal and child health.[7]

The HIV epidemic in KPK is a complex and multifaceted challenge that demands immediate and sustained action. It requires not only medical intervention but also a societal transformation—an environment where individuals feel safe to seek care without fear of discrimination and where families and communities support those living with HIV. Without focused efforts, the virus will continue to spread, leading to unnecessary suffering and further burdening an already strained healthcare system. Now is the time to act, before the window of opportunity closes further.

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