

**The Price of Inaction – Emerging Epidemics in China,  
Eastern Europe and India: In Memoriam  
Lucille Teasdale Corti  
XVI International AIDS Conference  
August 15, 2006**

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[START RECORDING]

**LIVIANA CALZAVARA:** Ladies and gentlemen, may I ask people to move forward. This is an interactive session where all of your participation is much appreciated. So if you'd like to take a seat closer to the front, please do.

Good afternoon, ladies and gentlemen. This session is dedicated to the memory of a woman of action, Lucille Teasdale Corti. I would like to thank her daughter, Dominique Corti, who is in the audience somewhere. If she could stand up, Dominique, and at least wave. Thank Dominique for a number of reasons. One, for making this short little video available to us, but more importantly is that in her early childhood, she donated very much of her mother's time, as her mother dedicated her time to the hospital rather than spending hours and hours with Dominique.

Could we please roll the clip?

[VIDEO CLIP]

[APPLAUSE]

**LIVIANA CALZAVARA:** Lucille Teasdale Corti's motto is, I think a motto that many of this room also live, and her motto was, "If you are not part of the solution, then you are part of the problem." As you saw in this video, we are proud as Canadians of this Canadian woman who worked with her husband, Piero to transform the 30 bed hospital into the one of the

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biggest renowned hospitals in tropical Africa. After contracting HIV in the operating theatre, she still continued to work until her death on August 1, 1996. She never faltered. She never considered her illness as a hindrance, but rather as a simple professional risk, so this is in honor of Lucille Teasdale, but also to all others who have dedicated their lives to HIV and AIDS that are no longer with us today. Her contribution also continues in partnership with IDRC and another four Canadian organizations to fund the continuation of international research.

Good afternoon, my name is Liviana Calzavara. I am the scientific co-chair for the XVI International AIDS Conference. I welcome you to Toronto and to Canada.

Since the XIV International AIDS Conference in Durbin, the world had awakened to the enormity of HIV in Africa, and the devastation that it can cause both social, economic and human. I'm also acutely aware of the fact that as early as the mid-1980s, there were indicators of the tragedy that was about to happen and there were pleas that went ignored. This session focuses on regions and countries where HIV is just starting to take a foothold, or where it has already taken a foothold, but it may be time to turn its impact around so that we will not be talking about other countries in the way we are talking about the continent of Africa today. The purpose of this session is

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to raise the global awareness of the emerging epidemics in countries such as China, India and Eastern Europe, and how we can mount an effective response, government and civil society working together to minimize the negative impact.

We have three invited speakers. We have Dr. Wu, Dr. Pokrovsky, and Dr. Kumar. Each will be telling us a little bit about the epidemic in their countries. We will then have an opportunity to have the session moderated by Dr. Sheela Basrur, and to hear from you, the audience and get your comments and ideas to identify ways that we can move forward in scaling up our response to HIV in these countries and similar countries.

I would like to start the session by inviting Dr. Wu, who is Professor and Director of the Department of Behavioral Intervention of the National Center for AIDS Control and Prevention in Beijing, China to come to the podium to start his presentation. He will talk about HIV and AIDS in China, trends, lessons, key challenges and opportunities for scaling up response. Dr. Wu.

[APPLAUSE]

**ZUNYOU WU, M.D., PH.D:** Good afternoon. Thank you, Chairperson. I would like to share with you the challenges we faced and look at the program. You will see how the three countries have the same title. I do not like how they have the same title. I am mortified a little bit, called HIV/AIDS.

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China takes action and meets the challenge for scaling up. For those who are not familiar with China, I will give you some background about China.

China is the largest country in the population. It has 1.3 billion population. The infection rates overall, it is very low, .05-percent. If that prevalence triples, it is still very, very low and becomes .15-percent. That will increase 1.3 million HIV infections. If infection rates into 4-percent, that is still low, however, every single new infection will be 50 [misspelled?] too many. That is more than total global HIV infection today. You can see how important it is that China successfully control AIDS epidemic, its contribution to the global response.

This gives you a very brief history of the epidemic in China. The first case was reported in 1985. The first outbreak actually occurred in 1989 among injecting drug users in southwest China between China and the Myanmar border. Before 1995, HIV/AIDS in injecting drug users was only limited in the Yunnan Province. After 1995 it spread out the Yunnan Province. Also in 1995, an outbreak AIDS epidemic occurred among former plasma donors that was well covered by international media.

By 1998, all [inaudible] provinces reported AIDS epidemic. Last year, we jointly worked with WHO UNAIDS. We met an estimated total of 650,000 HIV infections. This slide

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gives you a geographic distribution, two provinces here the most, once in Yunnan Province. It is proven by injecting drug use. Another one is Henan Province; it is predominately by plasma donation.

These two slides, give you a different picture. If you look at the left one, that one is really misleading. It does not reflect the trends of the epidemic. It reflects how many people you can have been tested. The more people tested, the more HIV infection you will find, or you will report. The huge increase is because of testing campaigns run by the Chinese government.

The right side reflects the true epidemic. We have two epidemic occurrences. One has occurred in the middle of [inaudible]. That is driven by former plasma donations, contaminated plasma collection. The second occurrence it is slowly and steadily increasing, that is driven by injecting drug use, and sexual contact. For the first wave, we almost controlled it. There is no new infection. For the second wave, it is tough. It is a challenge for us.

This gives you the proportion of people infected with HIV. The majority is caused by injecting drug use. Plasma donation causes about 22-percent. For the sexual contact, about 9-percent. We have high proportion almost, 26-percent

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reported unknown. The majority of these are actually affected by sexual contact.

Last year we did a new estimation. In 2005, we had a total of about 70,000 new infections that occurred each year. If we calculate by day, each single day, we have 192 new infections. Among these new infections, almost 50-percent is caused by sexual contact. When I say sexual contact that means the infected individual transmitted to their spouses, sex, commercial sex activity, and men having sex with men. And another majority accounted for 48.6-percent that is driven injecting drug use. Mother to child transmission accounted for a small proportion, 1.6-percent.

China's government strongly committed to fight against HIV/AIDS. In 2004, state council set up an AIDS working committee, also each of the provinces set up its own provincial working committee. Government increased financial support dramatically, and also [inaudible] down to the leaders and the visitors, AIDS patient's targets, has workers work with AIDS patients. That happens a lot to reduce stigma. Last November, state council viewed the largest video conference in the world. We had a total of 100 of 1,000s high government officials attending that conference. [Inaudible] Wu Yi led a speech. In the speech she said, "Now what [inaudible] it is proved. Intervention works. Intervention including condom promotion,

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needle exchange, national maintenance program, peer education." She repeated, "This is government policy. No more argument. No more debate, just implement it." Also China's government has a strong support from policy and legislation.

In 2003, the government issued four-three-one care policy. Provided free testing, free ARV treatment programs. In early this year, the government issued AIDS regulation that identified the responsibility of each level of government, and also for control of the AIDS epidemic. It prohibits discrimination towards patients with HIV/AIDS. Early this year, China government issued a new five-year action plan. We also have infection disease sector by a separate law. All these laws support prevention measures.

In order to control the epidemic, to set up an infrastructure is very important. Over the past few years, the Chinese government set more than 70 center sites, more than 3,000 visiting sites, also set up 3,700 screening labs, and 57 confirmatory labs. Also we promote prevention for mother to child transmission in more than 270 countries.

One important strategy we did in the past two years, its testing campaign. Over here, you all know that. How HIV spread. HIV spreading silently, quietly, without awareness. People get infected and they do not know. People are infecting others and they do not know. One important strategy is to

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identify people who are infected and provide a service to them. That could reduce transmission. That could provide ARV treatment to infected people. In 2004 and 2005, China's government ran a testing campaign. I'll give you two examples to illustrate how that testing benefits campaign. In the Yunnan Province during 1987 to 2004, over 18 years the total identified 14,900 HIV infections. During six months of intensive testing campaigns, they identified 13,486 HIV infections.

In the Henan Province, in the three months of intensive testing campaigns among former plasma donors, they identified HIV infections six times than the past 10 years. More importantly, during that testing campaign, they identified 12,259 [inaudible], one of expert from USCDC. He said, "This is like seven [misspelled?] strategy." In order to improve better management China's government set up real time reporting systems. For example, we have one HIV infection testing positive in the southwest corner between China and Myanmar border, just take a few minutes that we can report by the website that we can look at in Beijing.

We re-adjust our strategy to respond to the AIDS epidemic. More important strategy, we're saying testing is an entry point for prevention and for treatment. The second strategy is scaling up prevention that includes condom

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promotion, including national maintenance programs and needle exchange program. Now today, condom promotion covers sex workers, in more than 1,800 countries. We have 101 national maintenance programs in operation. By September we will have 305 in operation. For the needle exchange program, now we have 92 in operation. In the next few years we will have more than 1,000 for the needle exchange program and also for the national maintenance program.

The set of strategies is scaling up free ARV treatment programs. We started ARV treatment programs in 2003. In the past two to three years, the number of people receiving ARVs increased dramatically, now we a total 26,000 in the treatment program. By the end of this year, we will achieve 30,000 AIDS patients receiving free ARVs. Also, we will treat 600 children with AIDS.

I want to illustrate to you the outcome of the national maintenance program. When we designed the national maintenance program, we only thought it controlled the AIDS epidemic, however, its much more benefit from a national maintenance program. It reduced injecting behavior. It improves the quality of life for drug users. It increased the job opportunity employment for drug users in the treatment program. It also reduced drug related crime. We compared people in the national maintenance program, the incident rate among injecting

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drug users is 0-percent, however, for people who are not in the treatment program, it is a 5-percent incident rate for HIV infection.

We have planned and budgeted for the national maintenance program, 305 by the end of December. However, the Vice Minister of Public Security said, "No, you cannot do that. You must open 305 clinics by the end of September." By moving the 204 national clinics 90 days ahead, that will prevent 216 new infections, that will reduce 1,100 kilogram heroin trade. That will reduce US \$50 million heroin trade.

We coordinated and we agreed upon the principle for the harm reduction. We are, by the pilot test, it was approved. The national maintenance program reduced drug use, reduced drug related crime, reduced drug related AIDS epidemic. It improves quality of life for drug users that is consistent with China's government policy developing a normalized [misspelled?] society. It helps [inaudible] the heroin market. It reduces the new drug users; therefore, the national maintenance program should be used as much as possible. For the needle exchange program it addresses only injecting related AIDS epidemic, but not for drug use, not for drug related crime that will only be used the places national maintenance will not be available.

Now I'm going to talk about challenges we faced. One of the big challenges is how to work with men having sex with

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men. That's a big challenge. It's a headache for us, because this group, it's very dynamic. They have many different communities. Each community cannot get along with each other. Each community wanted to become the top country leaders, so we try very hard to work with different communities among men having sex with men.

Another challenge that we faced, is men to men HIV infected people. If we look at the red color, there is a total of people infected, but not all of them tested to know their status. Only a small proportion have been tested. Among people who have been tested, only a small proportion, they keep contact with how system receive, how service receive ARV treatment. If we do not increase this proportion, we are not able to win the battle.

If we look at a different group, for the former plasma donors, the majority have already been tested. Among treatment programs, almost 90-percent are now in the treatment program. For injecting drug users, a considerable proportion have already been tested, however, a huge proportion has not participated in testing. If we look at sexual transmission, the majority infected by sexual contact has not been tested.

In terms of social management, that is a headache. Let me give you an example, in one city, we have reported, 1,674 infected individuals, only about 60 infected people have

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contacted our system so they could receive service. Almost 900, they have no detailed contact information, the last follow up. The majority cannot receive follow up service. That's a big challenge we faced.

We try to meet that challenge; we want to achieve the no gap [inaudible] from testing to follow up of city to monitoring to ARV treatment, to monitoring drug resistance, to keep that as one low [inaudible]. We set our goal by 2010; China will limit HIV, no more than 1.5 million. We will work hard. We will scale up response to achieve that goal. To achieve that goal, we need US support. We need your [inaudible] and thank you very much.

[APPLAUSE]

**LIVIANA CALZAVARA:** Thank you, Dr. Wu. That was very informative and very impressive as to how quickly China has scaled up. We can leave this for our discussion later on. I would like to introduce our second speaker, Dr. Vadim Pokrovsky, who is an academician, and Head of the Russian Federal AIDS Center in Moscow, Russia. Dr. Pokrovsky will talk about the HIV epidemic in Russia, lessons learned, key challenges and opportunities for a scaling up response. Dr. Pokrovsky.

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**VADIM POKROVSKY:** I'm working on HIV infection for more than 20 years, so I would like to start with some history of the epidemic in Russia.

The first HIV case in Russia was registered in 1987, but in the nearest 10 years there was no evidence of the epidemic in Russia, and only in the end of '90s, the high-scale HIV epidemic started. Only in the year 2001, 80,000 of new cases were reported, and 90-percent of them were drug users. It means that there was a period of concentrated epidemic in Russia, and a very, very pessimistic prognosis was done in this period. For instance, US National Intelligence Council wrote that this situation is so bad that maybe up to eight million Russians will be infected in the year 2010. It means that from this prognosis that about 10-percent of Russians would be infected.

I can't say this prognosis was very scientific, but it was very useful from the position of advocacy, because in this period, this period was a period of reconstruction and revolution in Russia. There was much more attention to economic and political programs than for HIV infection, but of course, we were trying to produce our own prognosis. For instance, my prognosis for the future epidemic in Russia was on the predictions that there will be a situation of HIV infection in everyday population. And because we have from other sources

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we know that in many countries 50-percent is a regular level of situation, in everyday drug population. But I was afraid that there will be a second wave of the epidemic, because of the sexual transmission, only in the case that only one sexual partner would be infected from an infected drug user. It will be an additional two million of infections in Russia.

So we were waiting for two waves of HIV incidents. First one was at the level of the beginning of the century, and the second, five years later, but of course, we thought that it will not be end of the epidemic. After these two outbreaks, there will be a long period of new infections, so the prognosis was that there will be two waves of epidemics, first in the drug users, second in sexual transmission [inaudible].

Of course, it is lower than the prognosis of, as they call it, from this prognosis the total number of life positives, Russia will reach 2.5 million in the year 2020. If there will be no ARV treatment, at least 1.2 million may die before the year 2020, but it was a prognosis and what is real present situation in Russia. So after the year 2001 the decrease in the number of new registered cases started. But a cumulative number of new cases were increasing. Of course, the situation when the number of new cases is decreasing is not very good for advocacy, because somebody can say that it is the finish of the epidemic. It was a very difficult task to claim

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that there is a new situation now. What is very important is the number of deaths is still very low, and it means that we have some chance to prevent deaths of millions of people.

Other data shows that by incidents, it is already decreasing. The prevalence was growing fast. What is interesting is that it was a real decrease in the incidents, because the total number of those who are tested was the same, so it looked like a real decrease in the epidemic. Of course, there it was not the same situation in different regions of Russia, but it was very important that mainly industrials, most industrial regions were affected. This is a very serious situation, but some regions are still free of HIV infections.

So the main figures of HIV infection at the present moment are here on this table, you can see that approximately one million of Russians are, as it is estimated are HIV-positive. At the moment the prevalence rate among the adult population is near one-percent, but the number of those who died with HIV and AIDS is still very low.

So the first conclusion is that in spite of some good hopes, the HIV epidemic in Russia is in progress, and the number of those living with HIV is increasing. Estimated prevalence in the adult population is approximately one-percent, but the number of AIDS deaths is still very small, and we now still have the real disability to save a million lives

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using ARV treatment. But of course, it is very interesting from a scientific view and practical is the situation of HIV infected civilization of epidemic in everyday population or not.

So routine testing demonstrated that the real decrease in incidents [inaudible]. But scientific [misspelled?] studies show that there are many great differences in different regions from 1-percent prevalence in HIV drug users' population to 65-percent, so maybe it is a situation in some regions, and there is a possibility of new epidemics in other regions. So of course, there are no signs of situation in general, everyday population in Russia. Probably only in some regions, and of course, still we have risk of further transmission of HIV in everyday new population.

Is epidemic still concentrating, or maybe it is possible that there are signs of generalization of the epidemic, I mean, what about sexual transmission. First and very interesting group is MSM [misspelled?] previous level of incidents among tested population was very low, but in the last five years a significant increase, in spite of low testing of this community. So another conclusion saw that maybe Russian MSM [misspelled?] are now on an increase of HIV transmission, and maybe, maybe, it is a forgotten group in the sense of prevention and related activity.

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What about sexual transmission, regularly we use data from pregnant women for testing, but you see here that there is no significant increase in incidents in this group. If we look at the main risk factors, we can see that it is really increasing the number of those whose main risk factor was heterosexual contact. From the data for sex of gender data, we can see that the number and proportion of family and women who are infected is growing.

In other data, about sexual transmission we can get from testing of sex workers, but still it is very difficult to make any conclusion because many of them are drug users, and maybe this data on sexual transmission are contaminated that we are using.

So the conclusion for it is that there is much evidence of increasing heterosexual transmission in Russia, however, there is not enough data to confirm that the second sexual wave of infection has already started. So we have some time to work and to prevent this increase. We can look at this prognosis and we said that our present epidemiological situation is something between these two [inaudible]. [Inaudible] this is such a difference, because of course there is about a two-year period from transmission of HIV infection and diagnostic delay from infection to information.

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Of course, it is necessary to do something, unfortunately for many years, the activity of the Russian government was not very serious, and the period from 2001 and 2005 was a five-year period of intensive advocacy programs. Many agencies, minister of health, state [inaudible], Russian International, non-government organizations, UN Society and many, many other individuals and programs were working on advocacy of the fight against AIDS in Russia. Also, our Canadian friends are also participating very successfully in this procedure, and as a result annual funds for HIV programs in Russia increasing more than 10 times this year, about \$200 million, it is now the resources we have to struggle against HIV infection. It is the money of the federal Russian government and bank loans. It is the money of two big grants from Global Fund. There are many programs from international and the national organizations, so we have real chance now to organize an effective fight against HIV infection.

Unfortunately, I guess maybe it is the last opportunity to prevent for the spread of HIV infection and to prevent the generalization of the epidemic in Russia. I hope that everybody will participate in prevention of HIV, not only in their own country, but also all over the world. Thank you for your attention.

[APPLAUSE]

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**LIVIANA CALZAVARA:** Thank you, Dr. Pokrovsky. We're very happy to see that finally some financial resources are being put in from the days when we first started working together. Our next speaker is Dr. Rajesh Kumar who is Professor and Head of the School of Public Health and post-graduate Institute of Medical Education and Research in India, and we look forward to your presentation.

**RAJESH KUMAR:** Okay. Thank you Dr. Calzavara. Friends, before I take up my talk, I would like to express my gratitude to the organizers of this conference who have given me this opportunity to share some of my views with you in this very important session. This session is important because this is being held in memory of a very extraordinary doctor, Dr. Lucille Teasdale, who chose to work in a very difficult situation among people who needed her most in Africa, a continent which had been and continues to be in the grip of HIV. Although all these years, a lot of work has been done in Africa and we do see that in some of the countries HIV is on retreat, but all our situations continue to be serious in Africa. All these years we have seen a slow gradual spread of HIV in Asia, and India is no exception.

First report of HIV in India came from Chennai, one year after it was reported in China, 1986 and since then the virus has spread gradually. To begin with, among commercial

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sex workers in Mumbai, and later on it spread to injecting drug users in the northeastern part of the country, and then it spread even to the general population. By 1998, the southern part of the country, the four states, we had well developed HIV epidemic among the general population. The situation continues to be the same, more and more people are being infected by this virus over the years.

We have seen now that initially the spread had been quite rapid, but since 2002, particularly 2003, there has been a plateau and we are not adding too many people with HIV, although there is a lot of discussion about these numbers. National AIDS Control Organization of India estimates that we have about 5.1 million people infected with this virus in the reproductive age group. UNAIDS has given a little higher number, 5.7 million which includes children and people above the reproductive age group. Nevertheless, there has been an increase, and instead of entering into this debate over numbers, I think we should concentrate more on the trends. This information which comes from HIV sentinel surveillance sites, which are spread throughout the country among various groups, pregnant women, STI [inaudible], injecting drug users, commercial sex workers, MSM, these sites have increased to about 710 in 2005, and they will increase further this year to be more than 1,000. These sites test more than 300,000 men and

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women. This is, perhaps, the largest number being tested in the sentinel sites anywhere in the world. This information, I think, should be utilized to track this epidemic rather than estimating these numbers every year, although numbers are important for planning purposes, so therefore, the big question is what are the trends.

Incidents is the best major for estimating the force of infection, or new infections which occurring every year, but we do not have any cheap and valid methods so far, which can be applied in a large area. Next best that we have is if we can estimate prevalence in young adults that would be assumed to be a proxy for incidents. This is what we did for the year 2000 and 2004. We analyzed data of pregnant women in 15 to 24 years, and men who visit STI [misspelled?] clinic, 20 to 29 years. We had lots of demographic details of these men and women in the data set, which is accumulated over the years by National AIDS Control Organization.

We analyze this dividing the country epidemiologically into two parts, the southern states, where we have prevalence [misspelled?] problems of more than 1-percent, and the northern states which showed low prevalence among pregnant women. The northeast, the epidemic is largely driven by injecting drug use, so we left that out. What we find that in those who attend STI clinics, there had been a decline in the prevalence

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of HIV from 20.9 [misspelled?] to 20.3 in the southern states. This is a significant decline, whereas in the northern states, the prevalence continues to be more or less the same. There are no significant increases or no declines in the northern states.

Similarly, in the pregnant women, we find a consistent decline from 1.7-percent to 1.1-percent. This is 34-percent of related decline. The north continues to have low prevalence among pregnant women, and there has not been any increase or decrease in the prevalence there.

Now we also analyzed that these declines, or why these decline, what is responsible for this. So in an analysis in districts where we had targeted interventions, 58 districts, and 25 districts where there was no targeted intervention among sex workers, these belong to the southern Indian states, we find districts where there was targeted intervention, there is a very small consistent decline in HIV.

Sexual behaviors differ a lot between men and women, about 10-percent of men in India have multi partner sex, where as in women it is very low, two-percent. This is data generated by the National AIDS Control Organization in 2001 and 2002. This was all in the level survey, and there are significant differences between north and south. Multi partner sex among men, particularly, 14-percent in the south, and 8-

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percent in the north, but there was not much of a difference in the women. So two-percent women had multi partner sex, and 14-percent men. So this gap in between is made up by commercial sex which men indulge in.

To sum up, HIV trends in India we find there is some decline in southern India, but there is no change in the north, and this change, we think is because of changes in husbands use of female sex workers, maybe less of them use condoms. This is also consistent with the rise in the peer education programs, which has happened in the last five to seven years. These interventions have been taken up all over the country. We have several surveys done in different parts of the country which show condom use among female sex workers last climbed consistently show very use, even in all India survey done by NACO, we find quite high use, but when we see the last three months the figures are not as high as for the last climb, which means there is condom use, but not consistent condom use. Nevertheless, in the last proportion of commercial sex workers, condoms are being used there.

So what are the lessons? That simple, routine local surveillance has given us a lot of information, and we can track epidemic using this information. We find that in India there is no uniform epidemic, but there are several epidemics in different populations and sub-populations, and largely this

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is driven by sex, but in certain parts it is injecting drug use also. We also learned that targeted interventions are successful, particularly we saw the declines in the south, therefore we get this feeling that prevention works. We need to do it more and more in more areas.

Now is India on the right track? This is a big question. Well, there are northern [misspelled?] states have low prevalence but these are averages, and there are certain areas where we have high prevalence, and these are a matter of concern, because many people continue to say that northern [misspelled?] low prevalence so resources should go to the [inaudible] India, because their prevalence is higher. Northeast there is [inaudible] epidemic which is gradually spreading further to urban centers and metropolitan centers in the country. The ART programs, which are being initiated now, they are likely to cost more, and therefore, we need to shift many expenditures in the healthcare system to ART. These are the issues and this expansion of ART is a big challenge. Right now only 50 clinics cover about 20,000 population. We expect in the near future, the number will rise. The clinics will be outnumbered and the people on ARV will be about 100,000. Similarly STI services are available at the district level, and the need to be taken to sub district level. We need to integrate the care and service programs with other programs

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like MCH [misspelled?] and TB services. The key challenges in our country, which is very large and very diverse, the monitoring the program is very difficult and that remains a big challenge how we monitor the program and use evidence to make changes from time to time.

Other key challenges about sex workers and injecting drug use, the current mapping exercises say that we have about four million such people, but it seems it is quite an underestimation. We need a remapping exercise to better know the size and the locations of where these people are, and cover these populations, 100-percent coverage by targeted intervention. That remains a big challenge.

Lastly, the challenge is how to enhance our surveillance and use surveillance to do analysis which informs programs for better focus and better targeting. We need to link this biological surveillance of HIV and STI with behavioral surveillance. We also need to set up a vial repository where all the positive specimens and negative can be stored. Right now, after testing everything is thrown out, so that we can use this information later on when better techniques are available to track the epidemic using newer technologies. HIV incidents, now there are some tests, promising tests which are coming up that. We need to find out if those can be utilized to track this epidemic, risk

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stratification by using STI markers, and training of the surveillance of users in every district of the country. We have more than 600 districts and each district is about two million in population, so training local officers who can use this information to better target their programs.

Other gaps in India had been information about AIDS related mortality. We do have information systems which can give us mortality and further statistics, but we do not have systems which give us more specific mortality. WHO estimates that about 6.2-percent of the deaths in the reproductive AIDS group, that is 15 to 59, that is caused by or is related to AIDS, whereas now we are working with [inaudible] of India and Center for Global Health Research from Toronto University. Some preliminary estimates have been worked out. It shows that AIDS is only one-percent, is cause of proportion of deaths, but these are matters which use information to do interviews from the households, and that information is read by the physicians to categorize the causes of deaths. If you add lymphomas and fevers, and all tuberculosis related deaths, then the figure goes to 4.6-percent, which is far below than what has been estimated by WHO using econometric in their matters [misspelled?].

So we need to track mortality also in this country, and we have a lot of projections done for India, and some

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projections suggested that the rise will be very rapid. We have UNAIDS projections, upper limit and lower limit of UNAIDS. We are perhaps going, the epidemic is going, according to the UNAIDS lower estimate, and we have also estimates that we have done ourselves, and it seems that the epidemic is increasing slowly. If it keeps growing, particularly in the north, then we are going to add 20 to 40 million cases, new cases in the next 20 years. So that is a big challenge to us.

Opportunities are that we have now a good organizational structure both in the public sector, private sector, NGO sector, and we have now decentralized focus and government is committed to increasing finances for the health programs from [inaudible] percent to three-percent. And there is a lot of support among the international organizations for supporting India in its efforts.

Lastly, I would say that although NACO has designed a good program, and they have all kinds of strategies, which are there. This year they are launching a new program, NSCP3, but what I would say is that we need to focus on surveillance, because that gives us evidence based information for programs. We need to carry on our prevention programs with more vigor so that we do not lose this opportunity. Right now our prevalence rates are quite low, and if we do our prevention programs right

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at this stage, then we can halt HIV in its tracks in India.

Thank you very much.

[APPLAUSE]

**LIVIANA CALZAVARA:** Thank you, Dr. Kumar. It is great to see you are feeling optimistic about India's future. It is now my pleasure to turn the session to Dr. Shelia Basrur, who is the Chief Medical Officer of Health for the Province of Ontario, and also serves as the Assistant Deputy Minister in the Ministry of Health and Long-term Care, and in the Ministry and Health Promotion. Dr. Basrur served as the local Medical Officer of Health in the city of Toronto for over 17 years before joining the provincial government in 2004, and she is quite renowned for her actions and interactions around SARS, which I know she doesn't want me to mention. Dr. Basrur holds a Masters Degree in Community Health and Epidemiology and a Fellowship in Community Medicine with the Royal College of Physicians and Surgeons of Canada. Thank you, Dr. Basrur for agreeing to moderate the session.

**SHEELA BASRUR:** Thank you. We've heard from three very interesting speakers about the emerging epidemic in China, Russia and India, and while I make some introductory remarks for the question and answer session, I'll ask the members of the audience who do wish to make a comment or a question to please come up to the microphones. I understand that

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microphone four is the preferred one by the audio visual staff. Can you just point out which one is microphone number four, please? Number three, okay. So mike three, thanks, is right in front of me. Right under the spotlight, and I will paraphrase the question back to the audience so if you don't get it on the first pass because of volume or complexity perhaps, I'll do my best to rephrase it.

While our first questioners are coming forward, I'll just note from my observations that all three presenters really zeroed in on the sub populations that are at highest risk for the epidemic, and demonstrated the tremendous importance of information as a very powerful tool in measuring the size of the problem, and measuring the effectiveness of the interventions. Of course, while information is key, information also can be a supreme challenge to collect in a high quality and consistent manner; but nonetheless, I think all three presenters have given us much food for thought. So we have a line up now at mike three. Number one, please go ahead.

**MALE SPEAKER 1:** Thank you. My question is to Dr. Kumar. The question is that given that it is an Indian pharmaceutical company that is providing a significant number of antiretrovirals to most of the developing world, Sipla; I was wondering what you think the biggest bottlenecks are in

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preventing Indians from actually getting access to antiretrovirals?

**RAJESH KUMAR:** I think the problem is infrastructure. We have to do have infrastructure everywhere, and that means that the training of the doctors. That means setting up the labs, and this is being done. As I mentioned that within this year, the people who will be receiving antiretroviral therapy, the number is going to be three times then what it is now and the number of centers are also being increased. So it is – now the government has taken it up and now the program will be implemented. So there are not major difficulties, but it is, in a large country like India, you have to prepare the training, the labs and the like.

**SHEELA BASRUR:** Okay, thank you very much.

**FEMALE SPEAKER 1:** I have a question for Dr. Wu. Plasma donation was an important problem in China, although when we see the statistics of the Chinese epidemic, this group practically doesn't appear. I think it is very important because it is not only a phenomenon of China, it happened in Mexico in the '80s. It happened in India in the '90s, in the early '90s, even mid-'90s in China. Why doesn't it appear in the international statistics of HIV/AIDS, these risk factors for HIV/AIDS [inaudible]?

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**SHEELA BASRUR:** Can you please repeat what the exact risk factor is? I didn't catch it.

**FEMALE SPEAKER 1:** Paid plasma donation.

**SHEELA BASRUR:** Paid plasma donation. Thank you very much.

**ZUNYOU WU, M.D., PH.D:** I didn't get the question. What question is she asking? So let me just try to clarify. I understand you have a question. So the plasma donation caused an epidemic in other countries and why it is happening in China? Is that?

**FEMALE SPEAKER 1:** Nothing to do with that. My question – when you see the statistics of UNAIDS, you see the statistics of how people acquire HIV/AIDS; it never appears plasma donation, although it happened to be an important group in China. I'm repeating, it happened in India and in Mexico too. Why it doesn't appear – these risk factors. Why is it not recognized?

**SHEELA BASRUR:** So the question is why has plasma donation not appeared as a risk factor from an international standpoint, particularly in the presentation made by China?

**FEMALE SPEAKER 1:** Yes.

**SHEELA BASRUR:** Thank you.

**FEMALE SPEAKER 1:** Plasma paid donation.

**SHEELA BASRUR:** Paid donation of plasma.

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**ZUNYOU WU, M.D., PH.D:** Okay, I think at that time, our strategy it tried to block HIV from our side from the other country get into China. So if we look at the earlier stated policies, we have quarantined foreigners getting into China in the border control, you have been tested at that time. So we think HIV/AIDS is not a China issue, its other side issue. We try to block from that end. So when we set up the sentinel surveillance programs, it's many in the big cities, like Beijing, Shanghai, Kwan do. Suddenly, we find the epidemic occurred in the southwest corner between Myanmar and China we were so surprised. So at that time we do not recognize that plasma donation is a risk factor. By the end of 1994 and early 1995, we do note the problem, then the China government take immediate action, and close down all the plasma collection centers. They take one year to adjust and re-regulate it. Also, China's government issued a law called, blood sentinel [misspelled?]. That law created a history record that took one year to produce a law. That has never happened in the Chinese history. So I think that is a big lesson we learned.

**SHEELA BASRUR:** Okay, thank you very much. Next question, please.

**TREVOR HART [misspelled?]:** Hi, Trevor Hart from York University. This is a question for Dr. Kumar. I've seen this before in some of the Indian data. It seems that in the south,

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the epidemic is much more pronounced except for in the state of Karoli. I'm just wondering if you could speak to that, and if there are any lessons that India has learned from the experience of Karoli, that might be useful for India, as well as for other countries.

**RAJESH KUMAR:** Yes, I think you are right. Everything is so nice in Karoli. You see infant mortality rate. It is better than many of the developed countries. It is infant mortality rate is 16 per 1,000 live births, unbelievably, it is so low. Even all the statistics are so good in Karoli, and the reason is the population's education level is quite high in Karoli, and there has been a tradition of social equity in Karoli. There are so many factors in Karoli so that it stands out very clearly. But in Karoli, although a lot of people migrate to other countries, there is a lot of migration outside Karoli, but perhaps better care, perhaps being educated they use safe sex. It's not that in Karoli sex work is not there. It's there, but perhaps the condom use rate is higher in that state, but you are right, we need to study it further and try to gather more information and use that in the rest of the country.

**SHEELA BASRUR:** Thank you. Next question, please.

**AMI BISHOP [misspelled?]:** My name is Ami Bishop. This is for Dr. Pokrovsky. I was very interested in your

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projections of the epidemic in Russia, and as you mentioned there somewhat more optimistic than previous projections. I'm sure that everybody here hopes very much that is the true direction. I wonder if you could comment though, a little bit more on the reason for your relative optimism. Particularly given the fact, for example, that substitution therapy remains illegal in Russia, that other harm reduction methods, particularly needle exchange and other activities are frequently interrupted or prevented from the full benefit because of police abuse and interference, the somewhat hostile environment at times from the local NGO, and even international NGO at times, community and also the TB situation in Russia, and in prisons. I understood that your talk wasn't intended to address all of those points in detail, but just as a broader picture if you could explain a bit more about the reasons for your optimism. Thank you.

**VADIM POKROVSKY:** I am not optimistic at all because, 1.5 million deaths for Russia is much more than one million deaths for India, because Russia is a situation of the population now. Of course, if there will be a lower number of cases, it will be much better cases of HIV infection. It would be much better for Russia. So, I'm not optimistic, I try to be just more correct as possible, without any political interest from my side. Thank you.

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**SHEELA BASRUR:** Thank you very much. Next speaker,  
please.

**FEMALE SPEAKER 2:** Is it okay if I have a question for  
each of the panelists? Is that okay? Can I just go one, two,  
three?

**SHEELA BASRUR:** Start with one and we'll see.

**FEMALE SPEAKER 2:** All right, well the first question  
is to Mr. Wu. It was very interesting to hear about the harm  
reduction programs that China is implementing. I was just  
wondering, it's a very brief question so I'm hoping I'll get a  
second one. The programs that you have on treatment, and re-  
socialization of injecting drug users, particularly in urban  
settings, on what basis, voluntary, I'm hoping it's voluntary,  
and if so how do you engage injecting drug users into these  
programs. And how did you, if there was a conflict with the  
legal base pertaining to drug possession and use, how was that  
resolved in China?

**SHEELA BASRUR:** So the question was how injection drug  
users get engaged in program development and implementation,  
particularly if there are conflicts with the law.

**ZUNYOU WU, M.D., PH.D:** At an early stage, and we are  
very careful – in the first year of 2004, we only set up eight  
national maintenance programs where we set a very strict  
criteria to be qualified to participate in the national

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maintenance program. During that pilot program which gained a tremendous demand, and one of the two criteria where we were criticized people must get at least twice in the detoxification center or in the compository [misspelled?] treatment center, they can have access to the national maintenance program. A lot of drug users who have never been in the detoxification center, and also we require people must be a local resident to have the compliance rate. We get tremendous complaints, so this year we revised the criteria, and as long as drug users who are really addicted to drug use, they are qualified to get in, as long as they live in the places for more than six months, they are qualified. So we lowered the criteria to get in. Actually, they have a huge demand to participate in the national maintenance program, because it tremendously reduces the burden for money. If they use heroin each day, it takes about 300 to 500 Chinese Yuan. If they participate in treatment program for national maintenance, it only costs no more than 10 China Yuan, that is \$1.50. So it is tremendously reduces the economic burden for drug use, or also improves the quality of life. That's voluntary, it's not compulsory for participation. It is a lot against the law. The law, I just said earlier this year, we have a special law for AIDS. In that law, it specifically says community based national maintenance is effective program for controlled epidemic among

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injecting drug users. The program is not run by house department. It is jointly by the house, police officer and food and drug administration, three ministries.

**FEMALE SPEAKER 2:** Thank you.

**SHEELA BASRUR:** Thank you so much. I think in the interests of the remaining questioners, I'll encourage you to come up to the front if you like, and speak to the speakers afterwards. Next question, please.

**PAM:** Hi, my name is Pam. I am here on behalf of TakingITGlobal and the Toronto Youth Force. I have a question for Dr. Kumar. Dr. Kumar, I noticed in your key challenges, you did not necessarily address the issue of gender and equality. I know that probably was because it would be a big thing to try and address within one slide, but I was wondering if you could tell me a little bit about your knowledge of the primary prevention programs that are in place, rather than the secondary prevention programs. Rather than just targeting high risk or sub population groups. For women to be able to negotiate their own faith, sex behavior. What kind of work are people in India doing to try and change that social norm that it is okay for them to ask for their husbands to wear condoms, or is it okay for them to go get tested, or is it okay for that, do you know what I mean? Am I making sense?

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**SHEELA BASRUR:** So universal programs that address the general population and both reduce stigma and empower women.

Dr. Kumar?

**RAJESH KUMAR:** Yes, I agree with you. We have to protect women from their husbands, and the husbands largely get it when they visit sex workers. So to protect women from getting HIV is that we have to protect men to get it from the sex workers. The targeting prevention programs are right now focused on sex workers to prevent transmission to the husband. That in turn protects the women, but I agree with you that gender is a larger issue, and empowerment of women is an important component and there are other programs in the country like social welfare department who are taking it up in a big way, in a more general way, so that women also have their voice, and they can also assert. But right now negotiations or communication between husband and wife is not as it should be.

**PAM:** Okay, thank you.

**SHEELA BASRUR:** Thank you. Next question.

**MELE WONG [misspelled?]:** Hi, my name is Mele Wong [misspelled]. I'm Professor of Universal Science in Philadelphia, United States, and I have a question for all the panelists. Do you envision your countries to come out with a more comprehensive plan to access the most vulnerable populations? Do you envision your country that generates legal

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policy and rights framework to ensure their access to care among other things? I think what I have specifically in mind, is global public relations, like sex workers. Thank you.

**SHEELA BASRUR:** So the question is whether any of the speakers have legislation or policies that enshrine the rights of marginalized populations to care and treatment. Dr. Wu, go first.

**ZUNYOU WU, M.D., PH.D:** Yes, let me respond first. I think from China's government, all the policies and the laws guarantee the effective program to support prevention activity and treatment programs for marginalized growth. That includes injecting drug users, sex workers, men having sex with men, and migrants. What we do first is challenge, because people move around, and as I have just said, the challenge that we face, the one to work with is men having sex with men as a community. Another challenge that we face is migration. We have a lot of migrants that move from city to city. So that is a big challenge that we face. We do not have a policy barrier, but we do have a challenge. Thank you.

**VADIM POKROVSKY:** In Russia we understand and understood the problem of growing number of population access to treatment. That is why we ask Global Fund to provide money, especially for treatment of vulnerable population and also

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another project is mainly on prevention activities among a number of population. So we are working hard in this field.

**RAJESH KUMAR:** In India there is a debate going on how to reform the law, so as to protect the rights of the vulnerable populations. There are three legislations which have been drafted and they are being discussed. One is violence against women, and how women can access legal rights. Second is men having sex with men. Third is for commercial sex workers and how to intervene in or stop trafficking without harming or without harming the women. All these three find a lot of work is already going on in the legal spheres.

**SHEELA BASRUR:** Thank you. I think in the interest of time we will probably have an opportunity only for another two questioners. I'm sorry to say. There are many disappointed folks, but again, do feel free to come to the front and try to grab the speakers of interest at the end. Yes, please.

**NICOLE SIMMONS:** Yes, Nicole Simmons from Johns Hopkins University. This is a question for all three panelists. All three of your countries have major IDU epidemics, but I've only heard from Dr. Wu about how that will be addressed both in terms of HIV prevention and in terms of antiretroviral treatment for injecting drug users. I guess I'd like to start addressing this question to Dr. Pokrovsky.

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**VADIM POKROVSKY:** We have many programs of harm reduction in drug users. There is a question about methadone and it is under discussion now, and as I told you previously, that we have special money for after treatment for drug users from Global Fund grant.

**RAJESH KUMAR:** In India there is now an official policy for harm reduction and needle and syringe exchange programs. They have begun in the country in various centers.

**SHEELA BASRUR:** Okay, last question.

**BARBARA PILLSBURY:** Thank you, Dr. Wu for your good overview of the situation in China. My name is Barbara Pillsbury, and my question concerns the minority populations in China. The recent data show that over 1/3 of the HIV infections are in the minority populations, even though these minority populations are not even 10-percent of the total population of China. So given that China has traditionally approached HIV as a medical phenomenon, are there efforts, innovative efforts of any sort that are being made to work with the minority populations or with the organizations in Beijing or in the provinces that represent the minority populations?

**ZUNYOU WU, M.D., PH.D:** Thank you for that question, and if we would look at the epidemic in China, it is diverse. For the epidemic among plasma donation epidemic, the majority are high as in the globe [misspelled?]. If we look at the

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epidemic in the region of [inaudible], if we look at early stage, majority, more than 90-percent are minorities. In the central government we set up the state council working committee and commission for minorities is in that working committee. In the program in the [inaudible] we do have a specific program targeting minorities. That is one of priority, particularly for [inaudible] province. So we will continue working on that. Thank you.

**BARBARA PILLSBURY:** Thank you.

**SHEELA BASRUR:** Thank you to all of our questioners, both fulfilled and those who are still waiting, and in a particular way, thank you so much to all three speakers, Dr. Wu, Dr. Pokrovsky, and Dr. Kumar for sharing with us the most recent information from your three countries, very, very insightful questions and responses. I'm sure you'll agree. Please join me in thanking our speakers. [APPLAUSE]

Thanks also to Dr. Calzavara for sharing her very, very busy time with us today. Best wishes to you all for the rest of the conference.

[END RECORDING]

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