

**The Second Wave of the HIV/AIDS Pandemic:
China, Ethiopia, India, Nigeria, Russia:
Treatment in Second Wave States
June 7, 2005**

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ALAN MOORE: Thank you, I'm Alan Moore. I'm with CSIS and with the Global Health Council. I co-chair the committee on PEPFAR for the AIDS Task Force here at CSIS. I'm just going to introduce your moderator; but it seemed only appropriate that she be introduced.

When the President's program was initiated, it was temporary - it is temporary, legally; and it has some extraordinary challenges, some very aggressive targets, numerical targets, in treatment and in prevention. This session is on treatment, of course.

For the year 2008, the challenge was to go out into the government and beg, borrow, and steal the best people they can find; and with Michele Moloney-Kitts, they had a ten-strike. Michele has had 20 years in international health with the State Department. She had another career before that. She was a nurse-midwife who delivered more than a thousand babies [laughter.] She has worked and lived in various parts of Africa. She's worked in the AIDS field at the State Department for 20 years; and now she is the Chief of the Program Division at the Global AIDS Coordinator's Office. She will introduce the panel. Michele, welcome.

MICHELE MOLONEY-KITTS: Thank you. Thank you very much. It gives me great pleasure to be here today moderating

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the panel; and the subject of this panel is "Treatment in Second Wave States." And, following on our colleagues who talked about prevention, I can't resist but to make a comment that I don't think it should be either prevention or treatment, but it should be both. And, one of the most interesting things is the interface between the two and how we can really build off both programs mutually. But, we're very fortunate to have with us today a panel of outstanding speakers who've made and are making huge commitments to the fight against AIDS.

Our first speaker today is going to be Vice Minister of Health Wang, originally from Kai Fong Hanan [misspelled?] He graduated Thansi [misspelled?] Medical College in 1969; and he also had graduate work at the Chinese Academy of Medical Sciences as well as a residency at Mt. Sinai School of Medicine of the City University of New York. He has served as a physician in Epidemiology Department; and, also, he worked in the Thansi Provincial Health Bureau. He was the vice director there, and then became the director. In December of 1995, he became the vice minister of the Ministry of Health and joined the ministry's leading party group as Deputy Secretary to the group. Vice minister Wang is the director of the Office of the State Council of AIDS Prevention and Care Working Committee; and he's published

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numerous articles in journals on cancer, tetanus, epidemiology, and medical personal management. So with that, I'd like to hand the floor over to the vice minister. Thank you.

WANG LONGDE: Good Morning Ladies and Gentlemen. Thanks, Dr. Kitts and the CSIS for offering the opportunity to give you the brief introduction about the situation of HIV/AIDS epidemic in China. First of all, about all of you of the epidemic. By the end of March, the year 2004, the cumulative number of reported HIV cases was 114 thousand. The estimated number of infected people is about 840 thousand.

About today characteristics of epidemic, although the over-all national prevalence is slow, high prevalence exists in a certain areas and among specific populations. The HIV/AIDS epidemic is spreading from high risk populations into the general population. Next: Now, you need this map. You can see the high prevalence rate is existing in Viet Nam, Hunan, Ching Chung, and some other Provinces.

Next one is about today, the modes of HIV transition. You can see the two top proportions groups, proportion group IV drug users and commercial plasma donors.

Next one: The proportion of male and female reported HIV cases in China, you can see the major proportion is

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males; but female HIV, the infected cases are growing very fast. Now, the ratio about male to female, have been reached almost 2 to 1.

The second part of our today progress in HIV, is prevention and control in China. The central government of China shows strong political commitment. You can see the picture about the person who didn't help, visited HIV/AIDS persons and medical personals at UI [misspelled?] hospital, which is infectious stages hospital, just for the 31st of November, last year, and the Premier Monjabal [misspelled?] went to Hunan Province and visited people living with HIV/AIDS and their office and medical personnels during the last spring first festival in Chinese nona [misspelled?] calendar. The government-lead Natea [misspelled?] sector, cooperation mechanism has been established in China.

In last year, State Council established that States Council AIDS Working Committee and all the Provinces has also established this kind of committee. And, almost all the counties, which have higher prevalence rate of HIV/AIDS, also organized this kind of a committee.

The Ministry of Health has sent a National Medical Team to Hunan and Unan [misspelled?] Provinces. After we got some experience there, we will send the National Medical Teams to all key provinces.

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Next one is about the implementation of Four Free and the One Care policy. In order to implement the Four Free and One Care policy, ministries have independently or jointly issued regulatory documents. We have established nine trainee centers to train the technical person and for some teachers, who will give the knowledge to local workers.

And, a free ARV treatment program had been launched in the year of 2003. By the end of March, this year, over 60 thousand persons have received ARV treatment.

In the next picture, you will see the number of persons receiving ARC treatment has doubled, just with the one year. The pervasion of Mata Charter Transfusion [misspelled?] has been carried out in most provinces and regions. Next one is about struggling in the surveillance and testing work. The number of national centennial surveillance size increased from almost 200 to almost 300. Visiting service has been expanded throughout the country.

Next one, please. Education posters of prevention knowledge were distributed to all the villages, communities, universities, and middle schools. The number is about 4 million posters. In this picture you can see the Woman's Federation and the Youth leader to organize a lot of activities to do the face to face education. And a lot of performance has shown in the communities and rural areas.

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Next one: A number of the famers, actors or actress, and in your sports now, just like Yo Ming and Magic Johnson, and did a lot of activities.

Next one: HIV-infected people participating as campaign and combating stigma and discrimination. You can see Mr. Soon, who has been infected almost for ten years ago; and he now joins activities very often.

Next one: Six national ministries jointly issued a national implementation guidance on condom promotion and high-risk behavior intervention task force has been established in disease control center at all level of the country. The ministries of Health and the ministry of Public Security and other related ministries has launched 34 methadone clinics; and we have got some experience from the 50 clean user exchange programs. The scale of intervention has been greatly expanded. The number of methadone clinic will reach about 100 within this year. The central government and the local government increased the fund for HIV's control.

In next picture, you can see central government, it sponsored, has been increased to almost 8 million in the year of 2004. International cooperation with the UNS and WOHO, a number of countries' governments and some interiors has been strengthened.

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Although we already have infectious disease control lower, we have been working on the regulation for AIDS prevention and control. The regulation is expected to be issued by the State Council at the end of this year.

Even though we have got some progress as control, I think we are just a beginner in this field. There are a lot of difficulties or programs we should resolve or deal with, such as stigma or discrimination is still severe in communities and rural areas. The case discovery rate is still low; and we are lacking of many qualified technical persons, etc.

Also, I'd like to take this opportunity to thank very much the organizations, all the organizations, including the international organizations, relevant countries, NGOs, private sectors and persons who already give us lots of support in the public health field or in AIDS control. So, we'd like to work together continuously and closely with those people and to do our best job in order to control HIV/AIDS spreads in China and the entire country as soon as possible. That's all my presentation. Thank you for all your attention.

Thank you very much, Vice Minister. That was an outstanding presentation; I think one that really shows a very comprehensive approach to the epidemic that incorporates,

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basically, all aspects including the financing as well as the policy and legal fronts. So, I think we have a lot to learn from to where you're moving towards. So, again, now to look at another model.

We're also very fortunate to have with us today a person who I know is known to many of you, Professor Osotimehin; I can never pronounce your name correctly although how many times I try. Okay, Osotimehin - better huh? Not quite, but closer. He received his doctorate from the University of Ebodin [misspelled?] in Nigeria. He's completed his residency in Internal Medicine at the University of Bloomington Medical School in England. He also completed post-doctoral work at Cornell and has served as the Provost of the College of Medicine in the University of Ebodin.

Currently he's the chairman of the National AIDS Committee, National Action Committee on AIDS in Nigeria. And also, we're very fortunate; because he was, also, present at the last CSIS meeting here in Second Wave countries, having just assumed the position. So, I'm sure we're going to benefit from some real insight as he can tell us about how things have evolved or not over the last several years. Thank you.

BABATUNDE OSOTIMEHIN: Michele was trying to

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apologize for my name [laughter]. Truth of the matter is that, that's something that I've gotten used to all the 56 years of my life [laughter.] I remember very clearly that when I was in school in the UK, if I went to a class and the rule was being taken, the teacher would state "Mr. White, Dr. Black, Steve, [laughter] Morrison," and then, suddenly [laughter] there was this silence for about 5 seconds. I could see his type of struggle; I would just say, "I'm here, don't worry." [Laughter.] So, at least you had the courage to try, which was very good.

Let me thank CSIS and Steve Morrison for bringing me back to talk today. Yes, when I just started about three years ago, I was invited to speak. At that time, we were just starting; and there were many challenges, there are many things that we needed to put in place. And, I think, three years after, we've made some strides. Of course, there are still many things to do. Because I see that I'm restricted to talk about treatment, I would spend a fair amount of time talking about treatment; and I will go over some basic issues, which you might have to know in order to understand what the epidemic is like in Nigeria.

Now, this just tells you that most of our clients was, of who we were dealing with in the epidemic in Nigeria, would actually have contracted the virus through the sexual

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route; and the second most important through the very nature of it; and a very small percentage from blood transfusion. We don't have a handle on injection drug-users, although we know that there are communities of them in Nigeria.

And, the last year, I have been invited to a meeting of an association of men having sex with men; and the point in fact; there are 20 thousand strong in that organization. And, the reason why I got invited was they were starting to lose members to AIDS; they got visually alarmed. So, we have that with us; but, again, I don't have a handle on the figures arising from there. But, I'm sure that by the time we look at this again, it should make some contribution to it.

Now, this is the channel of the prevalence. Just like everybody else, our first case was described in 1986; and the first time we did, a seroprevalence of, a national seroprevalence of it was in 1991. We have seroprevalence sites in every state; there are 36 states in Nigeria, and we have seroprevalence sites in both urban and rural Nigeria. And, this is the trend that we have found, that as of 2001, we're at a 5.8 seroprevalence; and by 2003, it was 5 percent. We want to immediately say that 5.4, 5.8, and 5 is not significant. Now, these seroprevalence of this we carry out in antenatal cases of women who attend antenatal clinics. So, this is

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reflective of that population. We don't have data of general population; but in cases that we have seen, there's a close correlation between what happens in general population and the antenatal clinic population.

Now, this just captures what happens from state to state, I did talk about that six states, and the intensity of the colors; the darker it is there, the more, the higher the prevalence. And, we have a very inter-regionous epidemic in Nigeria with some states with as little as less than 2 percent, and with some as high as 12 percent. This is the figures that we got in 2003. Now where you look at the countries with burden of disease, Nigeria runs number three. South Africa was number one before; but, I think, India has taken over from South Africa. But, we are still number three. So, we're looking at the disease burden of about 3.5 to 4 million Nigerians who are living with the virus.

Now, we are supplementing or complementing the data from antenatal clinics with data from vulnerable groups and transaction our sex workers. Various sites in Nigeria, you have prevalences that vary between 35 and 66 percent. The longest [inaudible] is 20 to 25 percent. Patients who attend sexually transmitted infections clinics are as high as 13 percent. The problem of tuberculosis, the average is 17 percent. In some cohorts, [misspelled?] we have as high as 30

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percent, and very small number of people who are injection drug users as high as 8.9 percent.

Now, this is just a projection of what is going to happen or what we expect to happen if there is no - we don't intervene actively in the epidemic in Nigeria. We have a low scenario and a high scenario; and it just shows you that by 2010, we'll actually be on top - we'll be at 4.25 or more of people who will be living with the virus. And, of course, confidently with that will be many more cases of AIDS because as the epidemic matures there'll be many more people who come to the point to where they require treatment.

Now, one of the consequences, of course, of the epidemic, especially in the young population of, like, Nigeria, is the fact that we tend to get orphans. And, again, we expect that as the epidemic matures, we're going to get many more orphans that we have to deal with. Today, we record that we have about 1.5 million orphans due to HIV in Nigeria.

Now, when I was in medical school 30, 40 years ago, tuberculosis was an active issue; but by the mid-seventies and the eighties in Nigeria, we are pretty well almost driven or eliminated tuberculosis from our clinical wards. But, of course, with HIV and AIDS, there's a resurgence of tuberculosis; and this is the kind of trend that we're seeing and we're expecting to see.

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Now, I like this slide, because it tells many stories. Number one, that Mr. President, who has taken control [inaudible] of this response. He's really given us the leadership that we expect; and this was part of his speech that he made at the United Nations two years ago when he was reporting on what Nigeria was doing on HIV, etc.

Now, what have we done? Apart from many things, structures have been set up and we now have a vigorous response at both - at all the levels of government, national, state, and the local government. We also have set up systems in compliance with the three ones that UNAIDS and everybody signed up to. One National Strategic Free World, which, initially where we started, was called the HEAP. Now, we have the National Strategic Free World, which is now available from now until 2009. We have the national cohesion body called the National Action of Co-Maturing AIDS, which I chair; and, we have a National Monitor and Evolution of Free World who are called the Interims. I brought some of the output of the Interims, which we deployed last year; and some of the data that is coming out of the field as the guiding principles in modulating our response to each other in AIDS.

Of course, we have a national policy, which was launched last year by Mr. President, three years ago by Mr. President. Now, this is the main goal of the policy. I'm not

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going to read it, but it just tells you that it is all inclusive and seeks to achieve the objective of showing that HIV's - Nigeria's rid of HIV's it's in the long term.

Now, there are other policies and guidelines that we have also evolved. Where we started, of course, there was a bit of conflict between the health sector and the more sectoraries ones. And, the health sector, of course, being the traditional sector that looked after HIV and AIDS, had the institution and memory for HIV and AIDS and also resisted change from being a mono-sector-lead response to a mono-sector-lead response.

What we are doing now is we have a National Strategic Free World and the Health Sector Plan. The Health Sector Plan fits into the Strategic Free World; and so, there is one that the plan itemizes what health sector is supposed to do within Nigeria. We have a workplace policy, we have a national policy on orphans and vulnerable children, we have a bureau change and complications strategy, and, of course, there are other sector guidelines: The Minister of Defense has a sectoral guideline; Minister of Education has a sectoral guideline; and we also do have a private sector organization called the BOOKA [misspelled?] that has guidelines of its own. So, in many ways, we've been able to deploy the multi-sectorality of HIV; it's there in Nigeria.

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Now, it just captures what I'm talking about. Our Federal Ministries are prestigious today. There are 42 Federal Ministries that are working on HIV and AIDS with budget and people specifically looking after the HIV and AIDS responses. And, we also have distributed action committees at every state level, and local governments have local action committees.

And then, very importantly, we have civil society organizations. There is an organization called CISNAN [misspelled?] in Nigeria which houses more than 700 civil society organizations working HIV/AIDS in Nigeria. It's been in existence for three years, and they actually have been able to attract into civil society. And, we have been able to give to civil society resources that are in excess of \$15 million dollars for them to be able to work in HIV and AIDS. And, we also are working with Faith-based organizations. Indeed, in two weeks time, we're going to do a second Faith-based Forum to look at "What Will I Choose," Faith-based organizations in Nigeria.

And most importantly, we've also empowered people who live with HIV and AIDS. In 1999, before we started this response, there was no Nigerian who could come forward to say that he was living with the virus. Today we have more than 352 support groups across Nigeria, each one of them with at

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least 100 members. So, it has really grown in terms of people coming out and saying that they live with the virus. We still have stigma and discrimination; but it has reduced to a certain degree.

Let me speak to the Presidential Council on AIDS. Mr. President chairs the Council on AIDS with 17 of his ministers. So, he actually gives the policy direction for all that we do in Nigeria. Now these just captures all that we do, VCTP, NTCT, everything. We believe that we have come out of the grounds. We might not have been able to do everything in the way that we should do it; but we recognize that all of these are important.

I'd like to draw attention to the issue of family life education. Prevention is a major issue for us; and we believe that one of the places to start is our school. So, we have a curriculum that is approved by the Federal Government of Nigeria. And, that curriculum provides education for children from primary school all the way to universities, and is graded in such a way that it is appropriate for consumption at every level of education. That's one of the areas where, in fact, all the partners that work with us actually have contributed considerably to that.

Now, we believe that, going back to the last slide, that a solution lies not just to do something but is doing

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everything. Everything has to be done; and the solution lies in comprehension program for prevention and care services, and in everybody everywhere. And, that's what we keep telling people that every Nigerian must be on board for HIV and AIDS if we are going to win the war.

Now, we have also given the position of Nigeria and the advocacy of Mr. President and all of us being able to mobilize resources for our response. The government of Nigeria itself, if you look at what has happened, in 1998 in the budget, the federal budget of Nigeria, we had \$3 thousand total for HIV and AIDS. This year we have \$30 million. So, it's been a major, major shift. And, the World Bank created provide source with \$90 million for five years. PEPFAR this year is expected to provide about \$58 million for support and global funds about \$8 million annually. DFID and all of those supporters, and the United States, United Nations system provides us with technical assistance and some dire funding.

So, what we have is a life pool of resource that we have to position to be able to look after our response. But, when you look at this, you sometimes think that this is life; but where you then locate it in the population base we are talking about 130 million people. This is actually very small. So, we still continue to mobilize resources so that

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we can do more than we are doing now.

Now, what are we doing in prevention? I'll just mention that before I go into the issues of treatment. Now, general public education since transition awareness creation and all that, today, we have evidence that more than 80 percent of Nigerians both rural and urban have heard about HIV and AIDS; and that's, for us, is very significant. Starting from a position where we had people just who either did not know or were in denial. But, today, we now have that. Now, this does not hold up in terms of risk perception. They know about it; but they don't think that they are at risk. So, whereas 80 percent know, only 2 percent believe that they are at risk for HIV and AIDS.

So, that's still a major task in translating awareness and knowledge into risk perception. And then, I was talking to the National Family Life and HIV/AIDS education. We created a network for HIV and AIDS among youth; and that is working very actively. Indeed, the Nigerian network is the model for the African network. And, the Nigerian network is what is going to drive the youth forum at the next international conference on AIDS and HIV or on AIDS and STS in Nigeria.

Now, we have an active condom promotion and social marketing program that I'm going to speak to that now;

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because I think it's important for some of the things I'm going to talk about a little later. We did almost cede these to an international injue [misspelled?] that was actually doing good business in Nigeria, and was promoting condoms for us. And, we were doing - we liked what it was doing, and it was doing extremely well.

But, in the last year, we've seen a shift in terms of what they are doing. And, they are now going from condom promotion to promoting abstinence. I think it's because, of course, they're trying to attract resources from sources which restrict the issues of condom promotion. And, that's for us, is of great concern; even though we believe in abstinence as an option, I think that we must have the balance to picture so that we can give options to everybody to do what they have to do.

So, we as government of Nigeria have now taken a condom promotion business in order for us to be able to provide condoms. Now, even if the starting the program goes to introduce the female condom, where it was first introduced in Nigeria, it did not fly because it was very expensive; and many women felt it was clumsy to use, and it just didn't fly at all. We are beginning another campaign to try and see how we can get that on board.

Now, it was - give me time to take my breath

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[laughter.] Now, in 2001, at the OU meeting that Mr. President convened in Nigeria, he did announce that we would treat 10 thousand adults and 5 thousand children with antiretrovirals. And, that was supposed to be a feasibility to see, like a pilot, to see how it was feasible in our environment. Today we have an estimated 50 thousand patients. By the end of this year, we expect to treat 400 thousand. This just tells you about that. Now, exactly what I've just said, it's captured there.

Now, this is a break down. I'm sorry that this slide might not be as brilliant as you like to see. It's a break down of who is providing some of the treatment in Nigeria. The Federal Government is providing \$17 thousand. PEPFAR is providing \$8 thousand as of this point in time. Global Funds is providing \$12,400 slots. And, we have a very active private sector in Nigeria; and they are doing about \$9 thousand. And then, we have some injues that are providing treatment; and they're doing about \$6 thousand. They're our state governments. Some state governments that are taking on the business of providing treatment, there are about five of them; and they're doing about 1 thousand slots. So, this is like the way it is going. We expect that the PEPFAR slots will grow dramatically very soon. And, [Inaudible,] the FHI is doing a great deal of work there. Faith Alive, which is

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the Catholic [inaudible] services, also, doing a great amount of work there. And, the University of Maryland, in conjunction with those, also doing a lot of work there. So, that's what we are seeing there. But, we expect that this will change dramatically before the end of this year.

The target for PEPFAR for Nigeria is that PEPFAR will treat 350 thousand people in Nigeria by 2008. We would like to see that happen before 2008, because we reckon that with the population of 4 million Nigerians who are HIV positive will have a population of between 500 and 600 thousand who will require treatment. So, this earlier we get there the better for our people.

Now, this is just a projection as to where we are going to be in December. Now, I did talk about some of the things that we are getting back from the field. One of the problems that I have observed, and in most of Africa, is our ability to document what we're doing. And also, to monitor and evaluate effectively what's going on. Our monitor and evaluations systems are sometimes very weak. And, we launched MNE [misspelled?] instrument last year; and we deployed it. So, we are beginning to get back some data from the field; and I just included some slides. This is not comprehensive, but to show you that we are also very mindful of accountability and the issues that surround it.

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Now, this is a break down by sex of the numbers of patients who have been treated in their areas. And, it's interesting that more females than males who have been treated for, with their [Inaudible.] And, for biology, counseling, and testing, we also did find that there are more females that are coming forward for voluntary counseling and testing than males. The only thing is that for pre-testing, for pre-counseling, or pre-testing counseling, there are more females; but when it comes to post-test counseling, more males come back. I don't know why that is so. It just tells you, if you look at it. This is pre-test counseling that are more females. When you go to post-test counseling, there are more males. And, these are just the numbers of clients that are positive for HIV through our testing system.

Now, of course, these are ongoing things; and, of course, there are many challenges. Now, last week, only last week, I got told that we must treat 250 thousand by the middle of next year. Now, that is a major challenge, because if we actually do 50 thousand now, to scale up to 250 within one year is a major challenge, especially when you look at issues of the health sector and the structures that you have to deal with that would provide you with this kind of numbers. But, it's nice to set targets; because then, you can work towards it and feel comfortable for it.

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Now, issues of the health sector, and that's something that everybody talks about all the time; because in most of Africa, and Nigeria included, the health sector structures are so fragile that it's difficult for it to sustain some of the things that we will have to look at. And, of course, closely aligned to that, is the issue of human source capacity or human capacity requirements. Nigeria is fortunate that it has enough hands, but it needs to train for diverse specifically for ARVs or for HIV and AIDS. So, in a sense, we need to spend a lot of resource to get to that point.

Now, the question that we ask ourselves now is, given what we have to do, you have 600 thousand Nigerians out there that require treatment, how do you reach them? And, we are looking at community-based approaches to be able to do that.

Today there are 462 adult sites that are treating for tuberculosis. Now, can we use those sites at least to reach some people, even if all you are going to do with those sites is to counsel and test people? And then, you can then begin to see how to upgrade those sites to be able to offer treatment. I think that is one thing that we must look at as a model; because we would probably never be able to have enough within the traditional medical systems to be able to achieve what we need to achieve.

Now, for all of these, and I speak for Nigeria and the

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rest of Africa, the issues sometimes that confronts us and we talk about, is how sustainable is this going to be if, for an example, we're able to ramp up to 50 thousand. Now, you are treating people for life. Are we going to be able to sustain that? Now, are people, are donors, and are friends and partners going to physically stay with us for the life of this mission? It is something that, for us, is awesome; and we continue to deal with it on a regular basis, because it has an ethical issue to it. And, we continue to wrestle with that.

Now, there's also the issue, of course, of generic versus brand name. The first time I spoke in this auditorium, I actually was told by somebody from big pharma [misspelled?] in this country that we were using Nigerians as guinea pigs for generics that I was convinced, and I'm still convinced, that generics work. We have showed it quite clearly, and it worked. It's cheaper than buying branded drugs. But, we need to, given the fact that some of our patients are now taking resources from PEPFAR, we have to use branded drugs; because, especially because, most of the generics that are in the market have not passed through the years of the branded. So, there is one little footnote, there is aspirin in South Africa that is produced in generic, which is approved by the USFD. And, we're looking to that organization to be able to provide for us; because with aspirin, you can actually treat a patient for \$17

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in months. And, I think, that is still within the ballpark of the kinds of monies we like to spend. We like to liberate the resources and treat as many people as possible, because we're a poor country.

Now, of course, there are also the issues of supply chain management, how do you get the drugs to the people and be sure they get it all the time? We had the unfortunate incident about 18 months ago, two years, when we had stalk-outs [misspelled?] It was just about supply chains management. And, those are issues which you must contend with and try to put in place very well.

Now, the next point of alignment ammonization of all partners; it is not a small issue at all. In Nigeria today, there must be at least 50 partners that are working on HIV and AIDS. And, each one of them brings resources into the system. Nigeria is a large country with 130 million people and vast in terms of space. So, it is difficult for one person sitting in one place, or a group sitting in one place, to be able to oversee all of that. Now, we hope and we appeal to partners to ammonize with us; because if they don't, then we're going to get problems.

Today we have 17 percent of our patients who are resistant to one or two of the first-line drugs. Now, if we don't, if people don't follow the national protocol for

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treatment, then we get into problems. What we are planning to do, this year we have evolved a national plan for HIV and AIDS to which the UN system and PEPFAR has bought into.

At the end of by fall this year, September, we're going to convene a meeting of all partners in Nigeria to evolve the war plans for '06 and '07. And, we will all be accountable to pieces of the war plan to ensure that everybody's on the same page for what we are going to do.

And then, of course, continually, we need to do strategic information management and strengthening for what we - because the better information we get, the more that we're going to be able to do for HIV and AIDS, and the better quality of services we're going to do.

Now, again, I just on the score that we should strain the continuing of care model as investment in treatment of for producing infections is not adequate. We don't think it's adequate. Now, we need to do that. And then, we want to correlate efforts for AIDS and tuberculosis. And then, right now, we're looking at lookout productions.

Today there are three companies that are producing in Nigeria. Ramboxi, Aji Pharmaceutical, and Sempler Evans [misspelled?] And, there's a public sector move to produce with Brazilin and Galase systems [misspelled?]. So, we might also be able to kick in from Nigeria itself to provide some of

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what we need to consume. Nigeria is a latch country; and we believe that if we can do this and be successful, we can also provide resources and commodities for the West African corridor to use.

Now, and of course, I was of a wider consent of prevention and treatment. How do you balance it? We, Nigeria, we've invested \$10 million in this enterprise. But when, you now have 58 million that seeks after treatment, you can have a distortion if you don't manage it very well. Now, and I think that Nigeria can afford to actually sit back and think about it and balance it. There are sister countries in Africa that cannot afford to do that, because all of their programs are donor-driven.

And so, there has to be a conscious effort by programs and those who assist with planning of programs to balance prevention and treatment; because prevention is such an important issue. There's no country in the world where the majority of people are living with the virus, even Botswana has 38 percent. A majority of the people are still sero-negative [misspelled?]. So, prevention is the major, major issue; and we must look after it.

Now, I will just leave this. We have spoken to some of the things that we are doing. We put a lot of this on our website; and I'm just leaving the website address if you want

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to visit. I thank you very much.

MICHELE MOLONEY-KITTS: Thank you very much. Another outstanding and very informative presentation. To move us along, I'd like to now introduce Bates Gill, who joined CSIS and serves as the Freeman Chair in China Studies. He's going to be the discussing to help pull together for us some of the, kind of, key issues that emerged from these two presentations. He has served as a Senior Fellow in Foreign Policy at the Center for Northeast Asian policy studies at the Brookings Institute and directed East Asia programs in the Center for Non-proliferation studies at Monterrey Institute. And, he's obviously a specialist in East Asian foreign policy and politics.

So, with that, I'll hand it over; and if you can help us think through some of these issues we've seen.

BATES GILL: Thank you very much, Michele. I will be very brief. I understand you certainly want to have a conversation with the real experts who are here. I do want to take a moment to thank the sponsors and organizers for the opportunity, though, to give you some thoughts on these presentations; and largest thanks, of course, to our speakers for coming as far away as they have and providing us with such an impressive and comprehensive set of information and insight.

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Looking back 30 months, as Steve has asked us to do, and considering where we are today, these two presentations, I think, stand out quite dramatically. We, obviously see a remarkable change, a very dynamic and ambitious set of programs, structures, new monies, policies, guidelines, etc., unfolding at a very dramatic pace, extremely ambitious.

I think we should certainly congratulate the two gentlemen here for being such a central part of that occurring, in just a very, very short period of time. So, I think that's an important take away. There is a lot going on. And, just looking at China, where I focus most of my time, I can certainly say that the change has been remarkable in just the past three years or even two years.

Now, most of this remarkable change, I would say, and again, I may be speaking mostly, with regards to China, has certainly occurred at the central level, that is to say, the political will and the institutions and the structures at Beijing have clearly been put in place.

But, again, looking to how these countries compare to one another, being as large as they are and having the enormous populations and geographic expanse that they have, clearly the proof of these new policies, guide lines, and structures will be found at the very most local levels where, at least, in the Chinese case, for example, the HIV problem

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is at its worst. In China, at least, it's not an urban phenomenon yet. It is primarily a problem that afflicts far-flung, remote, and extremely poor parts of the country. And, China, contrary to what many people understand China to be, is actually a highly, decentralized and decentralizing place these days, making the centralized directives, structures, and policies all the more difficult to implement at local levels. And, I would assume the problem is similar in a country such as Nigeria.

So, what are some of these issues, then that arise on the prevention and the treatment ledger that we didn't really get a chance to discuss during these presentations? And, maybe, to prod our speakers to think through these a little more and tell us how they are responding to these questions.

Specifically, in the case of China, I'll just raise one more China instance, in the Four Frees and One Care and the China Cares HIV/ARV treatment program. These are given free of charge to those who have been identified, those 16 thousand persons who are under treatment or have received some treatment. That's probably a better way of putting it.

It's very difficult, is my understanding, at the local levels, to get doctors, for example, to take part in this program; because they're not paid. These are free drugs and much of the doctors' salaries, in China, are gained

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through the provision of drugs and other services. In other words, it's a fee for service system, especially at the lower and rural levels. How is it then, that we can overcome this contradiction? Where, on the one hand, you're asking doctors to provide drugs for free, but they may not be getting properly compensated in their view for being active in this way, in dealing with the treatment issue.

Secondly, what about reaching out to sensitive groups? With the problem, primarily, in Nigeria being one of sexual transmission, I presume that this requires a significant intervention in the trans-actual or commercial sex worker population.

In China, as you saw, the predominant vector is through the use of intravenous drugs, again, a population that is marginalized and undertaking illegal activity. In China, we've heard reports, for example, in some parts of China, I don't know how widespread this is; but some public security authorities, actually wait around places where interventions are taking place, precisely, so that's easier for them to round up likely drug users or likely commercial sex workers. How can we overcome these problems, especially at local levels where central authorities just don't have the necessary reach and enforcement powers?

A third issue, which did not come up in either

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presentation, is the question of resistance, drug resistance. We have to talk about resistance, if we're going to be on a panel that discusses treatment.

I know the China case more familiarly. There, there is a very basic front, single line of treatment; there is no second line of treatment available in China today. And, that first line treatment is not a practically good one; and it does have severe side effects, which is going to clearly affect adherence among the patient population, not to mention, the ability in a poorer, more rural, and remote parts of China for doctors to properly counsel their patients so that they do properly adhere.

In my view, resistance is an issue that's looming right over the horizon in China; and there's already evidence, according some early studies by Chinese specialist. The resistance has already emerged and is going to be an even larger problem. It strikes me that, in spite of the heroic efforts to ramp up treatment in large populations, such as we have in China and in Nigeria, I'm not sure we've fully addressed the resistance downside of such a rapid ramping up.

And then finally, I wonder if it isn't the case of Nigeria, again not being familiar enough; but I know that it is in China. That this virus, disproportionately affects ethnic populations, that is to say, it's a non-rationally and

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culturally non-mainstream parts of the country. And this too, immediately raises all kinds of problems about prevention messaging and different languages, about getting the proper treatment to those people in languages and with materials that they can fully understand, not to mention the political sensitivity that often attend the relationship between the dominant ethnic majority, visa vie those afflicted minorities.

So these are just to mention that I think arise in countries of this type, which it would be interesting to have our speakers respond to. I think we'll find that there's a greater universality of some of these issues than we might recognize. So, just some quick questions.

How do you close the gap in such large countries as China and Nigeria between those person you know are HIV positive, as in the case of China, 114 thousand persons and those who you think are HIV positive, there's another 600 to 700 thousand persons in China, who we don't know who they are. How do we close that gap more rapidly in a country of a size like China or Nigeria?

We saw that in both countries there is this new flow of quite dramatic opening of new monies, pouring into these countries to help them deal with their prevention and treatment programs. How's that going? Is it really an

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overwhelming amount of money in some ways? Is it coming so fast in some ways, and I guess it's a problem that lots of people like to have, too much money; but, nevertheless, is it beginning to have a negative effect, perhaps, on your ability to deliver these programs as effectively as you would like to see?

And then, finally, I'd be interested to hear how much interaction our speakers are having with other Second Wave countries. Strikes me, there's a great deal to be learned from one another. For example, the fact that Nigeria has had to deal so predominantly with a sexually transmitted epidemic. I would think that there are great lessons, which could be transferred to China, which is about to face a sexually transmitted epidemic in a far larger scale.

Maybe there could be some lessons learned to get out in front. Likewise, as China has dealt with intravenous drug use more actively, perhaps there would be lessons for Nigeria to make sure that that aspect of the epidemic does not grow beyond where it has been up to this point. So, those are just a few questions, Madam Chairman, and I want to thank, once again, our speakers for their excellent presentations.

MICHELE MALONEY-KITTS: Thank you very much. I think, perhaps, since time is rather pressing, that what we should do is, maybe, take some questions from the floor, as

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well, and then invite our speakers to respond, so that we don't get too far behind schedule. So, yes, okay, I'm not sure where the microphone is; we have one here, in the front.

FEMALE SPEAKER: Yes, for China, Professor Vice Minister Wang Longde, adding the question of the rural migrants, so large a population, now moving to the cities.

MICHELE MALONEY-KITTS: Okay and we have one in the far back there.

FEMALE SPEAKER: I was wondering if -

MICHELE MALONEY-KITTS: Could you give us your name and your organization?

LAURA KELLY: Laura Kelly, representing SELF, at the moment. I was wondering if the Nigerian Representative could speak to the differences between the prevention treatment and the surveillance programs between the Muslim North and the rest of the country.

MICHELE MALONEY-KITTS: Okay, alright. I think if we can stop there, perhaps, if Vice - Vice Minister Wang, would you like to respond first? And then -

WANG LONGDE: In order to give you my opinion or views, precisely, I just ask - you're name?

VICTORIA SEAGLE: Vickie Seagle.

MICHELE MALONEY-KITTS: Victoria Seagle.

WANG LONGDE: Yeah, yeah - ask the lady to translate

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for me, okay? [Laughter]

VICTORIA SEAGLE (TRANSLATOR): There were several questions brought up just now, and I'll basically divide them into six categories and try to answer them. First of all, it seems that there's a lot of concern about the rural areas in China. It's true, that in the rural areas in China, when it comes to both medical technology, as well as the personnel involved, we don't have a very high sophisticated level of technology; and we don't have enough people.

So, the first thing we're trying to do to help us to solve this kind of problem at every level of government, we're sending experts and doctors down to the next level of government. For example, in the areas of high prevalence, what we're doing is, we're taking some of the better doctors from the county level; and we're sending them down to village level to have them work on these issues.

And, as for the doctors, who are actually involved in going down to the villages to help out with these projects, they're getting very good treatment, shall we say? In other words, what I'm trying to say is, they're not just getting money from the drugs that they give to the patients; but they're being taken care of by the higher level of the government, so that they have the motivation to do that.

The second issue, I heard just now, is the dealing

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with the issue of sensitive population groups. And, okay, first of all, let's look at drug users and commercial sex workers in these two areas, while we have different government agencies and different policies and responsibilities directed toward these two population groups.

Okay, for example, with drug users, the understanding that we've come to with the minister of public security and the other public security entities at the local levels is for these drug users, if they are already enrolled in the methadone clinics, then, they are to be considered people who are already receiving treatment; and so, they can't be dealt with directly by the public security agencies.

And, for commercial sex workers, what we've done with the minister of public security, is - well, it depends who actually finds them. If it's the minister of public security or some of the other public security agencies that - they're the ones that actually find these commercial sex workers, then it's their job to give them education or to do what they would do to handle them under their system; but if it's the minister of health that actually gets a hold of these commercial sex workers, first, then we work according to our system. We educate them; and we also give them education, as well as information, on how to prevent the transmission of AIDS.

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The third issue seems to be about drug resistance. Basically speaking, we've only been doing the antiviral treatment for about a year. But, through our monitoring, we have found, at the local levels, that there are a few patients, not a lot, but some patients who are experiencing resistance to the drugs. So, what we're trying to do is, working - recently, that is, we just started working very hard to try to have a second line for people who are resistant to the first line of drugs. What we're doing is, starting to import from foreign drug producers, this second line of defense against the disease for the people who have developed drug resistance to the drugs that we are able to produce in China.

So, what we're doing is -it's kind of a huge country, so, what we're trying to do to deal with it is we've got this at the highest an experts group; and then we have then divided into a smaller experts group. And, each of them is working on overseeing the quality in the area that they're responsible for.

This fourth issue, as I see it, is education and awareness among minority groups in China. Many of the publicity and educational materials that are produced at the central government level in China are all translated into some of the local languages that the different minorities

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speak in their communities.

The fifth issue is, trying to find more cases. Someone brought up the issue of how many cases we know we already have, as opposed to the cases that we think might be. So, to try to raise our ability to discover the cases that are out there.

The one and only most important thing right now is to try to do better in the area of prevention and educating people on how to prevent the onset of this disease, especially starting from very early on.

As a matter of fact, in the essential department of education, we have already made specific regulations on having a certain part of the curriculum, a certain amount of time spent, devoted to teaching our college students, as well as high school students and middle school students and even the higher grades in elementary school students about HIV/AIDS.

And then also, we have screening sites all over the country in the area of VCT. We already have over or about 3,700 such sites. And then, another measure we're taking up in this area is trying to do more screening of people, who are considered to be high risk population groups. And, when I talk about these high risk groups, first of all, we had the people who were donating blood for money in the past.

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Basically, that was occurring a lot in the middle of the country in China; so, in the middle of the country we are doing a lot of screening toward people who donated their blood commercially. So, for instance, the province of Hunan, [misspelled?] in that province, where we have a lot of that going on, we've already screened 280 thousand people for that purpose. And, after that, we've so far found that there are about 25 thousand people who are infected.

And also, we've talked to the Minister of Justice; and we've come to an agreement with them where we can do screening on criminals, as well as people who in detention centers, and also drug detox rehabilitation treatment centers. Just in the Province of Udinese, [misspelled?] itself, we screened 410 thousand people for that purpose and we found 11 thousand of them to be positive.

And, actually, we've also reached a sort of agreement with the deal, the Minister of Justice as well as the Ministry of Public Security for these people who are considered to be high risk groups. Before they're put in jail or before they're put in these kinds of detention centers, we will do the testing. And that kind of policy is good to help us try to stop the spread of the diseases in such places as jails and detention centers.

And, the sixth issue that I heard just now, is the

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migrant workers that come in from the countryside. And that's a situation that's very specific to China, right now. We've got a lot of these agricultural workers, people from the provinces, who are just swarming into the cities at this point.

However, this is not just an issue that we come across when dealing with trying to prevent AIDS. Actually, in trying to prevent other kinds of infectious diseases and other issues, we also face this major problem that's specific to China right now. So, we have several entities, which are in charge of managing the existence and the swarming of these people into the cities.

First of all, we have commercial management committees that are set up to manage these people. And then, we also have tons and tons of these construction sites all over China; and these construction sites are supposed to be regulated and managed by the Minister of Construction in China.

So, what we're trying to do is have better contact with these two entities that will help us do a better job of trying to discover, find the patients, and screen the patients.

And then, also, we're working through various organizations or alliances or federations or anyone that

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might come into contact with these migrant workers to try to give them education and do more publicity work to raise their awareness of the issue. Thank you.

MICHELE MALONEY-KITTS: Thank you very much. I think, again in the interest of time, Professor, I'd like you to have the last word for us here.

BABATUNDE OSOTIMEHIN: Well, it seems to me that the only one [inaudible] [laughter]. But I would just mention a couple of things. There is the issue of, how do you deal with populations [Inaudible,] transaction, and sex workers? We actually have [Inaudible] that engage with them and work with them. And, in several cities in Nigeria today, a good number, in Abuda [misspelled?], particularly, I know that 80 percent of the sexual casualty on the road actually carries condoms. That is something that has happened in the last two-three years. We also work with the police not to arrest them. Prostitution, as it is, is seen as illegal; but we have a response with the police system. And, we're talking to them to ensure that there's no harassment.

And then, there is Africa. Africa is an international injue that is working in Nigeria, is working with women who are in the fringe to try and create all time employment for them, so that they can provide them with opportunities or an option to choose between what they are

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doing and that.

Now, if you ask about drug resistance, I mentioned it; but I didn't go into details. There are 13 sites in Nigeria today that are looking at drug resistance. And, we appreciate that there are issues of drug resistance; and we must look after it. And, I did say in my talk that 70 percent of our patients have resistance to one drug or the other. And, I wanted to introduce the guidelines that we would have for the ARV program, which actually has first line, second line, South Asia, and all that.

So, for every clinic where we go, they have these. And, we have procurement systems that ensure that those drugs are in place. Now, there was also the question about inter-region [Inaudible] and how do you deal with issues of providing information to every part of Nigeria? That we do quite well, because we have a decentralized response in many ways. And, finally, I will speak to the issue of - the question I was asked about - how do you deal with Muslims in the North as a guest? Now, we have one country, and in a sense, our response goes out to everybody. And, Muslim and Christian, alike, we send out the messages about it. Of course, as I did say, from state to state and from zone to zone, we are quite right in terms of what kind of messages we pass; but we do try to reach to everybody. And, there's no

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clear division in that sense about HIV and AIDS. Very similar to what our Russian colleague said and the Indian colleague, HIV and AIDS is one thing where all of us agree that we have to do something; and all of us are united to do something. Thank you.

MICHELE MALONEY-KITTS: Okay, well thank you very much and again, your outstanding leadership on these issues and your willingness to talk about very sensitive things, I think is really laudable. At this point, I think lunch is there; and the request is that people get their lunch and then come back so that the lunch-time speaker, Dr. Jake Gibbs [misspelled?] can begin. So, take about 10 minutes; and if we can have one last round of applause for outstanding guest. Thank you.

[END RECORDING]

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