

The G-8, Russia's Presidency, and HIV/AIDS in Eurasia

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Principal Authors

J. Stephen Morrison
Jennifer Kates

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Center for Strategic and International Studies
1800 K Street, N.W.
Washington, D.C. 20006
Tel: (202) 887-0200
Fax: (202) 775-3119
Web: www.csis.org

Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, Calif. 94025
Tel: (650) 854-9400
Fax: (650) 854-4800
Web: www.kff.org

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The G-8, Russia's Presidency, and HIV/AIDS in Eurasia

J. Stephen Morrison and Jennifer Kates

Introduction

The Importance of the Historical Moment

This July, Russia will host the Group of Eight (G-8) summit for the first time, presenting important opportunities for Russia, its Eurasian neighbors, and the other members of the G-8. This document focuses on one such opportunity—that of turning the G-8's attention to the Eurasian HIV/AIDS epidemic, particularly in Russia, China, and India. It explores the multiple, shared interests of these three nations and other G-8 members in strengthening their coordinated response to HIV/AIDS and the current and potential role of Russia, China, and India in combating the global epidemic outside their borders. It also offers several options that the G-8 could consider to help achieve greater coordination when it meets next month in Saint Petersburg. An annex includes brief background summaries of the history and status of HIV/AIDS in Russia, China, and India.

The G-8 comprises the world's most powerful and wealthy market democracies and accounts for the overwhelming majority of international resources to combat HIV/AIDS.¹ In recent years, its members have strengthened the global response to HIV/AIDS and other chronic and emerging infectious diseases, especially in Africa.² They have done so by identifying gaps; engendering high-level political leadership; mobilizing significant

¹ UNAIDS, *Resource Needs for an Expanded Response to AIDS in Low- and Middle-income Countries* (Geneva: UNAIDS, August 2005); and Jennifer Kates, *Financing the Response to HIV/AIDS in Low and Middle Income Countries: Funding for HIV/AIDS from the G7 and the European Commission* (Menlo Park, Calif.: Kaiser Family Foundation, July 2005).

² John Kirton and Jenevieve Mannell, "The G-8 and Global Health Governance," paper prepared for a conference on "Global Health Governance: Past Practice: Future Innovation," sponsored by the Centre for International Governance Innovation (CIGI), the Institute of Population Health, University of Ottawa, the G8 Research Group, Munk Centre for International Studies, University of Toronto, and Rotary International, Ottawa and Waterloo, November 10–12, 2005; and John Kirton and Laura Sunderland, "The G8 Summit Communiqués on Health, 1975-2005," G8 Research Group, Toronto, November 2005.

resources; catalyzing the creation of new mechanisms, notably the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); encouraging international action in a range of related areas; and setting ambitious targets for the prevention and treatment of HIV/AIDS around the world. As such, the G-8 has acquired credibility and legitimacy as a major force in global health.

Much of the G-8's now widely acknowledged value in promoting global health has rested on its small, limited membership, its concentrated capacity in health resources and expertise, and the fact that several G-8 heads of state have been continuously in office in recent years and work relatively well together. Within the G-8, consciousness of the shared global vulnerability to emerging infectious diseases has steadily risen since the late 1990s, along with awareness of the radical disparities between the G-8 and acutely endangered areas such as Africa. Also during this period, however, the global health agenda has grown more demanding and complex, and concerns have been raised over the broad range of G-8 health commitments and its ability to monitor and fulfill them.

While sub-Saharan Africa will continue to demand a comprehensive, large-scale commitment by the G-8, the emerging HIV/AIDS epidemics in Eurasia, particularly in Russia, China, and India, warrant heightened engagement by G-8 leaders. These emerging epidemics have been classified as "second wave" because of their still relatively low prevalence rates. However, this region, which harbors the world's largest populations, is also home to some of the fastest growing HIV epidemics that stand on the brink of becoming generalized. More extensive investment of human and financial resources—by these countries themselves with support from members of the G-8 and other sources—is essential to avert potentially high future economic and social costs.

Russia's assumption of the G-8 presidency in 2006 marks the first time it has occupied this important role since formally joining the group in 1998. Its presidency offers the possibility of consolidating existing G-8 commitments while at the same time enlarging the group's HIV/AIDS focus to include Eurasia. It is a moment of special opportunity for the G-8: to turn its gaze on HIV/AIDS eastward, and for Russia and its neighbors, particularly China and India, to define and augment their domestic, regional, and global leadership roles in responding to the epidemic. Russia is well positioned to bridge the G-8 and the "second-wave" countries of Eurasia.

Shared Interests, Shared Concerns

Russia, the other members of the G-8, China, and India have vital shared interests that argue for enhanced, coordinated action on HIV/AIDS and tie directly back to the G-8's core interest in the better management of globalization.

Russia, China, and India are among the largest countries in the world; combined, they have approximately 40 percent of the world's population.³ They are global players in energy, technology, military policy, and increasingly, health. In addition, they are each

³ "2005 World Population Data Sheet," Population Reference Bureau, Washington, D.C.

substantial global exporters and importers whose burgeoning economic fortunes are interdependent with those of G-8 member countries.⁴

Intraregionally, the three share geographic borders, and each confronts the security, public health, and economic consequences of burgeoning migration and illicit trafficking in humans and drugs. Each is a regional leader with expansive domestic and international agendas—and thus able and often inclined to shape positively the policies and approaches of its neighbors and, to varying degrees, to use its rising wealth to that end. Each is also endowed with exceptional scientific and technical expertise.

Arguably of greatest direct import to the G-8 agenda, all three of these large nations share a common interest in sustaining the rapid economic growth that is helping to reduce poverty and generate development in their respective societies and is driving the expansion of the global economy. Growth in China, India, and Russia relies on secure regional environments, increased foreign investment, expanded investments in education systems, predictable access to energy—and improved public health. Indeed, the future economic and social vitality of all three rests on healthy populations with access to decent health services and increased capacity to preempt a generalized HIV/AIDS epidemic, provide care and treatment to populations already affected by HIV/AIDS, and respond effectively to emerging threats such as avian influenza. These are all health priorities that resonate strongly with the G-8's ongoing health agenda.

Russia, India, and China share specific challenges vis-à-vis HIV/AIDS. Each nation is currently faced with a relatively early, concentrated HIV/AIDS epidemic that is centered among highly stigmatized, difficult-to-reach populations, in particular injection drug users (IDUs), sex workers, prisoners, and men who have sex with men (MSM). The complicated and deadly interaction of TB and HIV is a growing problem, and there is a common intraregional drug and human trafficking dimension to the Eurasian epidemic that contributes significantly to the spread of HIV.⁵ Furthermore, of great concern to public health officials and observers is the mounting evidence that, within all three countries, the epidemic is steadily spreading beyond core at-risk groups into the general population, a development that constitutes an important tipping point.⁶ This trend underscores the urgent priority to put in place a comprehensive response to the epidemic that scales up prevention, treatment, and care services and combats stigma, while at the same time investing in the development of better tools for tomorrow—a greater array of drugs, diagnostics, and new technologies such as vaccines and microbicides.

Recent Movement on HIV/AIDS

Beyond these shared interests and concerns, Russia, China, and India have all shown promising recent movement on national policies related to HIV/AIDS, including dedicating higher levels of political leadership and resources to combating their

⁴ National Intelligence Council, *Mapping the Global Future: Report of the National Intelligence Council's 2020 Project* (Washington, D.C.: GPO, December 2004).

⁵ Christopher Beyrer, "The Next Wave: The Emerging HIV Epidemics of Eurasia," presentation at the 3rd IAS Conference on Pathogenesis and Treatment, Rio de Janeiro, July 24–27, 2005; and Department of State, *Trafficking in Persons Report: June 2005* (Washington, D.C.: U.S. Department of State, June 2005).

⁶ Jennifer Kates and Phillip Nieburg, *HIV Prevention in Complex, Macro-scale Societies* (Washington, D.C.: CSIS, December 2005).

epidemics. Indeed, over the past three years there have been significant and welcome policy shifts in all three countries. Each in its own way has entered a period of greater openness and experimentation in approaches, including partnerships with the private sector (including business) and religious and nongovernmental organizations (NGOs). Popular expectations have risen, and there is a greater sense among the leadership of each country of the strategic import of achieving better control over global infectious diseases. The latter has been reinforced by the shared experience over the past year in confronting the threat of avian influenza and, in the 2002–2003 period, in battling SARS in China and neighboring states.

In addition, they have each recently shown a rising interest in being part of the global response to HIV/AIDS. All three have solicited and received financial support for domestic HIV/AIDS efforts from the Global Fund and the World Bank, and each has active and broadening relations with government aid agencies in other G-8 countries as well as with private foundations. Uniquely among the three, Russia is also a donor to the Global Fund, and it has sent an initial group of physicians to work in selected African HIV programs. The State Council of the Russian Federation, a high-level advisory body to the head of state, recently undertook a review of the country's national HIV/AIDS policy strategy. Russia also recently hosted the first Eastern European and Central Asian AIDS Conference, under the auspices of the International AIDS Society (IAS). China has fielded multiple expert missions to Africa and begun extensive exchanges in Africa of medical personnel for training purposes. India has financed HIV/AIDS programs in a number of African countries. Its pharmaceutical industry has established production facilities in Africa and Latin America and plays a pivotal role in making antiretroviral treatment affordable in developing countries. In addition, India's advanced medical research expertise and its extensive nongovernmental sector have attracted considerable international attention from HIV/AIDS experts.

The G-8's Evolving Role on HIV/AIDS and Global Health

Background

The G-8's engagement on HIV/AIDS dates back to the 1987 Venice communiqué. Subsequent action by the G-8 on HIV/AIDS, and on global health more generally, accelerated significantly beginning with the 1996 Lyons summit. By the late 1990s, the G-8 was emphasizing resurgent infectious disease as a shared problem tied to globalization, and its members began pressing for action to restructure and strengthen the performance of the World Health Organization (WHO) and other UN bodies, particularly with respect to HIV/AIDS and other major infectious disease initiatives. An important UN-led initiative was the Roll Back Malaria campaign, launched in 1998 at Birmingham, England.⁷

More recently, the G-8 has shifted its attention increasingly to its own independent initiatives, often involving new models of public-private partnership, and has set ambitious funding goals. The G-8 has at the same time elaborated several core principles

⁷ Kirton and Mannell, "The G8 and Global Health Governance"; and Kirton and Sunderland, "The G8 Summit Communiqués on Health."

on global health, including the need to: give Africa high priority; work toward more funding, research, and international cooperation; and achieve improved access to affordable, effective medicines, not just for HIV/AIDS but also for malaria, tuberculosis, and polio. These principles were spelled out most clearly in the G-8 Health Action Plan issued in 2003 at Evian, France.⁸

The Global Fund, arguably the most significant G-8–led infectious disease initiative, emerged out of the 2000 summit in Okinawa, Japan. The UN General Assembly Special Session in June 2001 discussed and supported the proposal presented by the UN secretary-general and several donor countries to establish a global HIV/AIDS and health fund. At their summit in Genoa, Italy, one month later, G-8 leaders endorsed the proposal and announced pledges totaling U.S.\$1.3 billion. The G-8 that year also began annual health ministerial meetings, prompted in part by bioterror concerns in the wake of the September 11, 2001, terrorist attacks in the United States.

At the 2004 G-8 summit in Sea Island, Georgia (U.S.A.), HIV/AIDS-related discussion centered on medical research and incentives around vaccine development and advance purchase commitment schema for vaccines and other technologies. To that end, the G-8 announced the development of the Global HIV Vaccine Enterprise, a consortium designed to accelerate HIV vaccine development by enhancing coordination, information sharing, and collaboration globally.

Most recently, at last year’s summit in Gleneagles, Scotland, the G-8 declared 2005 the “year for Africa” and committed to ensuring, as nearly as possible, universal access to antiretroviral treatment (ART) by 2010. Leaders also pledged to double assistance flows to Africa and all developing countries elsewhere by that year and to accelerate debt relief and trade reform. The Gleneagles summit also saw the expanded inclusion of civil society groups in the process.

In general, international funding for HIV/AIDS—primarily from the G-8 and other government donors, through bilateral channels, the Global Fund, the World Bank, and the private sector (including nonprofit entities)—has significantly increased over the past several years due in large part to the G-8’s engagement and leadership.⁹

This period of G-8 expansiveness with respect to HIV/AIDS and global health has not been without strains, however, including criticism of G-8 overreach. The Global Fund’s future funding remains uncertain, and it is unlikely to attain the level of support originally envisaged. An assessment of pledges made at Gleneagles suggests that it is highly unlikely there will truly be a doubling of assistance to Africa by 2010. Doubts are already being expressed as to whether the target of universal access to antiretrovirals by 2010 will be achieved. At a more general level, there is disquiet over the proliferation of G-8 initiatives, about whether the G-8 pays too little attention to WHO, UNAIDS, and other existing international bodies, and about whether the G-8 is able to monitor and attain its targets effectively.

⁸ Ibid.

⁹ United Nations, “Declaration of Commitment on HIV/AIDS: Five Years Later,” report of the secretary-general, March 24, 2006. Also see: UNAIDS, *Resource Needs for an Expanded Response to AIDS*; and Kates, *Financing the Response to HIV/AIDS*.

These issues notwithstanding, the G-8's leadership on HIV/AIDS specifically, and global health more generally, remains vital in galvanizing needed attention, funding, and innovation.

The Russian Presidency of the G-8

Consistent with G-8 actions over the past decade, Russia has made infectious diseases one of three priority areas for the St. Petersburg G-8 summit, along with energy and education. While it had been understood within the G-8 that Russia would include HIV/AIDS as part of the larger infectious disease platform,¹⁰ Russia just recently announced its intention to elevate HIV/AIDS as a prominent focus for G-8 action.¹¹

Russia has also made clear its desire for G-8 members to evaluate ongoing initiatives, take account of as-yet-unfulfilled promises, and be more disciplined in deciding how and when to commit to new priorities. It has emphasized that there should be few if any new G-8 targets or macro-pledges, that the G-8 should give priority to working through existing institutions and mechanisms, and that members should concentrate on fulfilling existing promises and carrying on ongoing initiatives to a successful conclusion.

Russia has pressed for a close alignment between the G-8 health agenda for 2006 and Russia's own domestic priorities. In terms of the latter, President Vladimir Putin has defined the four "national projects" for Russia as health, education, housing, and agriculture.

Russia has also shown increasing openness to consulting systematically with a range of nongovernmental groups, both in Russia and in other G-8 member countries. Importantly, it has also reached beyond the G-8, extending special invitations to China, India, Brazil, South Africa, and Mexico to contribute to the health ministerial session that took place at the end of April and for heads of state from these five countries to be present at the G-8 summit in July. By bringing China and India into the G-8 orbit in this way, Russia has laid the groundwork for enlarging the G-8's health agenda systematically to encompass Eurasia, and it has opened the question of whether China and India can actively assist in sustaining and consolidating existing G-8 commitments on HIV/AIDS and global health.

A Potential G-8 Eurasian Agenda on HIV/AIDS

In 2006, the year of Russia's presidency, the G-8 is well positioned to spearhead a Eurasian agenda on HIV/AIDS that draws systematically on the shared interests and concerns outlined above, addressing both regional and global dimensions of HIV/AIDS. There are several promising areas for concerted action with India and China that have relatively low entry costs, hold the promise of high potential gains, build out from existing G-8 commitments and priorities, have broader public health benefits beyond

¹⁰ Agenda items posted on official Web site of Russia's G-8 Presidency, <http://en.g8russia.ru/agenda/diseases/>.

¹¹ Official Web site of Russia's G-8 Presidency, "AIDS to be discussed at the G-8 summit on Russia's initiative—Putin," <http://en.g8russia.ru/news/20060421/1148041.html>.

HIV/AIDS, and align well both with Russia's own domestic priorities and the emerging Russian-led agenda for the St. Petersburg summit.

Options that deserve consideration by the G-8 membership include:

- **A Health Leadership Forum.** Russia, India, and China might form a regional Eurasia health alliance that would link with the G-8 through the G-8 health ministerial meetings. Alternatively, the G-8 might formally launch a leadership forum on global health—"a G-8 plus"—in which Russia combines the G-8's established ties with African leaders with the rising influence and leadership commitments of the Chinese, Indians, and other Eurasian states on matters of global health, with a special focus on HIV/AIDS. The creation of the latter forum would build on the G-8 health ministerial meetings begun in 2001. Either forum would create an identifiable structure that signals the seriousness of G-8 members' intentions and helps to move forward substantive endeavors, such as those identified below. As part of this effort, the G-8 might also request that several key existing global health institutions and initiatives (such as UNAIDS, the STOP TB Campaign, and the Roll Back Malaria Campaign) prepare an annual report to the G-8 that details progress and persistent gaps in attaining G-8 global health goals.
- **Sustainability of Financing.** The G-8 might use broadened engagement with China, India, and other countries in Eurasia to focus on the sustainability of financing to meet expanding future demands to combat HIV/AIDS and other infectious diseases. Indeed, if the G-8 is ever to realize the commitment to universal ART access by 2010 embraced at Gleneagles in 2005, it will need far greater domestic resource commitments by China, India, and other key Eurasian powers. Similarly, it will be important for the G-8 to recognize that Russia, China, and India are increasingly well-endowed states that are able to deploy their wealth and power outside their borders in support of multilateral initiatives. The G-8 will also need their engagement on projected needs and costs; steps to improve the quality of data; and global strategies to strengthen the viability of existing institutions and mechanisms such as the Global Fund, the World Bank, and WHO—as well as new initiatives and proposals such as the International Finance Facility, advance market commitments, and international taxation mechanisms. Today, there is mounting uncertainty about how the international community will meet escalating future global health demands. This issue stands implicitly at the very center of the G-8 agenda on global health, and it is one in which the G-8 cannot plausibly begin to make real progress until the views, internal commitments, and international influence of China, India, and others in Eurasia are fully factored into any G-8 strategy.
- **Enhancing Global HIV-Prevention Efforts.** The G-8 might incorporate China and India into an effort to broaden and intensify global HIV-prevention efforts.¹² Up to now, the G-8 has focused primarily on HIV treatment and has understandably concentrated its attention on Africa's advanced, generalized HIV/AIDS epidemic. The G-8's efforts in the prevention field have been uneven and incomplete; meanwhile, global prevention efforts have not yet reversed the steady growth of the

¹² UNAIDS, *Intensifying HIV Prevention: UNAIDS Policy Position Paper* (Geneva: UNAIDS, August 2005).

HIV/AIDS epidemic, and the epidemic is spreading in Eurasia at a disturbing rate. The G-8 might add a priority focus on the early, concentrated epidemics seen in large populous regional states such as Russia, India, and China. These countries face special prevention challenges, including the need to confront stigma more directly; expand access to prevention, care, and treatment services for high-risk groups such as IDUs, sex workers, MSM, and prisoners; simultaneously address the dual impacts of TB and HIV; and reconcile tensions between public health and crime control policies. There is also an urgent priority in these countries to ensure that the rights of people living with HIV/AIDS and members of vulnerable populations are protected. Recent accelerated action by China to tackle the dual epidemics of drug use and HIV/AIDS could be examined closely. There is also the need to address the intraregional drug trafficking and migration dimensions of the Eurasian epidemic.¹³ These issues could benefit from concentrated region-wide attention given that the spread of HIV/AIDS in China, India, and Russia is affected, to a significant degree, by the drug routes that connect Asia with Europe. Finally, it will be critical for the G-8 to ensure that these efforts are grounded in international HIV-prevention best practices and models that have taken form in the 20-plus years of fighting HIV/AIDS.

- **Addressing the Global Health Workforce Deficit.** The G-8 might enlist China and India in a systematic dialogue on the global health workforce deficit, a situation that is detailed powerfully in a recent WHO report.¹⁴ Special attention could be given to coordinated expansion of public health education and training on HIV/AIDS and infectious diseases. Action in this area could also include consideration of how G-8 member states, the predominant recruitment market for health professionals from low- and middle-income countries, could help increase other countries' retention of these key workers.
- **Building Public-Private Partnerships.** In varying ways, the governments of China, India, and Russia are each at an early point in setting policies to promote public-private partnerships—involving NGOs, religious groups, and the private sector—to surmount barriers to participation in research and access to products and services. Recent experiences with public-private partnerships suggest that such mechanisms will inexorably play a large role in the expansion of research, prevention, care, and treatment programs. The G-8 potentially has a role to play in helping expedite the transfer of knowledge, expertise, and models from Africa and the G-8 countries themselves.
- **Supply, Procurement, and Regulation of Essential Medicines.** The G-8 might initiate a focused dialogue with Eurasian powers on sensitive, complex regulatory issues that impact on World Trade Organization (WTO) accession and will critically affect the delivery of affordable and adequate volumes of essential medicines in the future to low- and middle-income countries. Russia is beginning efforts to scale up ART delivery domestically and is already facing supply and procurement challenges. China and India are both large-scale prospective consumers and producers of antiretroviral drugs and other medications. Their impact on global markets for HIV

¹³ See Christopher Beyrer, "The Next Wave," and Department of State, *Trafficking in Persons Report*.

¹⁴ WHO, *The World Health Report 2006: Working Together for Health* (Geneva: World Health Organization, 2006).

drugs and other medications will only grow and become more complicated. For that reason alone, there is a strong and compelling argument for the G-8 to include the two countries in ongoing deliberations over a future strategy to ensure an orderly, uninterrupted flow of affordable medications into Eurasia.

- **Expanding Scientific Research in Eurasia.** The G-8 might make a priority of expanding scientific research in Eurasia on HIV vaccines. A promising, complex web of scientific research linkages already binds G-8 member states with China, India, and other Eurasian states. By forging research partnerships among G-8 countries, Eurasian states, and African nations, the G-8 can strengthen research and health care infrastructure, clinical trial sites, and regulatory capacity—thus accelerating research for the development of better tools and new technologies. Russia has recently signaled its intention, as part of its G-8 presidency, to pursue initiatives in this area. For example, it is expected that at the St. Petersburg summit Russia will propose the establishment of an international HIV-vaccine center in the host city. Russia is also looking to create an international reference laboratory, under the auspices of the WHO, to monitor the broader epidemiological situation in Russia, Eastern Europe, the South Caucasus, and Central Asia. These and other similar initiatives in Eurasia will provide valuable platforms for integrating Eurasian powers more fully in global efforts to develop an HIV vaccine and find a cure. This would ensure that the experience and expertise of Russian, Chinese, and Indian scientists are fully leveraged in the science of HIV/AIDS. The G-8 potentially has an important role in supporting these initiatives with technical, financial, and other assistance.

Annex: Status Update on HIV/AIDS in Russia, China, and India

Below are brief background overviews of the status of the HIV/AIDS epidemic in Russia, China, and India, including key trends and issues as well as a summary of the countries' responses to date. Several recent analyses, cited but not summarized here, have outlined the potential damaging economic and demographic impacts of an expanded HIV/AIDS epidemic in these countries.¹⁵ These studies underscore the urgent imperative to stem the tide of HIV/AIDS in these "second wave" states that are so crucial to the global political economy.

HIV/AIDS in Russia

The first case of HIV was registered in Russia in 1987, but Russia's epidemic did not experience a steep rise until the mid-1990s, later than many other nations.¹⁶ Today, Russia accounts for the majority (nearly 70 percent) of HIV cases in Eastern Europe and Central Asia and has one of the fastest growing HIV epidemics in the world.¹⁷ HIV/AIDS cases have been reported in all 88 regions of the country, although most cases are concentrated in 13 regions. Together these 13 regions accounted for 60 percent of all reported HIV cases in the country by the end of 2005.

According to the Russian Ministry of Health, more than 335,000 cases of HIV infection have been registered in the country.¹⁸ UNAIDS and others estimate that the actual number is much higher, with recent UNAIDS estimates placing the number at approximately 940,000, with an upper range of 1.6 million.¹⁹ National HIV/AIDS prevalence is estimated to be 1.1 percent.²⁰ A distinctive feature of Russia's HIV/AIDS epidemic is its disproportionate impact on young Russians: 80 percent of people living with HIV/AIDS in Russia are under 30 years of age.²¹ In addition, and unlike China and India, Russia faces significant demographic and health challenges that are exacerbated by HIV/AIDS, including population decline and falling life expectancy among men in particular. Greater attention to its HIV/AIDS epidemic is therefore of paramount importance.

¹⁵ National Intelligence Council, *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China* (Washington, D.C.: GPO, September 2002); United Nations Development Program (UNDP), *Reversing the Epidemic: Facts and Policy Options* (Bratislava: UNDP, 2004); Nicholas Eberstadt, "The Future of AIDS," *Foreign Affairs* 81, no. 6 (November/December 2002); UN Population Division, *The Impact of AIDS* (New York: United Nations, 2004); Futures Group Beijing, *Socio-economic Impacts of HIV/AIDS in China* (Washington, D.C.: Futures Group, March 2002); and Mead Over et al., *HIV/AIDS Treatment and Prevention in India: Modeling the Costs and Consequences* (Washington, D.C.: World Bank, June 2004).

¹⁶ Transatlantic Partners Against AIDS (TPAA), "Key Facts about HIV/AIDS in the Russian Federation," Moscow and New York, February 2006.

¹⁷ EuroHIV, *HIV/AIDS Surveillance in Europe: End-year Report 2004*, no. 71 (St. Maurice, France: Institut de Veille Sanitaire, 2005); UNAIDS, "Fact Sheet: Eastern Europe and Central Asia," Geneva, November 2005; and TPAA, "Key Facts."

¹⁸ TPAA, "Key Facts."

¹⁹ UNAIDS, *2006 Report on the Global AIDS Epidemic* (Geneva: UNAIDS, May 2006).

²⁰ Ibid.

²¹ TPAA, "Key Facts"; and UNAIDS, "Fact Sheet: Eastern Europe and Central Asia."

HIV/AIDS in Russia is still considered to be a concentrated epidemic, although there are important shifts underway. Injection drug use was the early and main driver of the epidemic in Russia and remains the predominant means of transmission today. At the same time, the share of infections due to heterosexual transmission has risen considerably in recent years, and mother-to-child transmission is also on the rise.²² In addition, while men continue to represent the majority of HIV cases, women account for an increasing share. In some regions of Russia, women account for 30 to 50 percent of new HIV cases, a trend even more pronounced among the younger age cohorts.²³ These shifts are consistent with those of other countries whose epidemics started much earlier.

The Government's Response

The first governmental response to the epidemic was undertaken by the Soviet Union in 1987 through a decree entitled “On Measures for Prophylaxis of Infection of AIDS Virus.” This decree largely focused on mandatory testing, criminalization, and other measures designed to protect Soviet society from what was then perceived to be an outside threat. By 1990, however, new legislation, “On Prophylaxis of AIDS Disease,” was passed that addressed the needs of those living with HIV/AIDS and included antidiscrimination measures.²⁴ A governmental committee on HIV/AIDS was created the following year, but it ceased to exist upon the collapse of the USSR at the end of 1991.²⁵ Institutionally, the Soviet Ministry of Health established a separate centralized network of AIDS centers that in the early stages ensured prevention of infection outbreaks through infected blood donors and through infections in hospitals (with the exception of the tragic outbreaks in Soviet pediatric facilities in the late 1980s). The creation of this separate network meant, however, that HIV-prevention and treatment efforts were not integrated into the larger health care system, and to this day, health care providers have generally remained poorly trained and informed about the disease.

In 1995, the Russian Federal HIV/AIDS Law, which remains in effect today, was enacted. It established a wide range of guaranteed rights for persons with HIV/AIDS in health care, labor relations, education, and other aspects of social life. A broader governmental response was not initiated until several years later, however, and it has only accelerated significantly in the last two years.

In November 2001, the Russian government approved the national AIDS program—the “Prevention and Control of Socially Significant Diseases (2002–2006)” —which is currently in operation and includes an “Anti-HIV/AIDS” subprogram.²⁶ The subprogram succeeded the two previous HIV/AIDS federal targeted programs, adopted in 1993 and 1996, respectively. Its original budget was 350 million rubles (U.S.\$12 million) per year, with upwards of 90 percent expected to be provided by the country’s 88 regions. In 2003,

²² Russian Federal Scientific and Methodological Center for HIV/AIDS, Informational Bulletin No. 25.

²³ Russian Federal Service on Customers’ Rights and Human Welfare Monitoring.

²⁴ S. Polubinskaya, *Federal Law “On Prevention of Spreading in the Russian Federation of Disease Caused by Human Immunodeficiency Virus (HIV Infection)”*: Background, Content, and Perspectives, Policy Brief no. 1.3 (Moscow: TPAA, November 2004).

²⁵ TPAA and UNAIDS, *HIV/AIDS, Law and Human Rights: A Handbook for Russian Legislators* (Moscow: TPAA, 2005).

²⁶ *Federal Law on the Federal Budget of the Russian Federation for 2005*, Federal Law no. 141-FZ, November 4, 2005.

the Coordinating Council on Prevention of Mother-to-Child Transmission of HIV Infection was established, and the Coordinating Council on HIV/AIDS of the Ministry of Health and Social Development followed in 2004. Also in 2004, the Interfactual Deputies' Working Group on Prevention and Fight Against AIDS was established at the State Duma.

In 2005, the federal budget included 186.8 million rubles (U.S.\$6.5 million) for implementation of the Anti-HIV/AIDS subprogram. Regional budgets in the 2002–2004 period contributed more than 2.4 billion rubles (U.S.\$84 million).²⁷ Additional funds were allocated through the federal Ministries of Defense and Education and Science. Since then, the government's resource commitment has risen sharply. The 2006 federal budget approved by President Vladimir Putin commits 3.1 billion rubles (U.S.\$105 million), a 20-fold increase over 2005, to finance HIV treatment and prevention under the National Public Health Project. The amount allocated in the 2007 federal budget is expected to rise to 7.7 billion rubles (U.S.\$260 million).²⁸

In an important recent development, the Russian State Council reviewed the country's HIV/AIDS policy in April 2006; this was the first time that HIV/AIDS was considered at such a high political level. That initiative was part of the Putin government's decision to designate comprehensive health reform as one of the four domestic "national projects" (along with housing, education, and agriculture). Following the review, the president issued a decree establishing a new Governmental Commission on Prevention, Diagnostics and Treatment of HIV-infection, to be implemented by June 1, 2006.

Russia has also been involved in several important regional HIV/AIDS initiatives. In 2002, the Commonwealth of Independent States (CIS) Inter-parliamentary Assembly working group was established to draft a model law, "On Prevention of Spreading of HIV/AIDS in CIS countries," which is expected to be completed later this year. In 2005, a ministerial meeting, "Urgent Response to the HIV/AIDS Epidemics in the Commonwealth of Independent States," held in Moscow and hosted by the Russian government, was attended by CIS ministers of health, justice, interior, development, and social services, as well as representatives from NGOs, health experts from the public and private sectors, and other officials from the UN and CIS governments. The Moscow Declaration that was adopted at this meeting calls for scaling up responses to the HIV/AIDS epidemic in the CIS. In May 2006, the first regional Eastern European and Central Asian AIDS conference took place in Moscow.

International Donors and NGOs

Russia's partnership with donors and its own role as a donor vis-à-vis HIV/AIDS are recent phenomena. In April 2003, the Russian government signed a loan agreement with the World Bank that includes an HIV/AIDS component of U.S.\$46.8 million.²⁹ The Global Fund has approved two grants to Russia, one for U.S.\$89 million to an NGO consortium primarily for HIV prevention, and another for U.S.\$120 million to the

²⁷ Resolution of a meeting on the monitoring and prevention of HIV infection in the Russian Federation, October 11–13, 2005, Suzdal. Approved by the head of Rospotrebnadzor on November 23, 2005.

²⁸ See *Federal Law on the Federal Budget of the Russian Federation for 2005*.

²⁹ World Bank, "World Bank Helps Tackle Tuberculosis and HIV/AIDS in Russia," press release," April 4, 2003.

Russian government for treatment.³⁰ Russia is also a donor to the Global Fund: the government has contributed U.S.\$22.5 million already and has pledged an additional U.S.\$20 million to be paid by 2009. Several bilateral donors are active in Russia, including Canada, the EU, Sweden, Germany, the Netherlands, the United Kingdom, and the United States. While not designated as a focus country under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Russia is considered to be a "priority country" in the U.S. global HIV/AIDS strategy and received almost U.S.\$14 million in U.S. bilateral aid in the 2005 U.S. fiscal year.³¹

NGOs, both indigenous and international, play an important role in the response to HIV/AIDS in Russia, with many operating programs and providing services for several years. More recently, the private sector, including business, has begun to play a more visible role in addressing HIV/AIDS. For example, in 2004, a group of leading Russian media companies launched the Russian Media Partnership to Combat HIV/AIDS (RMP) in partnership with Transatlantic Partners Against AIDS, the Kaiser Family Foundation, and UNAIDS.

However, recent legislative action establishing greater state controls over Russia's NGO sector has raised serious concerns about the future role of NGOs in the response to HIV/AIDS and other issues.

Challenges

Russia is focusing greater attention and resources on HIV/AIDS as part of a broader, ambitious national health reform effort. Substantially increased funding for HIV/AIDS is beginning to flow, and the country's leadership is engaged directly at unprecedented levels. But major challenges are on the horizon.

- **Policy.** Russia is under increased pressure to demonstrate that its policies align with international best practices and that the allocation of resources reflects policy reforms. Priority areas where more high-level leadership action is needed include the following: accelerating prevention for high-risk groups; strengthening legal protections for people with HIV/AIDS to minimize stigma and discrimination; substantially enlarging access to treatment; legalizing substitution therapy for IDUs; and legitimizing and legally protecting the nongovernmental sector.

Despite the existence of some improvements in the legal protections afforded to persons living with HIV/AIDS, formidable HIV-related stigma and discrimination persist. Access to both prevention and treatment services remains highly limited. For example, it is estimated that ART is available and accessible to only 6 to 15 percent of people who need it. Members of high-risk and marginalized populations, in particular drug users, are largely disenfranchised from access to services. Medication-assisted treatment for IDUs, including methadone therapy, is illegal in the Russian Federation for any purpose. Finally, the long-term legal status and political legitimacy

³⁰ Global Fund, "Portfolio of Grants to the Russian Federation," <http://www.theglobalfund.org/Programs/Portfolio.aspx?countryID=RUS&lang>.

³¹ Office of the Global AIDS Coordinator, *Action Today, A Foundation for Tomorrow: The President's Emergency Plan for AIDS Relief, Second Annual Report to Congress* (Washington, D.C.: U.S. Department of State, February 2006).

of the nongovernmental sector remain uncertain, a situation that could have negative consequences given how critical NGOs are to an effective, comprehensive HIV/AIDS response.

- **Capacity.** Russia's increasingly decentralized public health infrastructure still needs to address critical access gaps for needed HIV prevention, treatment, and social services. To achieve its ambitious objectives on HIV/AIDS, Russia will require a far clearer and more dynamic strategy for building the institutional capacity to implement programs. It will need to clarify its long-term financing plan, how it will go about training sufficient numbers of key personnel, and how it will put in place adequate laboratory infrastructure. Though there has recently been a significant reduction in the cost of antiretroviral drugs, primarily due to the drug pricing requirements established by the Global Fund, and adequate financial resources have become available, major barriers stand in the way of efficient, equitable, and sustainable treatment scale up. These barriers include weak health care infrastructure, pervasive stigma, and lack of support services for the most vulnerable groups.

HIV/AIDS in China

Since China's first reported HIV case in 1985, HIV has spread throughout the country to all 31 provinces and municipalities. As of the end of 2005, the Chinese Ministry of Health estimated that approximately 650,000 persons were living with HIV/AIDS in China, about three-quarters of whom are in five Chinese provinces: Yunnan, Henan, Xinjiang, Guangxi and Guangdong.³² This recent estimate, just confirmed by UNAIDS (with the adult prevalence rate estimated to be 0.1 percent),³³ is lower than previously believed, but UNAIDS and other experts caution that this is primarily due to enhanced surveillance rather than an actual decrease in infection rates; in fact, there is concern that new infections may be on the rise.³⁴ In addition, most cases of HIV in China are not yet registered, which means that most of those infected—upwards of 80 percent—do not know their status. This has obvious implications for the continued spread of HIV in a country with a population of 1.3 billion, the largest in the world.

Trends in the epidemic in China indicate its impact on certain populations. Prevalence among IDUs tripled between 1998 and 2004; it increased even more significantly among sex workers, rising nearly 50-fold since 1996. Among pregnant women in highly affected areas, prevalence rose from nil in 1997 to 0.26 percent in 2004.³⁵ In addition, while China's epidemic remains concentrated, several emerging factors—such as the increase

³² See People's Republic of China (PRC) Ministry of Health, UNAIDS, and WHO, *2005 Update on the HIV/AIDS Epidemic and Response in China* (Beijing: National Center for AIDS/STD Prevention and Control, January 24, 2006), p. i. See also, "China Has 135,630 Reported Cases of Reported HIV Infection," Xinhuanet.com, November 28, 2005. The figure of 840,000 HIV-positive persons in China was reported a year earlier in China State Council Working Committee on AIDS and UN Theme Group on HIV/AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment, and Care in China (2004)* (Beijing: State Council AIDS Working Committee Office and UN Theme Group on HIV/AIDS in China, December 1, 2004).

³³ UNAIDS, *2006 Report on the Global AIDS Epidemic*.

³⁴ See PRC Ministry of Health, UNAIDS, and WHO, *2005 Update on the HIV/AIDS Epidemic and Response in China*.

³⁵ *Ibid.*

in China's commercial sex activity and risky behavior in the "floating population" of migrant workers—could contribute to more widespread transmission.³⁶ In some provinces, HIV prevalence exceeds 1 percent among pregnant women as well as people who receive premarital and clinical HIV testing.³⁷ HIV transmission in China is no longer due primarily to injection drug use (more than two-thirds of cases in earlier years); in 2005, an estimated half of infections were attributed to sexual transmission, either heterosexual or homosexual.³⁸ MSM are a particularly vulnerable group in China because they face significant discrimination and stigma, which complicates their access to information and services. Mother-to-child transmission also appears to be on the rise.

The Government's Response

Chinese laws and regulations addressing HIV/AIDS (both directly and indirectly) date back as far as 1984. They were initially focused on keeping imported blood products and foreigners with HIV out of the country.³⁹ In the 1990s, laws began to address broader principles and policies related to HIV prevention and control. The government issued the first significant law, the "China Mid- and Long-Term Plan for HIV/AIDS Prevention and Control," in 1998. The "China Plan of Action to Contain, Prevent and Control HIV/AIDS (2001–2005)," which followed in 2001, called for an increase in the central budget for AIDS from 15 million yuan (U.S.\$2 million) to 100 million yuan (U.S.\$12.5 million) per year, and provincial and local government spending was even higher.

Beginning in 2003, the Chinese government response to HIV/AIDS accelerated significantly, driven by factors such as increased international attention, the outbreak of SARS and other serious health-related challenges in the country, and the rise to power of a new national leadership, including new leaders at the Ministry of Health. National and provincial budgets for HIV/AIDS were further increased. A high-level interagency body—the State Council Working Group on HIV/AIDS—was established in 2003 to better coordinate the national response. In 2005, the national budget allocation for combating HIV/AIDS was increased to 800 million yuan (U.S.\$100 million), and provincial and local government spending was estimated to be 280 million yuan (U.S.\$35 million). There are indications that the budget will nearly double for 2006 and 2007 to perhaps 1.5 billion yuan (U.S.\$187 million) each year.⁴⁰ A national treatment program has been initiated in the country,⁴¹ and by the end of 2005 approximately 20,500 patients in 605 counties in 28 provinces had been enrolled.⁴²

³⁶ Bates Gill, J. Stephen Morrison, and Andrew Thompson, *Defusing China's Time Bomb: Sustaining the Momentum of China's HIV/AIDS Response* (Washington, D.C.: CSIS, June 2004).

³⁷ PRC Ministry of Health, UNAIDS, and WHO, *2005 Update on the HIV/AIDS Epidemic*.

³⁸ Office of the State Council Working Committee on AIDS, "Progress on Implementing UNGASS Declaration of Commitment in China 2005," Beijing, December, 2005, p. 11.

³⁹ UN Theme Group on HIV/AIDS in China, *HIV/AIDS: China's Titanic Peril* (Geneva: UNAIDS, June 2002).

⁴⁰ "Spending on HIV/AIDS Prevention Set to Double," *China Daily*, December 28, 2005.

⁴¹ "Four frees and one care" refers to free antiretroviral treatment for farmers and indigent AIDS patients, free HIV testing, free access to medicines to prevent mother-to-child transmission of HIV, free schooling for AIDS orphans, and care for families affected by HIV/AIDS.

⁴² PRC Ministry of Health, UNAIDS, and WHO, *2005 Update on the HIV/AIDS Epidemic*.

Awareness and education programs have also been expanded, as have surveillance sites. More extensive interventions—including condom promotion and distribution, needle and syringe exchange programs, and methadone replacement therapy—have been planned or already launched as part of an effort to stem the spread of HIV among certain marginalized populations such as IDUs and sex workers. In 2004, for example, new national guidelines for methadone maintenance treatment (MMT) were developed, a governmental task force on MMT was created, a pilot MMT program for IDUs was initiated, and needle exchange programs were introduced in several provinces.⁴³

In January 2006, the State Council announced long-awaited HIV/AIDS regulations that took effect on March 1, 2006. The new regulations are important because they bring greater national attention to the challenges faced by people with HIV and codify anti-stigma and discrimination rules. The regulations also stipulate the role of different government agencies at national and local levels and spell out the rights and obligations of HIV-positive persons and their families.

International Donors and NGOs

Since 2003, the Chinese government has demonstrated increasing openness to accepting assistance from international NGOs, the private sector, and numerous governments. International cooperation programs to combat HIV/AIDS have been estimated to have contributed 1.87 billion yuan (U.S.\$229 million) to China's HIV/AIDS response over the past two years.⁴⁴ Two Global Fund grants have been signed—U.S.\$98 million in Round 3 and U.S.\$64 million in Round 4—for HIV prevention, treatment, and care in China.⁴⁵ China's Round 5 Global Fund application (submitted in June 2005) foresees a sharp increase in the amount of funding earmarked for NGOs and civil society organizations, particularly NGOs led by people living with HIV/AIDS. The expectation is that increased support will be channeled to groups working with sex workers and MSM.⁴⁶ China is not a PEPFAR focus country, but it is considered to be a “priority country” for the U.S. global HIV/AIDS strategy; it received between U.S.\$5 million and \$10 million in U.S. bilateral aid in the 2005 U.S. fiscal year.⁴⁷ The United Kingdom has also been active in HIV/AIDS efforts in China. While the UK-funded “China-UK” HIV/AIDS program (which allocated U.S.\$37.6 million to HIV/AIDS services in Yunnan and Sichuan provinces) is expected to conclude in 2006, the government recently announced plans to provide UK£105 million (U.S.\$195 million) over the next five years to help China tackle issues related to poverty, including HIV/AIDS and tuberculosis.⁴⁸ Australia is also funding several HIV/AIDS efforts in China with projects expected to total AUS\$18.4 million (U.S.\$13.6 million) through 2008 and also supports a regional project on HIV/AIDS that includes

⁴³ China State Council Working Committee on AIDS and UN Theme Group on HIV/AIDS in China, *A Joint Assessment of HIV/AIDS Prevention, Treatment, and Care in China (2004)*.

⁴⁴ “New Rules to Combat AIDS Spread,” *China Daily*, October 28, 2005.

⁴⁵ Global Fund, “Portfolio of Grants to China,”

<http://www.theglobalfund.org/programs/search.aspx?lang=en>.

⁴⁶ Information about the Chinese application to Round 5 of the Global Fund is available on the China AIDS Info Web site at <http://www.china-aids.org/gf5/china-aids-gf5--final.pdf> and on the Global Fund Web site at <http://www.theglobalfund.org>.

⁴⁷ Office of the Global AIDS Coordinator, *Action Today, A Foundation for Tomorrow*.

⁴⁸ UK Department for International Development, “China: Country Assistance Plan 2006–2011,” London, March 2006.

China.⁴⁹ The Chinese government has strengthened cooperation and exchange with UNAIDS, WHO, and other international agencies.

Important private, international donors have also begun to provide funding and technical assistance to combat HIV/AIDS in China. For example, it was announced in May 2005 that Merck & Co., a U.S.-based pharmaceutical company, will work with the Chinese Ministry of Health to implement a five-year, U.S.\$30-million program for comprehensive HIV/AIDS patient management. The Clinton Foundation has worked with international and Chinese partners to provide lower-priced HIV drugs, strategic planning, and doctor training, and it recently announced a partnership with the Australian government to provide HIV testing and antiretroviral drugs in China.

China has also been involved in several important HIV vaccine research efforts. These include a collaboration among the Aaron Diamond AIDS Research Center, the Chinese Academy for Medical Sciences (CAMS), and the Yunnan Center for Disease Control and Prevention, with trials potentially taking place in southwest China in a few years; a vaccine being developed by scientists affiliated with the China National Centers for Disease Control, in collaboration with the U.S. National Institutes of Health and European partners; a vaccine development effort by Guangzhou Life Sciences; and a therapeutic vaccine partnership between French and Chinese scientists working through CAMS.

Challenges

Despite major increases in new resources, the establishment of new programs, and an unambiguous shift in the central government's stance toward dealing with the disease, significant challenges lie ahead in China.

- **Policy.** Combating HIV/AIDS is still largely seen as a “health problem” in China to be tackled by the Ministry of Health, rather than as a broader socioeconomic challenge that requires sustained high-level engagement and leadership and a more comprehensive and coordinated response from across the governmental and nongovernmental spectrum. In addition, there is a critical need to translate the central government's commitment to fight HIV/AIDS to provincial, prefecture, and county level authorities.

There is also a great need to refine the national policy approach toward marginalized groups such as drug users, sex workers, MSM, migrants, and ethnic minorities. Stigma toward these individuals remains a powerful factor, including among health care workers. Legal protections for them are generally weak. Ethnic minorities, especially those in southern and western China, are disproportionately affected by HIV/AIDS and presenting special linguistic and cultural challenges.

NGOs, both domestic and international, continue to have an ambiguous legal status in China, and they remain vulnerable to political, legal, and financial complications with local and central authorities. Much stronger and clearer policy action is needed to

⁴⁹ AusAID, “Aid Activities in China,”

http://www.ausaid.gov.au/country/cbrief.cfm?DCon=1020_3096_4280_204_3400&CountryID=36&Region=EastAsia.

enlarge and protect the space for NGOs. Public-private partnerships, which harness the skills and resources of governmental and nongovernmental sectors in a collaborative environment, are a relatively new concept in the fight against HIV/AIDS in China. They are slowly catching on but will take time to be developed.

- **Capacity.** The public health system in rural areas is debilitated and dysfunctional. Overall, resources and capacity are lacking at many levels. Medical professionals lack not only the expertise and necessary incentives to treat HIV/AIDS patients, but also the necessary equipment and technologies to properly diagnose, counsel, treat, monitor, and care for them. Ancillary treatment, counseling, and social services are not sufficiently available to those in need.

Since the mid-1990s, the government has stepped up its efforts to regulate the commercial blood supply, thereby reducing the threat of spreading HIV through tainted blood supplies. This useful effort may have had unintended negative consequences, however, by driving the practice of commercial blood donation underground and thus creating potentially greater risks to donors and recipients.⁵⁰

HIV-testing capacity is severely stretched. By the end of 2005, there were only 3,756 HIV-screening labs and 63 confirmation labs in operation across the country, a resource limitation that causes multi-month delays between blood drawing and receipt of results. And, despite the launching of HIV-treatment programs, access to ART remains limited.

HIV/AIDS in India

Since 1986, when the first case of HIV was reported in India, the virus has spread from urban to rural areas and from high-risk groups to the general population and to what were earlier known as “low-prevalence” states. The Indian government’s figures released in May 2005 estimated that there were 5.19 million people living with HIV/AIDS in India. UNAIDS now estimates that there are 5.7 million people living with HIV/AIDS in India, the most of any country in the world, with an adult prevalence rate hovering at just under 1 percent (0.9 percent).⁵¹ Because of its large population size (the second-largest country in the world), India accounts for more than 7 in 10 people living with HIV/AIDS in the South/Southeast Asia region. HIV has spread to all of India’s states and territories, with 6 out of 28 states considered to be high prevalence (exceeding 1 percent).⁵² Three additional states have concentrated epidemics, with prevalence rates of 5 percent or higher among high-risk groups.

Distinct locations have different primary modes of infection. Heterosexual transmission accounts for 85 percent of the country’s infections, especially in the economically dynamic states of the south; meanwhile, in northeastern states such as Manipur and Nagaland, injection drug use is a major factor. Some cities have gone further in preventing the spread than others. For example, workers in the sex trade in

⁵⁰ “China Shuts Down Illegal Blood Stations,” *China Daily*, October 21, 2004; and “Donation Contributes to 95 Percent of Clinical Blood Use in 2005,” Xinhuanet.com, February 24, 2006.

⁵¹ UNAIDS, *2006 Report of the Global HIV/AIDS Epidemic*.

⁵² Kaiser Family Foundation, “Fact Sheet: HIV/AIDS in India,” May 12, 2005.

Kolkata (formerly Calcutta) have formed a union to implement key interventions such as sexually transmitted infection (STI) prevention and promotion of condom use,⁵³ which has kept the prevalence rates well below the 50 percent in cities such as Pune and Mumbai (formerly Bombay). The state of Tamil Nadu, where the virus was first identified, has seen HIV prevalence level off in the last two years and may even see a reduction in the size of the epidemic. Women account for 39 percent of India's estimated HIV-positive individuals, and HIV prevalence has been increasing among pregnant women in many regions of the country.

The Government's Response

The Indian government established a National AIDS Control Committee under the Ministry of Health and Family Welfare in 1986, the same year that the first HIV case was identified. It launched a national AIDS control program in 1987. Today, India's AIDS programs are implemented through the National AIDS Control Organization (NACO), a semiautonomous organization within the Ministry of Health that was set up in 1992 with financial assistance from the World Bank. NACO also works closely with NGOs and is allowed to accept money from international donors, as well as from private sources, a significant exception from standard government regulations. NACO has facilitated the development of 38 state AIDS control societies (SACS), which operate in all states and union territories and in three cities.⁵⁴ The government's overall HIV/AIDS budget for the 2004–2005 fiscal year is estimated to be U.S.\$69 million.

In addition to national and state AIDS control programs, the Indian government works toward HIV/AIDS prevention and treatment through a number of health care programs established for government employees. Indian Railways—which operates the largest health care system in the country—offers HIV testing, counseling, and treatment, as does the military and the Central Government Health Scheme, which provides health care to employees of the central government and their family members. Health officials estimate that, as of early 2004, some 15,000 people were receiving ART through these plans, some in government hospitals and others through referrals to private hospitals.

In December 2003, the government announced a U.S.\$44-million plan to offer free ART through the public health system, beginning in April 2004. The drugs would be provided by three large generic drug manufacturers in India, which were already making cheap antiretroviral drugs for other developing countries. The government's goal is to have 100,000 people on ART by the end of 2007. Exact figures are hard to come by, but it is estimated that 35,000 people were receiving ART as of April 2005. More than 7,000 of them were receiving ART free of charge from public-sector facilities, while the others were enrolled in privately funded plans.

International Donors and NGOs

Numerous donor governments are working with India to address HIV/AIDS, including Australia, Canada, the United Kingdom, and the United States. While not a PEPFAR

⁵³ Ying-Ru J. Lo et al., "Controlling the HIV/AIDS Epidemic in India," in *The Burden of Disease in India: Background Papers*, ed. National Commission on Macroeconomics and Health (New Delhi, Ministry of Health and Family Welfare, September 2005).

⁵⁴ Kaiser Family Foundation, "Fact Sheet: HIV/AIDS in India."

focus country under the U.S. global HIV/AIDS strategy, India is considered to be a “priority country,” and it receives more funding than any other non-focus country—some U.S.\$26 million in the 2005 U.S. fiscal year.⁵⁵ The Global Fund has approved two HIV/AIDS grants to India totaling U.S.\$234 million and an HIV/TB grant for U.S.\$14.8 million.⁵⁶ The World Bank has been a main supporter of NACO, providing U.S.\$84 million for Phase I of the national AIDS program and U.S.\$191 million for Phase II.⁵⁷ The role of NGOs and public-private partnerships in combating HIV/AIDS has been particularly important in India. The Bill & Melinda Gates Foundation has implemented Avahan, a large-scale initiative in India through which it has committed more than U.S.\$200 million. Other private initiatives include that of the Heroes Project, an initiative launched by U.S. actor Richard Gere. In 2005, the Indian government, the Heroes Project, the Kaiser Family Foundation, and the Avahan initiative convened the country's first-ever media leaders summit on HIV/AIDS.

The government has also shown great initiative and commitment toward the research and development of microbicides and preventive HIV vaccines. The Ministries of Health and Science and Technology have established partnerships with international agencies such as the International AIDS Vaccine Initiative and the U.S. National Institutes of Health to undertake upstream research to address critical research questions and conduct early Phase I clinical trials. Through the Ministry for Science and Technology, the government has also been proactive in establishing a Global Political Advocacy Initiative that works through South-South and North-South relationships to raise awareness and build support for an accelerated effort for the research and development of preventive HIV vaccines.⁵⁸

Challenges

- **Policy.** India's enormous population includes countless regional and social microzones, each with its own dynamics. The country has to move from targeted awareness and successful interventions among high-risk groups to developing a strategy that is valid for the whole country but tailored to local characteristics. Issues of social stratification—caste, gender, and class—are common in many countries, but in India the clear hierarchy along wealth and social lines makes it particularly difficult for government policies to overcome practices and customs observed for centuries.

Even the best medical facilities have refused to admit HIV-positive patients out of fear that they might infect the staff. The emphasis on biomedical measures for fighting HIV/AIDS has tended to remove attention from the equally necessary task of fighting the social stigma attached to the disease.

⁵⁵ Office of the Global AIDS Coordinator, *Action Today, A Foundation for Tomorrow*.

⁵⁶ Global Fund, “Portfolio of Grants to India,”

<http://www.theglobalfund.org/programs/search.aspx?lang=en>.

⁵⁷ World Bank, “HIV/AIDS in India,” Washington, D.C., June 2005,

<http://siteresources.worldbank.org/INTINDIA/Resources/HIV-AIDS-brief-June2005-IN.pdf>.

⁵⁸ Speeches by Kapil Sibal, Indian minister for science and technology, at the World Economic Forum Regional Meeting, New Delhi, November 2004; at the Dublin Forum, June 2004; and at UNGASS, June 2005.

- **Capacity.** India's current surveillance system is impressive given the sheer size and population of the country. But it needs to be deepened to provide more fine-grained data for smaller geographic units before India's health managers can get an accurate picture of the pandemic in India. In addition, India's medical institutions and universities are hampered because of their long-standing practice of relying primarily on government grants.

Even in a country with such extensive professional talent, lack of capacity—medical, managerial, and infrastructure—within the public health system often remains an obstacle to the development of an effective response to HIV/AIDS.