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**Plenary Discussion  
PEPFAR The Global Fund to Fight AIDS, Tuberculosis and  
Malaria; UNAIDS; UNICEF; The World Bank and The World  
Health Organization  
June 4, 2008**

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**MALE SPEAKER:** A very important presentation from Agnes really reminded us that work around knowing your epidemic, if it is poorly designed and poorly managed, will not bring information, evidence, understanding, around particular groups within our populations. And the focus of her presentation is really to remind us of really two groups in a way.

Firstly, of those most of at-risk populations or injecting drug users, men who have sex with men, men within prison context, that if their perspectives are not considered within the development of knowing your epidemic work then the actions required will not be considered in national studies and responses.

Similarly that if the voices, if children's perspectives are not championed, are not actively pushed for within these analyses then clearly again, they will not be reflected. So reminder, you see what you look for and importance also of ensuring participation within processes of knowing your epidemic, knowing your response.

We are moving now beyond the plenary in terms of the major presentations to now have a panel join us to reflect on knowing your epidemic and responses from a number of different perspectives. And I am looking for Sam Akwari [misspelled?].

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So David Apuuli is joining us and also Flavia, Flavia  
Kyomukama. Is she here? Flavia, okay.

So what we are wanting to do now is reflect on know  
your epidemic, know your responses from five different  
perspectives. What is the perspective of knowing your epidemic  
and response from within private sector? And we are very  
pleased to have Jenny Gillis here from SAB Miller. What does  
this mean in the context of a private sector of a large brewing  
company? How does that translate in that environment?

David Apuuli will be reflecting a position of the  
Ministry of Health. What does it mean when knowing your  
epidemic, knowing your response in the context of Ministry of  
Health? Moses Sinkala from the Catholic Medical Mission Board  
of Zambia, Flavia representing the interests of the  
constituencies of people living with HIV and Annie Shakrasivili  
[misspelled?] reflecting from a perspective of UN AIDS and I  
think broader perspectives coming from the Ukraine.

Within this work, we are wanting to focus around three  
core questions around knowing your epidemic, knowing your  
response. Firstly is around how good, how complete is the  
information, the data, the knowledge that you require to know  
your epidemic and your response.

Secondly is how good are you in the interpretation and  
the analysis of that information. Thirdly, how good are you in

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the translation of that knowledge and learning and information into concrete actions, which strengthen your responses to HIV.

What we would like to do is to understand across different constituencies within their places of work, of faith, of home, of community - what knowing your epidemic means.

Jenny, could you kick us off? We have got three to five minutes for each and then we will try to tease out conclusions, similarities, gaps, and challenges.

**JENNY GILLIS:** Thank you very much. The private sector, of course, is certainly different in terms of having a defined population when we are talking about our employees and their families but we face the same challenges that were raised by Agnes and by David when we look to working within our supply chain in our communities.

Really if I look at some of the data that we use in the private sector, we use what is commonly available in terms of prevalence levels to give us some indication of when we need to respond in a particular country but one of the problems that we have and I think one of the gaps is that we find that some of the data available to us is confusing and conflicting and really what that has done is to galvanize the private sector into doing a lot of their own research and their own prevalent studies early on, their own cap surveys.

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We, in the private sector, like to work with certainties and absolutes and so to deal with data, which might be conflicting or confusing, that is really a problem and, as I said, I think that the private sector has done a lot of their own work and we use that then to form our strategies and our policies going forward. So it is actually critical that we have the kind of information that we need.

I think that some of the data that has become available and then has changed after a period of time might have undermined the private sector response and I think particular of a country like India and I think that that is unfortunate. If I look at how we use the data, certainly we use data to determine when we need to initiate the response in a particular country.

And if I use [inaudible] as an example, we are present in 60 countries throughout the world and we look at this as a global issue because it is one of our sustainable development priorities. So we have certain requirements and guidelines that our countries need to actually look at in order to comply with our sustainable development strategy.

One of those is prevalence in that particular country but what we ask is that our countries who need to analyze the trends on an ongoing basis look at not only what the prevalence is but also what is happening in terms of that epidemic and we

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heard examples of concentrated and generalized epidemics from David but also you know what are the social, economic co-factors, which might fuel the epidemic in that particular country. We used this data to develop our global position statement and our global strategy, which then informs our local strategies and guides our countries in what they have to do and when they have to respond.

Because we are the private sector, we focus a lot on targets and we are the people in - reach these targets. So we expect all our countries to track the epidemic in their country every six months and report on that and that is viewed by the board on a fixed monthly basis. So it really has a high priority in terms of our global board.

This really galvanizes countries especially where we have new and emerging epidemics into taking action. Six targets as I mentioned and we expect people to comply with these targets and people are measured and countries are measured on these targets and the performance against key indicators.

One of the challenges that we are facing at the moment - we really need some more information on epidemics in other regions like in Central and South America, in Russia, China, and India. What we are doing is in about three weeks time, we are going to be hosting a scenario development exercise in Russia with stakeholders from all the different groups will be

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participating. Our focus is going to be specifically on the impact in the private sector and we will be using that information not only to share with other private sector companies but also to inform our strategy in Russia in that time going forward [applause].

**MALE SPEAKER:** Thank you Jenny for stressing the importance of data defining what needs to be done but also introducing too this important contribution of the private sector of management for results. I think that there are probably issues, which we might want to draw upon later around knowledge, translation, into results and some of the accountability tools, which are being used within private sector.

Could we move on now, David, Dr. Apuuli from the perspective of the Minister of Health for the government of Uganda.

**DAVID APUULI:** Thank you Mr. Chairman. First of all, I am not the Minister of Health in Uganda. I am the Director General of the Uganda AIDS Commission [inaudible] we have been very busy and I am hosting you and I am signing in for Dr. Akwari who is a friend of mine. We have known each other for a long time. In fact, we were classmates in the medical school.

Now what is important is what my President said yesterday in the context of what we are talking about the - in

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being able to understand the epidemic and therefore identify gaps in order to plan for moving forward and being able to grapple with various aspects of this epidemic and also we must realize and all the donors are listening that therefore it is important that whatever we do in various countries, the funding must address these gaps and our analyses and our results and the results are different in every country.

For us for example, I know that we are the second generation epidemic. So the indicators - why we are succeeding is very different from those who are the first generation epidemic, our generalized epidemic at a different state and therefore perhaps it is much more important and crucial to understand where we came from and what we are doing.

I think that the most important thing that we have been able to do here is to find, the craft some methods of collecting data and some of these has been done and since we are some of the pioneers in the struggle, as [inaudible] in 1989, the first series of surveys was done in this country to establish what was the prevalence of HIV/AIDS.

So using series of surveys, of course, is one of the best sources of data and that will help us to identify what we are talking about when we talk about the vulnerable groups, when we talk about children. We need to be able to understand what is happening in these populations by looking actually at

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represented samples of the whole country, the blatso  
[misspelled?].

So we have done that, done another series of surveys  
two or three years ago and we are doing another series of  
surveys beginning September of this year and that has given us  
an insight in fact in this country to what has happened to the  
epidemic.

For example, we know that the biggest number of new  
infections now and because we have been able to calculate  
incidence and go beyond prevalence, which is a very important  
thing that I said last year in [inaudible] that really we must  
aim at getting at prevalence studies and UN AID is doing a good  
job trying to help about five countries in this region to  
understand. Prevalence is not a good indicator of what is  
happening in your population and therefore being able to craft  
a program.

Every country, I think, in the whole world and the  
globe, I think the oldest methods that are used here in Uganda  
is the [inaudible] of surveillance data, various clinics, which  
gives you a proxy of what is happening.

Then we have large cohorts. For us, we have some of the  
biggest cohorts surrounding since 1989, a total population of  
about 10,000 15,000 and blood is taken now from everybody every  
year and we are able to track.

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And then populations surveys, demographic surveys and behavior, behavior studies and then as well as looking at special groups like commercial sex workers in terms of [inaudible] people and look at towards the records and so on and so on but the important thing is the analysis of these results is important and for us here, we have walked with the DC, we have walked with the futures group to be able to do predictions and be able to understand our epidemic.

Lastly but most important, I have about half a minute I think is that it is not sufficient for you to reach there and get data and analyze your [inaudible] without using it in programming. For us, it was just if you go to the website of Uganda's commission, you find our five-year strategy plan.

That strategic plan was informed by careful analysis of these studies of understanding our epidemic and therefore deciding which are the [inaudible] areas of how we must reduce the number of new infections over the next five years.

I do not know whether I still have any more time or I should stop there but maybe there will be questions. Thank you very much. I came in to stand for Sam Akwari and I hope I have been clear and that you have understood what is happening here. Mr. Chairman I thank you [applause].

**MALE SPEAKER:** Dr. Apuuli I thank you and I do apologize. Key points are again some real value-added coming

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from the perspectives of the government or the Uganda Rights Commission. It is important for the development of tools and methods and capacities to serve the epidemic and the response. So system strengthening around know your epidemic, importance of developing new and better tools particularly for the measurement of incidence. The key recommendation or observation that data is useful but only if it is thoroughly and well analyzed.

Fourthly, we have a good example here in Uganda of how evidence and information has directly informed the new strategic plan and has been translated into targets, budgets, institutional responsibilities, and there might be further discussion, which we would like to have of that process here in Uganda.

Then I think with the opening statement, which came from David was very important, importance of donors and partners to participate within these exercises and for them to exercise flexibility in changing their support programs based upon what is learned and what is included within revised strategies. Important lessons learned from the Uganda experience.

I would like us to move forward now and to invite Moses Sinkala from the Catholic Medical Mission Board to bring us some perspectives from the perspective of mission-operated

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health services but also faith communities - knowing your epidemic, knowing your response.

**MOSES SINKALA:** Good morning distinguished ladies and gentlemen. First and foremost, I would like to point out that in the last couple of years, Zambia has made dramatic improvements in terms of HIV care and prevention services.

Now almost 60-percent of people are on therapy, so on treatment and the PMTCT has actually increased from 15-percent to almost 40 and all this work has been done in partnership - faith-based organizations, private sector as well as the government.

The faith-based organizations provide about 30-percent of health services in Zambia and rural areas, this is about 50-percent. Now from the faith-based organization's point of view, when we look at the adequacy of the data, the sources of the data will depend much more on the mission and level data, which is from the demographic and [inaudible] surveys from research, particularly operational and the informative research, and also from more health management information system developed multiple reports, which is the facilities sent regularly.

However the gaps, which exist, is the completeness of sending this data on a monthly basis from the facilities. The other source of data, which is the also a little bit weak, we

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also use some mathematical models but as you may be aware,  
there may be some gaps there.

How do we interpret this data? [Inaudible] level to  
assess program effectiveness and weaknesses. From this we can  
now try to [inaudible] people who are mostly affected, define  
the vulnerable populations, you better characterize the people  
in treatment, the people taking [inaudible] and those ones  
participating in [inaudible].

And [inaudible] present at the next steps are actually  
to look to do the mapping of where these people are coming from  
and one good thing in rural areas where we are doing most of  
the intervention is that the population are much more stable  
than urban areas in terms of movements.

We use the available data also to define the population  
most at risk and what is emerging is that the new infections  
are actually all coming in the stable relationships and the  
marriages. I think maybe the thinking, which used to be there  
is that new infections and prostitutes or sex waiters or truck  
drivers. But what we are seeing, it [inaudible] new infections  
actually in marriages and that this means that we need to spend  
quite a lot of more resources to change the trend in these  
stable relationships.

Again when we look at the sex workers, the prevalence  
rate there has been perpetually high and the - this might be a

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little bit controversial, no matter how much money are you going to spend, that much resources you are going to spend there, to change the behavior of the sex workers, it is much more challenging than changing the behavior in these stable marriages because they are motivated much more to look after their family than on the other side where we have high prevalence of HIV.

The governor also helps us in designing appropriate programs, approaches including monitoring and the progression tools. A lot of data exists in Zambia from research whether [inaudible] or clinical trials, I think the challenge, which we have is to use this data so that we can target interventions that can make a big difference. Many thanks [applause].

**MALE SPEAKER:** Thank you very much Moses. Again, stressing some of the important areas around partnership, relationship between the CMB [misspelled?] and the government, the national information systems and the need for partnerships to be developed around that.

I think the issues, which you also raised about the need to develop better and stronger systems for unpacking vulnerability and risk, which in generalized populations particularly within stable relationships, systems, tools, methods, of knowing our epidemic, knowing our responses in those contexts.

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And I think the last point raised by Moses something which we might want to come back to. The question of digestion of data - there is a lot of information around, very often, we are not too good in harvesting that, digesting that - what exists and we are too busy thinking of new or more things to be done before actually milking current and existing information available. Thank you very much Moses.

Let us move on and hear from the perspective of communities and people living with HIV. Flavia?

**FLAVIA KYOMUKAMA:** Thank you very much Mr. Chair. Fellow persons living with HIV on their own, distinguished guests, ladies and gentlemen, I am Flavia Kyomukama from the National Forum for People Living with HIV Network in Uganda and this is a [inaudible] organization to bring together groups of people living with HIV to have a common voice to advocate for the rights of persons living with HIV to access services and change then the institution to be able to participate effectively in the HIV and AIDS response in Uganda.

However, I will not do much on that, I will give an experience of people living with HIV. I would like to draw from our recent behavior survey on the Uganda Demographic Household Survey, 2006.

We have more infections within relationships among the marrieds and we realize that among the marrieds, 43-percent

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women have been sexually violated or abused and among those who have been divorced or separated, at least 53-percent have been sexually violated and these are women and girls.

Within the same studies, we realize that 49-percent of women who are currently with a partner have been abused by those partners they are living with and 25-percent by a previous partner or spouse. Therefore, it is no wonder that we have more incidence and prevalence of HIV among women and girls in Uganda and I think in Africa and the other developing countries.

On the side of service provision, I would like to categorize women who live with HIV in a number of groups. We have children who are girls. We have young people who are age 15 to 18. We have young people who are age 18 to 24. We have the widowed. We have the separated. We have the single. We have the married. We have the discordance and we have probably to mention the commercial sex workers. All these are women with different needs. Probably all affected and infected with HIV and need to be addressed specifically.

We have for prevention, we have some elements of prevention is that of AB and then ABC and then later on we have AB and we have the consequences of removing the C, which to some extent, was protecting us, which has been also a setback. We have prevention of mother-to-child, which is available but

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only that one-percent of the women can access and for some of the children who are born with HIV, only six-percent of those who are eligible - adults and children, six-percent children can access ART.

How much are we putting into positive prevention as a strategy? People living with HIV need to be put in the forefront to ensure that we advise, we support planning and programming to ensure that these programs really benefit us. [Inaudible] the challenges, resource allocation is still limited because we do not have the capacity and the - to engage with our public or private colleagues because they have long experience and exposure and we are just coming on board. We need to be stronger and we need support from both the public and the private to be able to make meaningful involvement.

We have qualities, which are [inaudible] the sexual offenses bill. We have the domestic relations bill. We have the land bill, all these highly impact and could reduce considerably the effects of HIV if passed but men [inaudible] women and men opposed some of the clauses that would give us an element of equity or equality and we also have the Equal Opportunities Commission, which the bill has been passed that has not yet been operationalized.

I would like to see our government probably working on this and ensuring that we have equal opportunity as women and

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men and also to remind our leaders that they should not be complacent. They need to take everyone on board and ensure that the stigma that we want to see in our health facilities, in our schools, is [inaudible].

But of course you can only do this if you have people living with HIV at the forefront and therefore we would like to see more involvement in the national level planning and the implementation but more so in monitoring and evaluating projects and programs.

Of course, the mistrust, the dynamics of mistrust between the public, private, and civil society, which is slowly waning but we hope that in the near future, we can develop good coalitions, good partnerships, and ensure that people living with HIV have the ample skills they are able to access services. They are able to live with dignity and respect and enjoy their full rights. Thank you very much [applause].

**MALE SPEAKER:** Not bad for four minutes. Key things, again some of the new perspectives, which we need to focus on in knowing our epidemic, knowing our response is critically important and again, it is really enforcing the points, I think, raised by Agnes of the importance to have deliberate attention and resources addressing the particular needs and rights of women, girls, and children. Now that needs to be

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programmed in and to design into the ways - know your epidemic,  
know your response work and analysis that is undertaken.

Secondly Flavia highlighted importance of much more attention around issues of sexual violence and gender-based violence and I think that - that implies further scrutiny and discussion of what are the tools, the methods, the modes of participation for attaining the information, the data, the evidence, but also for ensuring the analysis and follow-up in actions.

A particular call for something, which we talk about a lot but do not do too much, which is the challenge of knowledge translation is around more effective participation of positive people in translation into positive prevention programming. It is something, which comes out of every piece of analysis that is something often weak in national strategies.

There was also the final points around the importance around pro-positive decision-making amongst those involved in legislative form, in mainstream development decision-making, and of the need to strengthen resource availability and capacity for participation of communities of people living with HIV within knowing your epidemic, knowing your response work. Flavia, thank you very, very much for those interventions.

Our last intervention is from Annie [inaudible  
00:29:50] from the Ukraine. I have been practicing this name

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and I am not sure that I have got it right. I think that we should all say it together. We welcome Annie Shakrasivili and she is going to talk about some of the context of concentrated epidemics within the Ukraine.

**ANNIE SHAKRASIVILI:** Thanks very much Mark and thanks very much for having me here. I would like to say that this is my second time in Uganda after 13 years. I am not all as old but long time ago, I did a project with the AIDS Information Center here when I was the ES fellow at CDC. So it is great to see Kampala [misspelled?] more prettier and grown so much.

I would like to take this opportunity and give a very brief summary of the epidemic in Eastern Europe and Central Asia. Since this meeting is more focused on Africa and many of you may not know how severe the epidemic in our region is. Let me give you just some figures.

Since 2001, the number of people living with HIV in Eastern Europe and Central Asia has increased over 150-percent from 630,000 to 1.6 million in 2007. With Ukraine having the highest adult HIV prevalence in whole Europe, equal to 1.63-percent and Russia, with the highest absolute number of people living with HIV in the region, which is estimated at close to one million.

Of all the new cases of HIV in the region, 90-percent have been reported in two countries only, Ukraine and Russia.

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The major drivers of the epidemic are unsafe injecting drug use and highly risky sexual practices such as mostly related to exchange of sex for money and drugs and sex between men. So if we are talking about the region with highly concentrated epidemics among IV use, injecting drug users, sex workers, and MSM as it has been just recently become known.

The recent mapping of the epidemics in this region, within the framework of the mapping of the AIDS pandemic initiative, confirmed that the epidemic will remain concentrated but there are certain risks and certain worries that we have, which I will come back to later on.

So how adequate are the data and where do they come from within the region? So the main sources of data are coming from rather passive case report-based national government implementing and supported surveillance systems and large-scale screening and testing programs such as those for women in ante-natal care, blood donors, certain occupational groups and others.

Massiveness of screening and testing for HIV programs are impressive. For example in Russia with the population of 145 million people, over 25 million tests are performed a year. In Ukraine, with a population of 45 million, 2.5 million tests are performed each and every year.

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There is solid ante-natal care surveillance in place. In Ukraine for example, over 90-percent of pregnant women are tested for HIV. From global - another source is mostly because the prevention programs and other programs such as ART and PMTCT are supported through the global fund program.

Those data also come from behavioral laboratory studies and central surveillance that are focused on most at-risk groups such as drug users, sex workers, also sexually ART and PMTCT activities but with the low coverage of those programs related to drug users and sex workers that do not exceed on average, ten-percent, and that is ever covered, we certainly have an issue with what exactly those data are looking at what subgroups of those most at-risk populations those data are coming from.

Now the challenge here in terms of the epidemic and the knowledge about the epidemic in this region is that we do have a lot of big pockets of unknowns and I would like to also allude to the reasons why is that so.

Firstly, when talking about such subgroups as men who have sex with men and injecting drug users, stigma and discrimination towards this population is really enormous in the region. In some countries, it is lesser expressive but still we are dealing with this particular reason when we need to really understand better what is it that is driving the

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epidemic in terms of the unsafe, [inaudible] safe and injecting drug use behaviors.

In the countries of Central Asia, for instance, and others, same sex is [inaudible], therefore, it is very hard to even understand what it is happening in that subgroup. Although there is good ante-natal care surveillance system in place, other surveillance systems have their own shortcomings as they are mostly project-driven.

Therefore, in our region, we have little information about young and newly initiated injecting drug users, female injecting drug users, known drug users, men who have sex with men, and prisoners. And this is mainly due to be designed of the outreach programs that are mainly funded through the Global Fund programs where the main actors are the outreach workers that are former drug users, that are mostly men, and relatively older, so over 25, 27 years old.

So here we are talking about the gap in which we have in terms of understanding who are these riskiest subgroups of those most at-risk population and certainly sound and good epidemiology, good public health approach, and certainly surveillance systems, and additionally research are badly needed in the region.

The other question, which we are more and more frequently asking ourselves is if there is a large-scale of

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sexual transmission, of HIV independent of injection drug use happening in this country. Yes, we know that the proportion of newly registered HIV cases that are attributed to sexual transmission is increasing over time.

Yes, we also know that there are high rates of sexually transmitted infections in the region, also the studies on STIs are really lacking and are small-scale and also we know that there is a relatively high rate of HIV among STI patients and the recent ante-natal care surveillance system in Ukraine had shown that in some regions, mostly those that where the epidemics have started in the mid-90s, the rate of HIV prevalence has exceeded already one-percent and they are really significantly increasing within the last two or three years and yet, no conclusive evidence exists in the region about independent from drug use, sexual transmission of HIV.

So [inaudible] would also like to add the lack of research into overall sexual behaviors in the populations and other than just several DHS studies, now DHS [inaudible] has been carried out in the region and one small study, the longitudinal in Russian Federation, there were no research into central behaviors overall in the populations ever done in our region.

So who are the riskiest groups among most at-risk populations? That is also another issue that we more and more

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are focusing on and we know for one particular study in the Ukraine that among injecting drug users, those that inject stimulants - that is pseudoephedrine - not opiates, practice riskier drug injection and sexual behaviors than those that use opiates.

Therefore, certainly when we talk about harm reduction efforts and especially substitution - opiates - substitution treatments, this particular group, which we think is very large, deserves special attention because substituted therapies simply would not work for this group of injecting drug users.

Certainly another issue we have in the region is that no incidence studies have ever been done in the region apart from just two very small-scale studies and the difficulty there is that there is lack of validated assays for subtype A, which is predominantly the prevalent strain in Eastern Europe and Central Asia. So understanding where new infections are occurring is really limited.

So how do we interpret and analyze existing data in our region? Certainly the issue is in manpower and capacity to analyze the existing massive, massive bases of data that are collected from year to year.

More often, we are also discussing the issue of defeminization in the region. We do see more of the men being infected and the question is especially in the Ukraine, is

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whether it means generalization or at least tendency towards -  
I told - I talked about the high rates of HIV in pregnant women  
in Ukraine and that is where we should really be focusing on,  
understanding the behavioral aspects and behaviors among all  
these women.

Because yes, there are all these discussions about  
these women being themselves injecting drug users or partners  
of injecting drug users but yet we are seeing a large  
proportion of those that are not injecting and are not partners  
of these particular subgroups of males and certainly no quick  
response except for the recent outbreaks of HIV infection among  
infants to the contaminated blood transfusions in Central Asia  
are in place. So that is also another issue.

So overall, just to conclude, in our region, there are  
strategies and programs in place that are pretty much right and  
adequate to the specific populations but they are a very small  
scale and there are just elements of those and as David was  
alluding to, unless we scale up the efforts around the  
interventions as well as understanding of the epidemics, it  
will be very difficult for us to tackle the epidemic, which is  
growing very fast in the region. Thanks very much [applause].

**MALE SPEAKER:** Thank you very much Annie. If I may, just  
five brief reflections overall from this set of presentations  
and the panel discussion.

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Firstly, what is key is that knowing your epidemic and knowing your response is everybody's business. It is not just something to be done by somebody with a knack or within a national institution but if we are in private sector, managers and leaders have a responsibility of knowing the epidemic and response within their business and their workplace.

For us and many of us working with the international community of donors and agencies, we have a responsibility of ensuring that we know the epidemics within our workplace.

We have the opportunity knowing epidemic within communities, of people living with HIV, within faith communities, I think that this discussion has been helpful in pushing it beyond just something that is done to us at a national level to appropriate in the need to do that in all of our places of work and influence.

Secondly the message came across that there was a need for more investment and effort in knowing our epidemic and knowing our responses and a number of references were made for the need to develop stronger and better tools. One of the samples being around incidence measurement but also around the need to invest in capacities and systems to be able to continue this important work.

Thirdly a number of presentations highlighted the importance of ensuring participation within knowing your

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epidemic, knowing your response, and a particular focus was placed on most at-risk populations and sex workers, injecting drug users, of men who are having sex with men but also constituency often do not have direct voice - children and in some cases, women.

Fourthly, there was the recognition that knowledge is great but only useful if you use it to act and we have got several pieces of advice. Firstly, do not overcomplexify and secondly, focus on the key priorities for action.

Then the last point, which I think is important for us to reflect upon, is that many of us - when we learn new things have great difficulty changing what we are doing now. If we are going to know our epidemic and know our responses, we will appreciate that there are many gaps and there are many things, which we need to do it differently.

So amongst all of our organizations, whether they be governmental, nongovernmental, donor, faith, we need to be open to acting and responding on this information and evidence. That Mark, requires the address of sensitive issues, the movement from faith-based programming to real-based programming, is used by his programming to acting on informed choices of information, which is developed through this. Thank you very much to the presenters, to the panelists, and thank you very

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Plenary Discussion

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much as we have our timekeeper, Rita, for keeping us pretty  
much on time.

[END RECORDING]

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