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**Plenary: Knowing Your Epidemic and Response
PEPFAR The Global Fund to Fight AIDS, Tuberculosis and
Malaria; UNAIDS; UNICEF; The World Bank and The World
Health Organization
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MATT STERLING: And welcome to this, this is our first session in our Plenary and panel session. It is opening this important conference. It is a session on Knowing Your Epidemic and Knowing Your Response.

I am your Moderator for this session and my name is Matt Sterling. I am the Director of the Regional Support Team of UNAIDS for East and Southern Africa, and I have the privileged of leading our team through this session.

The backdrop to this session is that I think that we can take mixed pride and sadness over progress. Recent reports coming out from countries as a part of the omegas reporting process and recent evidence coming out of various national surveillance systems, national surveys and estimates, present a very mixed picture. We have a picture on the one hand of significant and important life saving progress in the expansion of programs run at direct for viral therapy and PNPCT. Substantial progress, but variable progress, across countries.

On the prevention agenda however, in the challenge of preventing new infections the progress is perhaps much less and disappointingly less than what we had hope for or perhaps what we had expected. And what we are seeing is that in many parts of our world, despite considerable interest and activity we are

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seeing high rates and continuing high rates of HIV infection taking place.

On further interrogation of back to the work around HIV prevention, when you start to interrogate and to look into the plans and strategies, I think that we can see some of the reasons why intervention has not been reflective as planned. This session is designed to explore these issues. What are the nature of these epidemics? What are the natures of our responses? What needs to be done or done differently to be more successful in halting these epidemics?

And as we know, action, successful action to prevent new infections is absolutely central to affective actions on AIDS. I think that yesterday's comments by the President, President Woseboney was an important introduction to this session. When he said and I cannot remember the exact quote, "but when you know the enemy and how he operates and behaves, then you know how to respond". And I think that this session today will help us explore that.

To do so, we have a two part session. Firstly we have two Plenary presentations from David Wilson and Agnes Binagwaho, and then we have a panel section drawing together reflections on Knowing Your Epidemic work from various constituencies.

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Time is of the essence, so I think that we should get directly into the program. And so I would like to invite David Wilson to the floor.

As we all know, David has been working on HIV and a champion and activist for prevention efforts. As an academic, as a researcher, as an activist, and more recently working within the World Bank for well over 20 years. I think that is probably when I first met you David, is about 20 years.

He is currently the Acting Director and the Lead Health Specialist at the World Bank. He has a number of continuing responsibilities, teaching in professorial positions and he has played an important role influencing the thinking and the agendas of a number of our organizations, particularly of the U.S. Government, of United Kingdom and within the UN System of UNICEF, UNAIDS and certainly the World Bank.

He is an extraordinary thinker and activist and is somebody who always expects of us a high level of scrutiny and attention to the realities on the ground to inform our decision making. We look forward to this year's advice. [Applause]

DAVID WILSON, PH.D: Good morning. I have chosen to speak without slides today because I think our core challenge today is not to revisit the many of data in a context where there has been so little progress and prevention science in the

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last two years. But, rather to try to integrate our data into a coherent argument.

And our quest to know our epidemics must begin with the simple accretion that there is no such thing as the global AIDS epidemic, but rather a multitude of diverse epidemics. No single set of prescriptions can be valid in, for example, Uganda, the Ukraine, Papua New Guinea or elsewhere.

The error of global guidance is truly over, but the most central and enduring distinction in HIV remains the difference between concentrated and generalized epidemics. Which are fundamentally different and not because of prevalence, but rather because of who gets infected and how. For two long globally, we have pursued concentrated approaches in generalized epidemics, generalized solutions and concentrated ones. Or simply hedged our bets and done a bit of everything, everywhere.

If only we had heeded the core distinction between concentrated and generalized epidemics from the outset, we would have avoided numerous futile arguments about the A,B and C's and we would have averted a lot of wasted programming. At the global extremes, the distinctions between concentrated and generalized epidemics are starkly clear.

South and North America, Europe and the Middle East and Asia are and always will be concentrated epidemics. In

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contrast, much of Eastern and Southern Africa face highly generalized epidemics. Yet, large swages in between these two extremes are unresolved. Are for example, the Caribbean, West Africa and parts of the Pacific, concentrated, low grade generalized or mixed epidemic. This really matters and unless we resolve it, we cannot program optimally.

The global move to know our epidemics which Mark introduced is extremely welcome. After all, it has enabled us to debate HIV prevention with greater vigor and boldness than ever before. But there are pitfalls that we can and must avoid. First and above all, we need to understand, but not over complicate, we could spend years painstakingly analyzing our epidemics and micro epidemics, but broad, bold, brush strokes are sufficient for effective, intelligent action.

And galvanized into intelligent actions, we can build and bolster our ships as we sail, without being deflected by endless analysis. So then instead, seeking to answer an overarching question, are our epidemics concentrated, generalized or mixed, and where in broad categories are our new infections, our emblematic last 1,000 infections occurring.

In sex work, among men having sex with men, and injecting drug use, or among adults with multiple partners. More specific answers can be distilled from and alongside well evaluated, large scale programs.

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Second and related, modeling incident infections to better know our epidemics has an important role that must be used cautiously and must be carefully triangulated. After all the seductive graphs and spurious precision that they have produced are alluring, but potentially misleading, and simply reflect on how much of the edifice of our understanding of East Asian epidemics relies on models, not actual evidence.

Third, in many countries we have seen inclusive participatory consensual approaches to better know our epidemics and these are laudable, but they may compromise rigor if they inadvertently reintroduce this credited orthodoxies. After all, simple reflect how many decades it took us to learn that there is no simple direct association between education, income, gender and HIV.

Numerous DHS classes and other studies have shown us that better educated upper income adults in richer countries with greater gender equality have more, not less HIV. What we know for certain is that we can prevent HIV if we tackle its direct immediate causes, multiple, unprotected sexual partnerships. And nothing should deflect us from that call focus.

Fourth, in the crucible of Southern Africa's raging epidemics, epitomized by Swazi Land, Botswana, Lesotho in South Africa, with uniformly high HIV prevalence. Our central

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challenge is not to know our epidemics better, we understand them. They are fueled by multiple sexual partnerships in the general population, but rather to ask ourselves how can we effect the fundamental changes in community norms and values required for behavior change?

Once we know our epidemics, in broad brush strokes, we can move to knowing our responses, but can we respond with proven approaches? The evidence to date as I suggest dispiriting. Simple consider concentrated epidemics driven familiar resources, sex work, men having sex with men and injecting drug use.

If we face concentrated epidemics driven by sex work, we know what to do in the real world end of scale. We know that programs promoting education, condoms, sexual health, solidarity, empowerment and rights can and have curbed HIV in Asia's three sexually initiated epidemics. Thailand, Cambodia, and South and West India.

But, turning to men having sex with men, the picture in the developing world is much less encouraging. While we know that programs focusing on education, condoms, sexual health and rights can work, particularly in context sex conducive to programs for men having sex with men, such as India where the National Aids Authority has recently petition the Supreme Court to legalize homosexuality or in Napaul where the third gender

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is in a official legal category. Or, in much of Southeast Asia where attitudes towards transgender communities are tolerant.

But we also know that in un-conducive environments we have made little progress to protect men having sex with men. Simply consider the example of Egypt, where a recent ground breaking Sierra Survey of HIV prevalence in Alexandria simply led to the accelerated arrests and imprisonment of men having sex with men. Or consider Iran, when an estimated 4,000 men having sex with men have been executed since 1979.

And when we turn to injecting drug users, the picture is perhaps even starker. We can no longer keep saying that needless syringe programs and substitution therapy work in the form of Soviet Union or Asia when we are no closer to implementing these programs at the population level required.

As Veteran Harm Reduction Specialist, Nick Kraft concluded in his recent Go a Harm Reduction Plenary, he no longer knows what to do to convince Asian Governments to promote harm reduction. Or as the Deputy Director of Indonesian's Bureau of Narcotics said to us, with exquisite job in these in these subtleties he was certain Indonesia would heed harm reduction advice if only it emanated from the United States Drug Enforcement Agency.

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We are not the right voices and we do not have the ears of the right people if we are to reverse epidemics among injecting drug users.

Turning to generalized epidemics, we face three major challenges. First, many of our most trusted interventions, mass media, school and youth programs, condom social marketing, SCI care and BCT are at best and proven at worse disproven at the population level.

Second, the most effective HIV prevention intervention in the history of this epidemic, male circumcision, has scarcely advanced since the three trials ended with an erringly, identical results two years ago. Ask ourselves how many extra men in Eastern and Southern Africa have received this remarkable partial vaccine since the studies ended, limitably few and yet, the scope for action is enormous.

In seven of the eight highest prevalence countries globally, all in Southern Africa, less than 20-percent of all men are currently circumcised. And where we have seen HIV fall in generalized epidemics, it has been because of partner reduction in the general population and at population level.

We have seen this in country after country and yet, except in early Uganda, these changes occurred largely in spite of, and not because of, formal programs. And so we know limitedly little about how to effect partner reduction that

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this should not weaken our resolve to invest in programs to promote partner reduction. Alongside studies to better understand how to achieve population level, partner reduction.

Turning briefly to the undetermined character of HIV transmission in the in determined epidemics of the Caribbean, West Africa, and the Pacific. If these epidemics are concentrated and due to sex work, we face the achievable objective of making sex work safe, which we know how to do. But if these are mixed, or low grade generalized epidemics we face a far, far harder challenge. How do we encourage countries such as the Taconga with an approximately 1-percent prevalence and numerous competing health and social challenges to invest in the fundamental, social and cultural change required for large scale population based change.

And this question poses a related challenge that I believe we can defer no longer. What is the proportionate AIDS response? HIV funding is vast, but largely concentrated in 15 to 20 countries in Eastern and Southern Africa. And in the crucible of Southern Africa's epidemics epitomized by Swazi Land, Botswana, Lesotho, South Africa. The question is not whether we are distorting too much in favor of HIV programs, but whether we are actually distorting enough.

Simply consider Francistown, Botswana, where fully 70-percent of a household population survey of women age 30 to 34,

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were HIV positive. In that context how can we possibly distort too much? And yet, there are also in large bounds of countries in Eastern and West Africa with a much lower prevalence than in previously believed and numerous competing health challenges. Where HIV receives a far greater share of the funding than, other major causes of disease burden.

In these context, we have to reposition, and integrate HIV in effective, well evaluated support of other health challenges. And paradoxically counter intuitively even, there are large number of lower and middle prevalence countries outside Eastern and Southern Africa where HIV maybe under funded. Consider the much stated example of Thailand, where HIV still contributes 14-percent of disease burden, and yet receives only 2-percent of recurrent health spending.

Or consider Indonesia, which has Asia's fastest growing HIV epidemic and in West Papua which it share with the Island of Papua New Guinea, the world's highest HIV epidemic outside Africa. And yet, HIV prevention funding maybe falling in Indonesia compromising vital programs.

In conclusion, let me reemphasize three key points. First, the move to know our epidemics is welcomed, but must not be overcomplicated. Broad, sturdy brush strokes are sufficient for decisive, intelligent action. Second, concentrated epidemics driven by sex work are imminently preventable, but

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protecting men who have sex with men and injecting drug users will require novel evidence, arguments, advocacy and allies. Our existing approaches simply are not working at the scale required.

And third, in generalized epidemics our core challenge is to reallocate priorities and resources away from the unproven or disproven approaches which currently predominate to the two proven that admittedly sensitive interventions that we do have, male circumcision and partner reduction.

So will we, in conclusion connectively have the courage not simply to abandon orthodoxies and entrenched interest, and accept the evidence that also the remorseless, unrelenting focus required to apply proven solutions at scale because that ultimately is what knowing our epidemics and knowing our responses must entail. Thank you. [Applause]

MATT STERLING: Thank you very much, David. As always clear to the point and sound council for us to take only our work further forward.

A couple of reminders coming from David, certainly around the complexity and the continuing evolutions of these epidemics, around the importance to suggest building understanding, but translating that into action. Thirdly, the importance of insuring that our efforts are increasingly focused on those actions which make a difference and are much

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more attention of both at an empowerment level, particular in concentrated epidemics and those actions in particularly in the male circumcision partner reduction within context of the generalized epidemics.

And a final point which I think that we need to bring back a lot of attention to as we go through the discussions today, is the changes that need to take place within our organizations to translate knowledge into action. To insure that the reallocation of time, of money, of political will and direction is focused on where it needs to be even if that is insensitive and difficult to work areas.

Thank you very much, David. Very stimulating and we will continue with that discussion through the course of today.

I am pleased to introduce our second speaker, and I think again, she is a champion of this region, of the world, Dr. Agnes Binagwaho. She is coming to us from Rwanda. She is the Executive Secretary of the Rwanda National Aids Control Program and she has provided with other leaderships in that country, extraordinary leadership for the mounting of a very well developed and ineffective response. And we learned much about that when we were in Tagali last year.

Agnes is active in everything what she does, she is a member of the Country Coordination Mechanism, she is a Chair of the PEPFAR Steering Committee. She has been responsible for

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the Mack Project in Rwanda and she has had an active involvement with all agencies and all national entities within that country.

She has an international role as well and is responsible on a number of boards and has contributed very frequently to a series of important journals. She has coordinated the Task Force of the Millennium Development Gulf Project around access to essential medicines and she is currently the Co-Chair of the Joint Learning Initiative on Children and HIV.

Agnes is important for us all, because she is a person who thinks and then does. She is somebody who has been an activist in identifying the emerging issues that need to be addressed. She has been courageous in talking about those issues no matter how sensitive that they might be and she has been absolutely scrupulous in assuring that those decisions, that that knowledge is translated into action.

We do look forward to you Agnes and your presentation of the neglected parts of these epidemics and how we might respond to them as part of Knowing Our Epidemic, Knowing Our Response. [Applause]

AGNES BINAGWAHO, M.D.: Thank you for those kind words. Yes, I have a presentation. I am very honored to be with you today to present the neglected part of the epidemic. It is

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very important to think about the neglected part of the epidemic because we can make quick changes if we identify them correctly.

As a Pediatrician and have the culture of the Joint Learning Initiative on children and AIDS, I am going to focus my example worldwide about orphan and weanaver children. There are other part neglected, not only on the weanaver children, we have also men who have sex with men, we have also presenters, discordant couples and sex workers.

The two first category, men who have sex with men and the sex workers and neglected for sake morale perception. We certainly cannot deny them and the people who are there before have the right because they are not considered as full citizens and for that reason they cannot benefit fully of the prevention care and treatment what is accepted in their country in our country, it is not only for Uganda, I have to tell the truth, we do not have that program for men who have sex with men in Rwanda.

For discordant couple, this issue has been known for years, even before I answer in the fight against HIV/AIDS we had call in Rwanda and still I do not understand why we neglect that part and the world just wake up about that. In Rwanda we have 33 programs for prisoners. In eight prisons with global fund and PEPFAR, we have prisoners who have already access to

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care and treatment, not only testing, but interval treatment for those who are in need of that. Inside the health facility of the prison and we hope that in the end of 2009 all the prisons in Rwanda will give that service.

Just for one reason, because we have understood that when we reach prisoners, if we neglected them they are going to infect the community where they are going to be released, and because of the genocide we had a couple of people in prison. And, also we believe that if we take care of this neglected part of the community in many countries, they can revenge and infect people voluntarily.

So, today I am going to focus on children, and according to Hemisphere and UNAIDS the majority of the problem is in this part of the world. We have 85-percent of children living under 15 who are infected in our continent, and 57-percent of death due to AIDS in children are in this continent. And one-third of the people living with HIV/AIDS has less than 25 years old.

That what I am going to focus on children, because those who are not infected are affected. They love their parents and they see that they are denied the right to have an education and for that they are vulnerable to get infected by HIV/AIDS themselves.

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Among the vulnerable we have to focus when we are doing action on the four African Child Girls, because they are the most at risk to be infected. I do not want to insist on that because it is known, but it is neglected. We do not focus our action on vulnerable children and especially on the child girl, and what is important to know is that if we do not protect them, we do not protect the next generation.

This is just to show you that we have data, we have a collection of data, year after year, PEPFAR meetings, EOT meetings, UNAIDS, UNICEF released data, but we just closed on the book and put somewhere in the cupboard, we do not use them. And all those global estimates in reality does not give us the magnitude of the problem in children.

There is a global estimates, but in reality we still do not know much concerning children and infection. How old are the children infected? How many of them really get interval treatment when they need it. How are they infected? 90-percent of the children are infected through the transmission from their mothers. What about the translucent? They are very few studies on that and we have to acknowledge that in some countries we can start to care about that.

We do not have enough information that what is best, we do not use information we have. Less than 5-percent of children worldwide needed interval treatment have access to

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that. I am very proud that in my country 62-percent of children in need have access to treatment. But in the world 95-percent of children are dying because they do not have access to treatment, and we know that.

What action are we taking with this knowledge? Less than 10-percent of children or maybe, vulnerable by HIV and AIDS get true support. When I talk about true support that means we take that child and we make that child an adult who can have a good life.

And we know that 90-percent of children are infected through the mother, but only 23-percent of the infected woman get access to the PNPCT program receives the right prevention. And more than that, those 23-percent come from only the 10-percent of the women who have access to the program. We know that, what have we done?

We have to acknowledge that the global effort coming from PEPFAR, Global Fund, World Bank, UN Families have done a great change in our life as people working in the field. But is the money well distributed? When families cannot cope, when children have a lack of true support.

There is a lot of service and I was introduced as the Executive Secretary of the National Aids Control Commission in Rwanda, but I am also the Co-Chair of the Joint Learning Initiative and we have commissioned 40 studies all around the

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world and those studies, it is Asia, it is in Africa, it is in Latin America, in Russia, they all give the same answer, children are neglected, and we should be concerned because they do not have a voice.

So, this is a slide I borrowed from UNICEF. This slide shows the evolution of the access of interval treatment for women in PNPCT program. What you can see is in Africa, only 31-percent of the women have access to the PNPCT. And in West Africa it is worse, only 7-percent have access. And what you can show too in Europe and in Columbia and Latin America, the access is decreasing. This was raised by UNICEF and suppose to be known by all of us, what action are we taking?

So, information are missing, but when we have information we do not use them, and when we know those information we do not take action. And this was proved also by a study done by Kim and Hull [misspelled?] and UNICEF, we do not use the data. Another thing we should do a better tracking of children who are infected in unknown manner, not through the mother, because this is linked also to women rights.

If those children are infected it can be blood, okay, we then need to reinforce the national distribution of blood. It can be rape, it can be sexual abuse, we all know that. What are we doing for those children?

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And If I said the example of children we can go to the other neglected part of the infection. The questions are the same, what are we doing? What are we missing? We are missing true data, the information.

When we have the true data and information we are missing true intervention because we do not plan in our country according to evidence and research, according to the fact that we want results. Sometime we have money, 8-percent for children we just plan to please our government and to please our partners, not to have results for whenever our children. And this can apply to other groups at risk.

So, in one hand we have sufficient data, and we do not have sufficient data in the other end and we don not use them. Our intervention are not evidenced based and the allocation of results for children does not reflect the magnitude of the need. There are only few countries also with legal protection for children. And even countries who try to do legal protection of children have problems to implement it.

I have to tell the truth, we have a legal protection for children. We have in Rwanda access all the vulnerability of children. We know what the vulnerability are, we are still have a gap of implementation even in the good will, because me, I put my hat as Pediatrician in the balance, children does not know where to go to seek support. That means government,

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communities and partners in the government should put according to analysis on how proactively implementers are taking in account the good of children. It is not enough to have policies to have a year mark we have to stand in for children. We need to spend it with reason.

An example of legal issues, adolescent have sex, we does not have to be blind about that. A 16 year adolescent who have sex cannot go for testing results without seeking the authorization of the parents. He will never go for the authorization because he does not want to talk about it with the parent.

That means he is going to be probably infected and infected others. This is to show you that there was an increase of children on interval treatment in the developing world between 2005 and 2006, but still with this increase we have only less than 5-percent of children needed ICE on ITEE [misspelled?]

I do not talk about the psychologist counts his work most of the time, totally inefficient. About resources if we listen to UNICEF, there is billion missing for the Four P's of children. PEPFAR has been setting a near mark around 10-percent, we have to spend for whenever children, but is those 10-percent used to make of those children, adults happy, healthy in the society.

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In many parts of the world, I can tell you no. Because when a child receives a piece of what he needs, he will still be in the road when he be adult.

Activists and Advocates and we see have see here 45 minutes ago, man who have sex with men coming to talk for themselves. We never saw children come talk to for themselves in such a gathering, because they have no voice. And I do not remember ever have seen adults come in and complain about what we do for children in such a gathering because they have no voice.

So, this I have already said, is just to show you that that is how we have them in Uganda, Tanzania and Nigeria, Rwanda. The legal framework I have talked about it. I just want to tell you that there are too big, because we say what is next? What is next for us?

There are two big studies now, group of people of who are thinking about this part of the neglected fight against HIV/AIDS. UNICEF is doing something which would be released at the end of the year and the Journal [inaudible], which is a group of 60 intelligent people who have reviewed what happened in the world, worldwide. We release also a report and the objective is to more efficiently reach children and their families is to extend access to essential service to children

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and to strengthen families and provide a better outcome for children.

It is also to give to the world, evidenced based data so that we have no longer excuse to not use the data we have. And recommend action to be taken for children and their families.

And in conclusion, I can tell you that we need better data, but first of all we need to use the data we have. First of all we need to use the data we have, because if we provide you with more data, what are you going to do with those data if you do not use the data you already have? For children and research we have a problem. There is an ethical problem because for them we need parental consent. There is still the constraint of the cost of the technology and the technical barrier for doing true research for children.

We still have a big confusion with words. What is vulnerable for my friend here vulnerably something we find in Uganda. In Rwanda we have our own definition, we should ammonize because when we have partners who come to help children, whenever children they should know what they do, we should know what we want to do.

Another thing, we need to acknowledge and this in the African part, we should follow the interest of our children of our situation and many of the data research done are decided in

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Washington, New York or Geneva. It should be decided in Kampala, Nigeria, Lousaka, etc., and I do not want to give all the Capitol of developing world.

Another thing, if children and youth constitute 60-percent of the population, do they get 60-percent of the funds, No! Who decide the location, at home, it is not the child and the woman. At country level it is not the families and the child. At donor level sometimes it is people who do not have the knowledge of the field. For researchers it is most of the time donor driven. I do not blame the donors, I blame us, because most of the time they say if you want to do something, you can do it. And appears to put children on treatment has a purity, no one decided.

So, another conclusion I will like to give to you is that the epidemic today is driven by the most centric population. We all acknowledge that, and it something in the wings, we are all going for more centric population. But if we neglect the children today, they will be the driving force of the epidemic tomorrow.

I personally already know some adolescents who have produced children HIV positive. That means in the world all those children will we save, I do not talk about the one we do not save or die, 95-percent. And we have to know that the

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children infected through the mother, two-thirds of them die before they are two years old.

But the children, in Rwanda we have 5,000 of them on treatment. And they are going to remain alive, but in a way or another they are still neglected and to those children when they will get 20 years old we are going have them protect the society because they are already infected. And you believe that those children are going to protect the society if they have been neglected, I guess no.

And what I would like to tell you to finish, is that those two reports will be released in the end of the year. Already the talk has that we should put the missing face of children in the center of the AIDS agenda. And if we do not do that, we are going to meet today, which are going to meet tomorrow.

And what we do today, we have a population of HIV positive adults that have been neglected at the younger age that will not forgive us and they will not take in account of all the message that we are going to give to them. Protect the society. Thank you. [Applause]

[END RECORDING]

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.