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**Ecumenical Pre-Conference 2008: Faith in Action Now. Day 3
Prevention
Ecumenical Advocacy Alliance
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KAREN PLATER: She is a Partnership Advisor at UNAIDS and has the focal point for work in religion and faith. She spent 16 years prior to this at the United Mission to Nepal in Medical Mission work and we are just delighted to have you come and moderate the session. Thank you, Sally.

MS. SALLY SMITH: Good morning everyone. My task is to moderate the Plenary Session this morning, and I would like to start by welcoming you all to the session and thanking you for coming.

As Karen has said, I am a Partnership Advisor at UNAIDS for work with religion and faith communities. And I want to start by thanking the organizers for putting HIV prevention in a Plenary Session and giving it such a high profile in this meeting. I think it is a very important subject and it is really good to see the faith community taking this seriously.

I also want to thank our speakers for coming along this morning and for speaking to us, and I will be introducing them to you in a few moments.

We have Dr. Musa Dnakyau, we have Dr. Purnima Mane and we have Mr. Prateek Suman, and I will introduce each to you as they come to speak.

As an important topic, it is not my role to speak about the topic, but I just wanted to set the scene. And as many of you know the global reports on AIDS was released last week by

UNAIDS and there is a couple of highlights in there about prevention that I just wanted to share with you. Any of you who is staying on for the main conference next week will actually receive a copy of the report as part of your registration pack, and we are trying to get some extra copies of the report on memory stick for those of you who will leave the conference before the main conference starts.

But we have a substantial increase in prevention efforts and they are really producing a result in the number of heavily infected countries, in particular, just a couple of highlights for young people. We are seeing that in some of the most infected countries, the condom use is increasing for those who are having multiple partners. And we are also seeing that young people are waiting longer before starting to have sexual intercourse and those are good things.

We are not yet seeing however, convincing evidence of numbers of partner reduction among young people, and I think that is one of the areas where the faith community can really have an impact. Many of you are teaching about life skills education, and you are involved in work with young people. And there is many different aspects of the HIV prevention that our speakers will speak about. But I just wanted to highlight the important role of the faith community in prevention and thank you for your efforts.

So before saying anything else, I would like to start by introducing Dr. Musa Dnakyau, and he is the Director of Medical Services. He is a family physician with Evangelical Church of West Africa. He is in the medical department in Nigeria and works in HIV work. He is a clinician with 14 years experience in HIV care, he is an educator and he is the Chair of the INA AIDS Ministry Board for seven years. Thank you.
[Applause]

REV. DR. MUSA DNAKYAU: Good morning. It is a special privilege and humbling to stand in front of you today. Some of you will have my name as Rev. Dr., my denomination does not take too kindly to self ordination. [Laughter] I just corrected to Dr. I am a church leader, but not an ordained one.

So, like I said it is a privilege to talk about an aspect of prevention that we want some of us to think about as we go through this conference. And for this period, I would like us to just look at just some faith community responses to prevention. Try to draw out some differences between risks and vulnerabilities and some of us practitioners share an experience from Nigeria and that will be all. I hope we will be able to do that in a very short time.

Now, HIV is not just a personal issue, but a public issue. And when I was in final year of medical school, I had an HIV patient as my final medicine exam. And the reason was because HIV was rare at that moment. Within this phase of five

years, I had lost uncles, aunts, cousins to HIV, within this phase of five years.

Something that was write in textbooks, again something very personal, and this quote is from one of a church leaders who had gone through this series we had done with church leaders. We tried to get them involved in prevention looking at root causes among different vulnerable groups.

Now, a little thing about the past, I know that in the past we had many initiatives in the faith sector, but we had some fundamental assumptions about this.

First of all we had assumed that people simply need to be told the truth and they will walk. And secondly, we believe that telling stakeholders to collaborate will insure that it happens, and thirdly that interventions without looking at enabling environment will have a sustaining part, but logic tells us that it does not happen that way, and I am sure that for many you who are practitioners you do know that consciousness does not automatically lead to commitment.

And such programs we have had in the past have not really done much to reduce transmission rates. They have not effectively led to handling the issues of human development that the epidemic itself has caused.

Another difficulty we have with prevention efforts is the fact that this epidemic requires discussion on some very difficult things, and during this pre-conference we have

mentioned some of them. Issues of sexuality, issues of stigma and discrimination, issues of illness and death. Things that people do not ordinarily want to talk about. It also gives rise to difficult questions about rights and responsibilities, as well as what exactly are affective methods of achieving behavior change, whether it is at individual level or at society level.

We just heard from the report some things are working, some things are not. But in summary, I think we can see that we have learned two things about prevention. One is that different settings require different approaches and I am sure most of you will agree with that. And secondly that vulnerability, risk and impact are all linked, and unless we tackle the issue of vulnerability, we really will struggle to have an impact in our prevention efforts.

Now prevention strategies need to address both risky behavior as well as factors that make people vulnerable. They are different, but important. These factors include, poverty, discrimination, inadequate education, lack of basic infrastructure, and of course gender and equality. If I ask you could list one of two more things that are unique to environment, to your context.

I like this quote from Louis Pasteur that "the microbe is nothing, the terrain is everything". It should help us to think clearly as we focus on prevention efforts. Sometimes we

think of HIV as a virus, but I think this quote should help us to really consider the terrain in which we are walking, the terrain of human beings.

Now, what kind of responses have we had? We have had quite a number of responses from the faith community. We have had campaigns for comprehensive prevention, the global campaign to overcome stigma and discrimination and so on, all the way to challenging the exclusion of people living with HIV.

However, the responses from the faith sector tends to be double edged. Now on the one side we do know that moralistic and judgmental religious beliefs and teaching do and can undermine efforts to eradicate the disease. But on the other hand, the strength is that ideological and ethical convictions as well as a compassion do contribute to the well being of persons and the goal of an AIDS free world. So, from the faith community we do have both sides.

Now the basis for the faith response I think is important for us to remind ourselves. I love the passage from John Chapter 10, reading from NRSV. The thief only comes to steal and to kill and destroy. I came that you may have life, and have it abundantly.

This concept of abundant life, I think is important for us to take away when we talk about vulnerabilities as faith community. Quality of life in this case, is defined by the concepts of justice, as well as wholeness. There is no way we

can talk about prevention without talking about the issues of quality of life, justice and wholeness.

Now there are differences between risk and vulnerabilities, as we will see. Risk, HIV risks refers to the probability of an individual, the community infected by HIV that through his actions or inactions or through some other people's actions or inactions.

Whereas vulnerability which we entrusted in today, is it reflects on individuals or on communities, inability to control their risk of HIV infection. Now they are linked, but not quite the same. And vulnerability in its own sense could be both personal as well as societal. Personal vulnerability deals with the issue of individual knowledge, awareness, life skills, which we have mentioned.

But there is also the issue of societal vulnerability, which sometimes in our programming we forget. The capacity to influence power structures which impact on people's lives is an important component of societal vulnerability for HIV prevention. Attitudes to sex and sexuality as well as religious beliefs, all those are important in whether a community, a population is vulnerable to HIV or not.

There is also the concept of key populations which is related, and we do know that we do have populations that within the context of an epidemic in a particular setting. Depending on the country, depending on the prevalence we could have

drivers who affect the dynamics of this, and this include men who have sex with men, sex workers, injecting drug users and prisoners. I mentioned this because in tackling root vulnerabilities we do need to focus especially on this key population.

Now variable groups are known to us in many populations which are vulnerable for various reasons which we will touch on. Woman and girls, young people, I am glad my colleague is going to talk about young people. People living in poverty because it affects their ability to touch on power structures, migrant laborers, people in conflict, post conflict situations, refugees, etc, et cetera. We could go on and on. This is unique to your own environment.

So, many of these populations are vulnerable to HIV and most times in our programming we do plan things to reduce risk, without considering things that will reduce their vulnerability. And I want us to look at the issue of best practices in reducing vulnerabilities.

We do actually have such an experience in this, and I know that some of the ideas we have planned, including the EAA's goals for comprehensive prevention, include things that affect root vulnerabilities and if you look through that list there are quite a number of challenging things and views to look at, including the issue of breaking of silence with regards to several of these issues, including the issue of

effective methods of preventing transmission, which we need to support.

We need to contribute to sharing and promoting scientifically based improving information. I am glad several of the sessions touched on this aspect. We need to challenge how full practices and traditions from wherever they come. We need to eliminate double standards. Particularly, when it comes to issues of gender, we need to address the factors that make children and youth in particular vulnerable to HIV.

In one of the sessions yesterday, I was very glad that UNAIDS agreed that in the strategy there was need to focus on children as a particular group. I think and I feel that this is essential in addressing vulnerabilities to tackle that especially. We need to address the epidemic in context of violence, how violence brings in a whole different dimension to our prevention efforts. Need to address other factors that make special populations ,which was mentioned at risk for HIV.

Now to make this very simple, I borrowed this illustration from Kafort [misspelled?], which I think illustrates what we are talking about, prevention, best practices. Many of us have seen this tree before. Now commonly we talk about mitigating the impact, and most of those programs actually deal with care and support and tackling of underlined factors, so they do touch on that.

But most of our programs tend to focus on reducing risks of infection, especially at the personal level. And if you note, most of that only affects immediate risk reduction, immediate risk reduction. And I would like challenge us to move onto the roots of the matter. Individual vulnerability as well as root vulnerability. I believe the same model in which ANERELA is champion in is a very good model with modifications that could tackle this aspect of root vulnerabilities. So, I do believe that as a faith community we do have models we can look at.

We have an experience that I would like to share with you from Nigeria. It revealed Nigerian partners supported by Terfront champions revealed that we do have very limited attempts most of all we are focusing on individual risk and not on vulnerabilities. And so a process of changing attitudes started from far back in October 2005, and involved two Evangelical Denominations, one of which I am a member covering about 8.5 million members in Nigeria.

Now, in our experience some of the things we started which was first of all the need to recruit champions for change, and this will look at how people who had champions for change, we had different groups. Again, this has been mentioned as important in mobilizing the church to think concretely in this issue.

To separate the different groups and then bring them back together, and that is what we did. We had project workers, we had senior church workers and we had local church pastors and their spouses who were involved in this process. They participated in a series of workshops as well, and these are some of the champions. Local, not Terfront champions. And it was a participatory performance set in a very local way, we enjoyed ourselves. We are in the process.

And one of the things we learned through this experience was that when we are doing this process, instead of focusing so much on HIV and the process of transmitting HIV which tends to push people towards individual risk, we found it important to look at fundamental issues, like causes and cures of disease, what are people's world view towards disease, very important.

Often as stigma and discrimination relates to the issues of world view, attitudes to gender, the use of power by church leaders. It was interesting when we did an exercise with many of the church leaders and it was shocking for many of them to find that they were quite autocratic. They never had it brought out in such an objective manner before, and so it was helpful for us in this process.

It was also important to talk about how people learn. A common thing we find in churches is that religious leaders believe that if you stand in front of a community and they

preach a sermon that people will walk away and change. We all know that is not the case, and so we focus on that and we did find that in addition, consistence, support and participation of people living with HIV in ANERELA particularly, was very helpful.

And members of the support group, local HIV support group, it helped to confront stigmatizing behavior and as a result of that, we had this experience like I mentioned on the land issues, local champions, people living with HIV. We then used mentoring and accountability, and for every practice that they changed we made sure it was institutionalized within their government structures.

Now, one of the comments that came from one of the church leaders I attended was, I consider myself born again, when it comes to my attitude towards people living with HIV itself and stigma. Now this leader had attended several workshops previously, but this focus had helped.

I want to propose to us a framework for this action, and this framework I borrowed from the ancient church leader's statement of commitment. They committed themselves to empower local congregations and communities. If we are going to tackle root vulnerabilities, we must have a model that empowers, rather than a model that pleases us as the experts, and it must be local congregations and communities.

In conclusion, this quote says "knowing is not enough, we must apply, willing is not enough, we must do".

I would like to thank Terfront and several of my colleagues who participated in making sure that this was done. Thank you. [Applause]

MS. SALLY SMITH: Thank you Musa. That was a very helpful introduction. I like what he said about assuming that just telling the truth would lead to behavior change, but that is not always true. That is an important lesson, is it not? And I think some of the factors that make people vulnerable to HIV infection and some of the things that the church is in and the faith communities are ideally placed to address, but are we really doing that, that is some of the challenge that I think he has laid before us this morning.

One thing I wanted to highlight was in fact, the Ecumenical Advocacy Alliance Theological dialogue on HIV prevention that was held in January in South Africa, and out of that will becoming a report and there is also a dialogue booklet on how to do HIV prevention dialogue in faith communities that will be a useful resource for churches in doing that.

So, with that I would like to introduce now, Dr. Purnima Mane. It is a delight to introduce Purnima. She is the Deputy Executive Director of the United Nations Population Fund, and she has also worked for the Global Fund for TB, AIDS

and Malaria. She has also worked for UNAIDS and was my Department Director for two years. And she is going to come and speak to us now. Thank you. [Applause]

DR. PURNIMA MANE: Thank you, Sally. Good morning everybody. I am really pleased to join you today for the HIV Prevention Ecumenical Pre-Conference on Faith in Action Now, and it is such an honor to be sharing the podium with two people who I know think very much like I do, as well as challenge us to go beyond what is known and understood as in "the truth". I thank you for giving me this opportunity to address you and be a part of this wonderful gathering.

I know that much good work has been done by faith based communities in responding to the AIDS epidemic all around the world. And on behalf of UNFPA, the UN Population Fund, I would like to pay tribute this work as well as particularly the work which is being done by the Ecumenical Advocacy Alliance in this regard. You campaign keep the promise, works to protect the rights of people living with HIV and promote an attitude of care and solidarity, rejecting all forms of stigma and discrimination.

This Pre-Conference challenges all of us to examine our work more closely to see what we can do more in terms of HIV prevention. What we can do to expand access to treatment, and of course to provide compassionate care and support to people living with HIV.

As we gather here on the eve the 17th International AIDS Conference, we are really challenged to chart ways together to insure universal access to HIV prevention, treatment, care and support by the year 2010. We are challenged to close the gaps that were highlighted at the high level meeting on AIDS that took place just in June in New York at the United Nations. We have a long way to go.

I do not want to go through the statistics since they were refereed to by Sally, I just want to emphasize that we have 45-percent of the new infections are among young people, and I think that is something that we need to pay special attention to. We need to actively foster their participation and leadership for a more effective response, and you will hear more about that from me, but much more from a young leader himself, Prateek.

To move this agenda forward, I have been asked to speak today about the most effective models of behavior change and the challenges and roles of young people in prevention. Both are topics on which one could speak for hours, so I have been really constrained to try and keep it to the time limit I have.

Fortunately for me, Dr. Musa has made an extremely good foundation for what I am going to say, because I am essentially just going to say what he did. Which is that behavior changes is important, but behavior change needs to happen in the context of a much broader society change, not change that we

should see as something distant and somebody else's problem, but a problem or an issue that we can all take responsibility for, and that we can all make happen. And let me talk about these issues.

Both the issues are very close to my heart. As a mother of two young men, I have one son in University and one starting his professional life. I have a vested interest in whether and how we are addressing young people's issues and listening to their concerns and opinions.

I would like to believe that for my sons the life they lead today has been possible as a result of a loving family, a quality education and a supported environment in which open dialogue was fostered, creating a sense of mutual trust, respect and responsibility.

I believe that this enabled them to avail of a range of opportunities, but we know that today many young people are not so fortunate. They are growing up in conditions of poverty and hardship that put their lives and health at stake. They lack the support information and access to services and opportunities to fulfill their full potential.

As HIV infection is the result of human behavior, it has long been understood that changing risky behaviors or maintaining health behaviors, we often forget in behavior change that we also need to maintain good and healthy behaviors.

All of these are essential to stop the spread of infection, but in fact, in almost all cases where epidemics have begun to be reversed, broad base behavioral changes was central to success along with the environmental and contextual conditions that supported such behavior change. And that is what Dr. Musa was referring to.

As a member of the HIV Prevention Working Group, I am pleased to be able to tell you that there are findings, and I will talk about some of them. Of its latest report which actually focuses on behavior change, looking at the latest evidence. Unfortunately, I do not have a copy to show you because it is going to be launched this week, but it is something that you should look at as a group.

This report points out that just like AIDS treatment, HIV prevention is lifelong and its impact must be continually monitored. Comparable to treatment, HIV prevention will only have effect if it reaches those who need it, and we do know that it does not reach those who most need it.

If you examine the efforts that have been going on in this area, we find that well designed behavior change programs seek to achieve results on multiple levels, to which Dr. Musa referred. They promote accurate individual knowledge. Of course, the exception of risk, but we know and as Dr. Musa said rightly knowledge and perception of risk in themselves are just not enough to change behavior.

Successful behavior change programs actually increase a person's motivation to avoid risky behavior. And they build the individual's skills needed to use prevention messages and tools properly, and to either avoid or effectively negotiate risky situations.

On a broader level, such programs also needs to influence the contextual factors which enable young people to translate the motivation, information, skills, tools everything that is accessible to them, turn all of that into actions to protect themselves. There is a gap between all of these tools, information, motivation and actions, and for them to make that leap there is a whole lot that society needs to do.

Studies show that young people when provided with accurate and comprehensive information, skills, education and services postpone sexual debut. And Sally referred to the findings of the UNAIDS report. They do reduce the number of sexual partners and they do use condoms when they think they need to be used.

The record on effective HIV prevention reveals that successful programs share certain basic characteristics. They combine different strategies, achieve sufficient coverage, increase motivation to reduce risks and build skills to protect against transmission.

But we know that prevention efforts must go beyond focusing on individual personal behavior because behavior does

not occur in a vacuum. Effective prevention involves influencing social, political, economic and cultural structures, systems and inequalities that make women, youth and special groups of the population particularly vulnerable.

Prevention efforts need to address stigma and discrimination, gender and equalities. All of the factors that Dr. Musa mentioned and the causes and effects of poverty and gender based violence which all of which hamper prevention, treatment and care.

These principles are highlighted very clearly in the *UNAIDS Policy Position Paper on Intensifying HIV Prevention*, and I am very proud to have been associated with the development of that paper.

The one thing I do want to emphasize that all of these factors that Dr. Musa and I are pointing out, very often result in a reaction among policymakers of switching off.

Why am I saying that? It is because it seems so distant, so far away or dealing with poverty, dealing with gender and equality, gender base violence, or that is too big for us to deal with. Let us deal with the here and now. Frankly speaking, this is an unfortunate reaction because none of these are really that far away. They are things that we can do. There are actions that we can take.

There are policies that we can put in place. There are programs that we can put in place that can phase into getting

the results that we want, including gender and equality, reduction of poverty. Otherwise, the world would not be changing the way it was changing.

I think it just takes will and intent and resources for us to get around the unfortunate, as I would say, reluctance that we have to addressing the social, political cultural barriers that actually make for the vulnerabilities to which there was reference.

Studies show that successful programs insure access to prevention commodities, like condoms and sterile injecting equipment for drug users. And here I want to make a point which brings us to one of the most important issues in behavior change for prevention, the silence that surrounds issues central to HIV.

If we want to make greater progress we have to break the silence. I am so glad Dr. Musa referred to that as the first point. And we need to create safe spaces for dialogue on sensitive issues that he referred to, sex, sexuality, drug use. We need to suspend judgment, avoid condemnation, listen to evidence on what works and embrace compassion with a view to reduce suffering.

Let me quote from the campaign of the Ecumenical Advocacy Alliance. "Silence is not an option, nor is an action. Injustice and suffering demand our advocacy in a world

that desperately needs people of faith, creatively working together for change".

I am really delighted to have gone through the document which was produced by the Ecumenical Advocacy Alliance exploring solutions which offers guidance on how to talk about HIV prevention in the church, and I hope you will have a chance to look at this wonderful document.

Within UNFPA, we have been able to reach some of the most vulnerable and marginalized communities, mainly through partnerships. Notable among them, with faith and interfaith based organizations. And we found that extensive dialogue with an open mind is required and there is a need to respect each others space and areas of engagement.

Cultural, knowledge, awareness and engagement of local communities are vital in advancing effective and sustainable change. Building partnerships with a range of community groups is absolutely imperative for such change to occur.

To build a strong constituency for HIV prevention, a broad based coalition of youth, women's groups, religious organizations, business leaders and AIDS activists is needed. Just as if you will remember the concerted global efforts that led to the dramatic increases and access to drug treatment, we need similar efforts now to expand HIV preventions.

And one of the lessons there that I will flag before I get to my conclusion is that we need to focus on the message of

knowing your epidemic. The nature and scale of interventions in the community will have to vary according to the type of the epidemic and the population it affects most seriously.

I will not go into the details of this, but a very useful document for that is a UNAIDS document which actually goes into what needs to happen in generalized populations, in generalized epidemics with specific populations recognizing that you probably need to do some HIV prevention in all context, but where do you need to put the focus, where do you need to put your resources is the question that we are often asked, and what is it that you need to prioritize in a phased manner.

I want to conclude by saying that young people in particular, can be powerfully educators serving as role models and reducing stigma. In fact, it might seem like something that all of us at the UN always say, but never do, is that young people should play a meaningful role at every stage in the design, implementation and evaluation of programs directed at them. And we are quite proud to say and open to criticism if necessary that UNFPA tries to do that in every spillet and you have heard about at some other session, I will not go into that here.

Young community members living with HIV in particular can be powerfully educators serving as role models, and I do not need to tell you that because you have amongst you lots of

young people who are also living with HIV who are doing tremendous advocacy and speaking up openly.

The central problem in HIV prevention is not lack of evidence, but failure to bring to scale programs that we know work. There is enough evidence to show that they work in a specific setting, and often that does not happen as I said for a variety of reasons.

Let me mention one organization that is working on this. GAP in Botswana which has one of the highest HIV prevalence rates. I quote Rev. Tom Monatsi [misspelled?] and ordained Methodist Priest in Francis town, Botswana who said, I remember it so clearly the first time I saw GAP perform, and I said to myself, this is it. The youth have a message we simply must give them a chance.

This is the part of you. I have seen this in Nairobi. I have seen it in Mumbai. I have seen it in Reho and I know you are seeing it all over the world. They can contribute in a variety of messages and I think all we need to do is to stand with beside them, to support them to unleash their potential.

Let me thank you for giving me this chance to address you. I would like you to encourage you again, to go back to the same message, break the silence around HIV prevention. And I appeal to you to give a chance to young people so that they can exercise their leadership to build a more effective

response and work towards what we look forward to, an HIV free generation. Thank you. [Applause]

MS. SALLY SMITH: Thank you Purnima. That was another really great challenge to us, was it not?

One of the things that struck me was that she said, that well designed programs, successful programs, not only promote motivation for behavioral change, they build the skills and they address the contextual factors that put people at risk. She encouraged us to break the silence around HIV, and to stand beside young people giving them a meaningful role in the planning, the implementation and the monitoring evaluation of the response.

With that, I would like to introduce a young person on this panel, Prateek Suman. Prateek Suman has been a member of the Youth Coalition, and is the Chair of the World AIDS Campaign Global Steering Committee. And it was a pleasure to work with Prateek two years ago on the Civil Society Task Force to advise the President, the Office of the President of the General Assembly and the preparations for the high level meeting on HIV/AIDS. Welcome Prateek. [Applause]

MR. PRATEEK SUMAN: Thank you, Sally. It is an honor and a privilege to speak with all of you today. We are here in Mexico because we are concerned. We are concerned about HIV and AIDS. We are concerned about how it has devastated the

lives, the hopes and dreams of individuals of families, of communities and nations.

We are concerned even more about the impact it may have on our children and their children. We are concerned that despite our efforts for the last 27 years, we are still falling behind in the response to the epidemic. For every two people put on antiretroviral drugs, another five get newly infected. We will not get ahead of this epidemic unless we scale up our efforts on prevention.

As Dr. Purnima Mane just mentioned, 45-percent of all new infections occur amongst young people, and 50-percent amongst women. Our efforts on prevention will not succeed unless there are more young people as Dr. Mane said, and especially young women. Less than 40-percent of young men and less than 38-percent of young women do not have the basic information they need about HIV/AIDS.

Our efforts on prevention will not succeed unless we insure that all young people have the information they need to protect themselves. Central to our efforts on prevention, has to be the provision of accurate, comprehensive evidence based sexuality education.

Evidence shows that if young people have the information, skills, services and commodities that they need, they can protect themselves against HIV infection. With no cure in sight for HIV/AIDS, prevention remains our first line

of defense. Together we must intensify HIV prevention, along with treatment, care and support. So, I am very glad that we are discussing this pertinent issue today.

In many communities, judges and faith based organizations are taking the lead in breaking the silence that surrounds HIV prevention, education. Churches that were daughs [misspelled?] of silence are now becoming lighthouses of information. We have already heard from Dr. Musa Dnakyau about the powerful programs in Nigeria.

In Namibia the Evangelical Lutheran Church has taken the lead and train hundreds of young volunteers to speak with other young people on HIV/AIDS. In the United States, the United Church of Christ has taken the lead and developed a program affirming persons, saving lives on HIV prevention.

However, we all know that this is an uphill task, and those who take the lead face much resistance. You face resistance from all the people in the community who prefer not to talk about these issues. You face resistance from members of your churches who are uncomfortable with discussing issues of drugs, sex and violence. You face resistance from all those who would rather be in denial and silence, rather than engage in action and change. But the stakes are too high to remain a status quo.

Each passing day, almost 3,000 young people get infected, that is two young people every minute. Those who

recognize the stakes must unite for change. Judges and faith based organizations are beginning to join hands with other civil society organizations in response to the epidemic.

Civil society organizations, who have not traditionally worked with churches and faith based organizations, are discovering the experience, the capacity and the outreach of faith based leaders. Resources are being developed to help churches that address prevention, and to help civil society partner with the faith based organizations, as Dr. Mane also mentioned. Yet, many challenges remain.

The first challenge is to continue to break the silence. Dr. Mane and Dr. Dnakyau both mentioned this. Whether there is silence, there is stigma. Where there is stigma, there is discrimination. Where there is discrimination, there is violence. Where there is violence, there is fear. And where there is fear, there is more silence. We have to break this cycle of silence.

Churches and faith based organizations must partner with other civil society groups to take every opportunity to talk about HIV prevention. We have to break the silence around young people's sexuality. Young people have sex just like everybody else. Being in denial of this basic reality does not help. Similarly, being in denial about drug use or homosexuality or sex work does not help. It makes these

conversations more difficult. Therefore, we need to continue to break the silence.

The second challenge is to develop prevention messages that are evidence based. Abstinence only on education does not work. HIV is too complex to be solved by acronyms like ABC. Young people need the entire alphabet. What is needed and what is proven to be effective is comprehensive sexuality education. The capacities now existing young people to be pure educators for other young people. Church and faith based organizations must partner with such young people to promote prevention education.

Thirdly and finally, the challenge is to overcome cultural differences and unite around the common purpose. The complexity of HIV and AIDS has brought many different actors into the same room. I think a quarter of a century ago, we would have never imagined a gathering such as this where activists, faith based leaders, gay groups, transgender groups, sex workers, positive people, negative people, gay unionists, business organizations, governments, women's groups, men's groups, media companies are all uniting for a common cause.

If AIDS has taught us anything, it is that we must unite. I believe we can all unite. We can unite because of our shared compassion for our fellow human being. We can unite because of our shared interest in the world that we pass on to

future generations. We can unite because of our commitment to the dignity of the human being and fundamental human rights.

We believe that all persons are endowed by their creator with certain inalienable rights, amongst them being life, liberty and the pursuit of happiness. We believe that the recognition of the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.

Let our faith in these beliefs unite us into action.
Thank you. [Applause]

MS. SALLY SMITH: Thank you, Suman. I would like to repeat one of the sentences that he said, because that was so powerful, is it not? Where there is silence, there is stigma. Where there is stigma, there is discrimination. Where there is discrimination, there is violence, and where there is violence, there is fear.

Let us just reflect on that for a moment. And also where there is silence, there is ignorance. And he also said that what is effective is comprehensive education, and that young people can provide that education, one to another. Some of those things are really important, are they not? There are things that we need to take to heart and really take into our dialogue, take into our planning and take into our programmatic actions.

I want to thank all three speakers for what they have shared with us this morning. I would like now to invite you to move into the discussion around your tables. In the last couple of days, what we will do is we will spend about ten minutes discussing a round the table.

And if you would like to come up with one question that you would like to address to the panelists, who will then have the opportunity to share those questions with the panelists in a few minutes time.

As in the other sections, we are not going to have time for everyone to give their questions. So also write your questions down, and put them in the baskets in the center of the table.

We would also like to ask you to come up with one action that we can take around HIV prevention as faith based groups and communities. One action and one question.

So thanks very much, you have about ten minutes and then we will come back together in Plenary. One more minute folks.

Can you join us again please? We have one question here already. Somebody have a microphone please. Yes, here we go. Thank you. We have time I think two rounds of questions. We will take four questions to start with, and we have the table just over here. Please go ahead.

FEMALE SPEAKER: Yes, we had a very dynamic discussion at our group. Our questions were, how can we learn from our targeted groups in order to develop affective behavior change? The targeted groups that we discussed that were of greatest concern to our table, include youth, but also includes sex workers, injecting drug users and the gay and bisexual populations.

MS. SALLY SMITH: Thank you. Another question. At the table in the middle, here.

MALE SPEAKER: Well I think it is very important we have many responses from leaders, priests. But they have all talked about breaking silence and to break silence we need the word, the voices of our great pastors of our bishops because here many people have broken the silence, but for youth prevention, talking about primary, secondary and technical education we need the voice of our bishops, of our great religious leaders.

So, how is it so difficult that our bishops, pastors, break the silence once and forever?

MS. SALLY SMITH: Wait. Wait, just one here and then the back. Thank you.

FEMALE SPEAKER: Thank you very much. Our table had more than one question, but you only asked for one. We would like our response either from the panel or from the moderator of this session to tell us whether there is statistics showing

people who are with disabilities and who are positive. Because some of us are looking for that statistic and we are not finding it, and we also concerned that their voices are not here. People who have disabilities, who are HIV positive. Thank you.

MS. SALLY SMITH: And at the back, thank you.

FEMALE SPEAKER: Yes, I am speaking for a whole table here. But we just had some excellent comments about people seeing prevention programs working on the ground in their communities. And we are just asking, why there is not more openness towards different types of prevention programs. We feel like there is been a lot of kind of speaking against the ABC approach in this conference.

But the latest UNAIDS report, there was some excellent data that has been mentioned from the podium this morning. And I would just commend to everyone, look at page 36 of UNAIDS latest global report. There is just an amazing numbers about HIV prevalence among young people has fallen in seven high prevalent countries. A, behaviors statistically significant have been seen in 13 countries. B, behaviors in 14 countries, C, behaviors in nine countries.

So this is really great news, and I think whatever we call different prevention approaches, maybe we get too hung up on the words, but this table is really just asking for more openness towards different types of approaches.

And if a community or a local program wants to call itself an ABC approach, and they are doing good work, why is not that as acceptable as a lot of the other types of approaches that people are bringing to the table here?

MS.SALLY SMITH: Thank you. We will hold it there for now. And I will give the panelists the opportunity to respond to the questions. Thank you.

MALE SPEAKER: Just one word from this table –

MS.SALLY SMITH: I know, just wait until the next round, please. Thank you.

MR. PATREEK SUMAN: Since I was the one who mentioned the ABC approach, I want to talk about it a bit. The idea is not that one approach is wrong or the other is correct, it is that you can only remain restricted to that so it cannot become a mantra to say that that is the only thing that works, and nothing else. So in fact, I was making the same point as you. To say that yes, use these approaches, but we need more. So that was my point.

DR. MUSA DNAKYAU: There was a question on how do we learn from our vulnerable groups? And I believe they have used a phrase creating a safe space, but sometimes you need someone to help you do that. And often for faith based organizations is just to look around at those who are already doing that. Who are already caring on dialogue, who are already having one

program or the other with those specific vulnerable groups to help you in how you approach to create that safe space.

There is an issue of why we are not hearing our great pastors and bishops. Well first of all sometimes all you need is one person. Yesterday, as part of a Plenary I saw one of our great pastor's wash the feet of some of our people here. And I feel it is a great moment. I do not know if you felt the same way, but I felt that history was being made while I was there yesterday. It is from such moments that we can have that happen.

But one thing I do notice is that bishops talk to bishops, I do not know if you have noticed that. Those of you who walk in the church, as senior leaders talk to senior leaders. And so if you have one, get him to talk to the others, they listen to each other.

DR. PURNIMA MANE: I wanted to also take up the questions on the statistics around people with disabilities. When I was in South Africa, I was quite impressed by how much effort there was to collect data on people with disabilities and HIV. As well as the fact that there was a strong constituency that was built around this issue, which as a result the government took it very seriously in terms of disability and HIV.

Unfortunately, data is a very slippery thing. Data is something that also has a political element. In that somebody

who has power, who has influence has to make sure that that data is actually being gathered. That is the first point. And often, areas like disability are not yet being gathered. We are having a tough time getting age desegregated data.

We are having a tough time getting sex desegregated data. We have been asking for it for the last 20 years. And that is not happening adequately. Some of it, of course now in the HIV epidemic we see sex desegregated data is beginning to appear. AIDS desegregated. And I am sure on this disability will with the kind of advocacy that we are seeing among people who feel this is an important issue.

So, I support your position, but right now there is not enough data for it, UNAIDS. I cannot speak on behalf of the department that puts the report together, but as a co-sponsor of UNAIDS, I know that some of the difficulties are because the data does not exist. The reliable data does not exist. And for that political lobbying at the country level needs to happen so that that data is collected.

I wanted to just speak a little bit about the other points, and I completely support the point that was made about getting one person to break the silence has an impact and secondly, building the peer partnerships.

In every sphere that we have worked over the last 25 years, we have found that peer leadership makes a difference, not just among young people, it is also among media barons who

speak to each other and say, come on we must talk more about HIV.

It is among political leaders who get together and talk to each other about the difficulties they have in their own country. It is with First Ladies, you mentioned any group it really is peer leaders that make the difference, and I think if you have one or two spokespersons even in that community, they will influence others to start breaking the silence. So, I completely commend the point that was made.

And on the point that was raised about speaking against, I apologize if any of us sounded like we was speaking against any or one approach. I think Prateek put it very well what we were trying to say, is that we need an area of strategies that are useful at different context, at different points of time. Obviously strategies that have evidence that they actually work. You cannot use just a strategy based on because you feel it is right, but also there needs to be some evidence that this is a strategy that will actually make difference in HIV prevention.

And we are saying that make all those strategies equally available to the people you are working with, so that they can exercise the appropriate choice based on their particular situation and context, not restrict yourself to either one or the other.

And I think that is really the point that was trying to be made by our group. There are others who have attacked certain policies, much more vehemently, but I do not think this group intended to attack any particular approach. Just to encourage you to add to the plat oral of alphabets as Prateek said. We need the entire alphabet if possible for those strategies to occur.

I also want to flag that in the case of women sometimes, neither a nor b nor c works, because they are not able to exercise any option, even if you give them d, e, and f, sometimes they are not able to exercise it. So, that we need to address the vulnerability factor that was mentioned if we are to address even a, b, c, so that women are empowered to exercise the option between any particular option that is offered to them. Thank you.

MS. SALLY SMITH: Thank you, Purnima. I just wanted to also add to that, that the data in the global report has come from 147 country reports, and they drew up those reports based on a number of indicators they are drawn up by UNAIDS and the cosponsors. And just also to let you know that there is the monitoring evaluation reference group that works on the development of those indicators.

And we have civil society representatives as part of the monitoring evaluation reference group, and we actually have someone here in the room from the faith based community who was

at that meeting last year who is a part of helping to revise the indicators.

So, just so that you know, there is input from this constituency into the design of the indicators.

And I also wanted to emphasize what Purnima said about the importance of working with constituencies in a broad based and complete set of prevention messages. And one of the things in UNAIDS that we came to do is to work with groups in their areas of strength and to build relationships so that we can build those partnerships, those collaborative partnerships, and not to force people to do things that they are not comfortable with. Provided we can provide a range of information that people can make informed choices.

I think we will take a second set of questions now.
Thank you.

MALE SPEAKER: It is no different from what we heard already. It was amazing I listened to the these three great speakers this morning. This table come up with some, they are looking for some answers, I do not know if you are ready. They want to know how to create this space at all levels, such as family, church, schools, communities, et cetera. So this is what this table come up with.

MS. SALLY SMITH: Sorry, I did not quite catch that.
You said, the space at all levels?

MALE SPEAKER: Yes.

MS. SALLY SMITH: How to create space at all levels?

Thank you. In the middle here, Bishop Hanson. We have a microphone.

MARTIN: I have a question, but before I am Martin from Nicaragua. My question is what to do for that the person who know these a, b, c topic and the behavior of these pandemic can assume responsibility and act according to their knowledge in HIV prevention.

MS. SALLY SMITH: We will take this table here. No, this one here first, and then you can move the microphone over here? Oh, never mind, okay, after you. This one first.

FEMALE SPEAKER: I want to take the opportunity to break a silence that I know at least few members at our table have been holding our tongues about during this conference. And I am curious as to why we are not taking up the opportunity to have a symbolic gesture as Bishop mentioned yesterday.

And why is it that for the march today against discrimination and homophobia we are not allowed to take our banners from the EAA along on the march? [Applause]

MS. SALLY SMITH: Okay, thank you.

FEMALE SPEAKER: Our table's question has not been answered. We are asking why we do not have the presence of the bisexual, lesbian community and sex workers, intravenous drug users as resource persons speaking to us in Plenary, especially

because they are also people of faith, and we can learn from them about prevention strategies.

MS. SALLY SMITH: Thank you. [Applause]

I would like to give the opportunity to Bishop Hanson to speak. Sorry, could you please give the microphone to Bishop Hanson because we have made a lot challenges to our religious leaders and I think we have to give them the opportunity to ask a question. Thank you.

BISHOP HANSON: I am wondering if it is not in this arena that we have the most difficulty working ecumenically and interfaith because we seem to be at an impasse around questions of morality. And how do we break the impasse when Ray recognized that we hold deeply held convictions that are born out of centuries of tradition and interpretation.

And yet, if we do not find a way to break the impasse which I think will not be broken only with Bishops talking to Bishops and Theologians to Theologians, but has to include people like you and people that are able HIV positive and on the ground.

I am wondering if the concept that we use to build deeper relationships between churches called, differentiated consensus, which means can we find that around which we agree and acknowledge those areas where we disagree should not divide us and prevent us from engaging, responding, educating, but I do sense that in this arena we have our greatest impasse from

the full capacity we have to work together ecumenically and interfaith.

MS. SALLY SMITH: Thank you. I am going to ask now the panel to respond to those questions, if you would just give us a minute to confer. Thank you.

REV. DR. MUSA DNAKYAU: Thank you very much for those excellent questions. Usually when a speaker says, thank you for excellent questions, he does not know what to say.

[Laughter] There are two other questions I will attempt to answer. One is the question of how do we create space in the family, schools, church, et cetera, at all levels.

And basically, the approach we used is nothing high tech. It is something that most of us know. How do we have conversations that respect others? And believe me, even with small children it is important to create that kind of space to be able to talk. So, how do we do it? It is basic, common sense in a way which is not common. Have respect for people to be listening and to talk. I do not know anything more than that, so it is basic communication that is how we create space.

There was a question about the gap between knowledge and behavior, which is really why we are here today. If people who knew everything about HIV did what you are suppose to do, I am not sure the epidemic would be at the level it is today. And that is the problem.

I will share with you about one of the young lady's who is a patient of mine, diagnosed with HIV. Started treatment, felt better and then she stopped treatment for some reason and then got married and did not tell the husband and then got pregnant.

All of this, off her medications and then she appeared one day in front of me. And I felt like, if it was possible to put on her on my knees and give her a spank. [Laughter] So sometimes people do have knowledge and they do strange things, but that is why we talk about the issue of the environment.

In her case, several things had happened at home, that led her to do some very weird things, and that is what we are talking about. Often the gap between knowledge and action is because of something in the environment that makes people not to do what is logical. So those are the two I would like to share about.

DR. PURNIMA MANE: There was some questions here that were raised that we as Plenary members are really not in a positive to respond. So, we are going to ask Sally to see how those questions can be answered because we have no answer to your question on banners since we did not make that decision.

And we do not know why if at all what you have said about certain communities, bisexual, transgender, populations, on gay and lesbian populations were not represented under Plenary. Do not know the answers to that.

But I they are in the room, and I hope they are going to make their voice heard because this is about a dialogue and I hope that that is the only way to stimulate the dialogue and not to preach or not to talk down to anybody. This is really an exchange.

On the last issue, I only assure I want to talk about and I want to add something on disability. I truly appreciated what the Bishop said about the impasse on the question of morality. In fact, this is exactly the way he described is exactly the way HIV has been handled if at all in many countries.

Not just with the faith based groups, but with many other groups. In terms of parking issues on which you will agree and moving forward and putting aside the issues in which you disagree, because you do not necessarily get consensus on those issues, they do come sometimes as a result of deeply held convictions or sometimes political ideologies or whatever the reasons might be.

I think the idea is that in this epidemic we all need to partner with each other, find out areas on which we can work together and proceed on those areas. I think that is the lesson that we have learned in this epidemic, rather than wait for all controversies and all differences to be sorted out because that is never going to happen, we are human beings.

When I think Dr. Musa was saying also about knowledge and behavior. There is another element that also is very influential in all of us, and it is not always possible to handle with rationality and that is emotions. We know in many situations people do not know everything about condom use.

They do not use it because they trust the partner. That trust comes out of a certain emotion that means something. Intimacy means something to that individual and at that point of time all that scientific knowledge is completely set aside. Human beings are influenced by emotions and some of that we do need to recognize. We are not robots and cannot really always act in a very logical fashion.

Yet, at the same time we want people to do that. That is the challenge we have, that we want them to use that knowledge in the best possible way to protect themselves. Not to do good for the world by having less statistics or for HIV, just protect themselves and protect their partner, that is all we are saying. But is not as easy and that is why we are here talking today.

Finally, on disability and HIV. I just wanted to point out to something that my colleague, Steve Krause reminded me. That in last year UNFPA organized a global meeting on sexual and reproductive health and people with disabilities.

So I am going to point you out to the work that was done there. It was a very good meeting, we have come up with

certain actions on how we can strengthen data collection the very point you pointed out to. And participation of people with disability in advocacy program design, evaluation, all of these.

It was quite a new kind of a meeting, part breaking meeting and we worked with many, many partners. Many of whom are represented here on that meeting and I hope those actions as UNFPA is trying to implement them, are also being implemented by our partners. Thank you. [Applause]

MS. SALLY SMITH: I am conscious that our time is coming to an end and-

[END RECORDING]