

ABC in Africa – What is the Evidence?
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BABATUNDE OSOTIMEHIN: Good afternoon, ladies and gentlemen. I would like to welcome you to this session that is going to be devoted to four presentations on the "ABC in Africa - What is the Evidence?" And with me is Laurie Garrett, who is co-chair of this session. I think this is a very interesting session because this paradigm has been with us for a while and we are trying to see where there is evidence to continue use this paradigm.

At this meeting, there are several questions about ABC and maybe after we are finished this session, we will have some correlating evidence to ensure that we are going to need to do this or that we might have to change the way we do business.

We have four presentations and then somebody who is going to do discussions and because of the time, we have only about a hour, fifty minutes but going to allow each presentator 10 minutes and then the wrap-up will be another 10 minutes and then we will have discussions after that.

Now it is my [inaudible] responsibility now to introduce to you to the first speaker for this particular session, Kevin O'Reilly, who is a medical anthropologist and epidemiologist, has worked with The World Health Organization for 14 years and CDC for 11 years before then all in the area of protection of HIV/AIDS.

[Inaudible] can say that he's a man after insidious prevention for HIV/AIDS globally. One thing that he wanted me to tell you and maybe

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you have observed it is that he has fallen down some. Kevin?

[LAUGHTER]

KEVIN O'REILLY: When they ask you to choose what you want to be introduced by I might as well as be creative. Good afternoon everybody and thank you all for coming. I think it's been a long week with many meetings and I admire your stamina. What I'm going to present today is a relatively noncontroversial review of a relatively controversial topic: "The Systematic Review of the Impact of Abstinence-based Interventions and Risk Behaviors in Developing Countries." And I would like to thank my co-authors Amy Melondly [misspelled?], Julie Dennison, and Mike Sweat, as well as other actors who helped this work. And I would also like to point out that just following this session, at 6 o'clock, there will be a satellite meeting where we will review even more evidence of other interventions as well, including a repeat of this in case you enjoy it so much you would like to see it twice.

What's the background, or why are we doing this? There is - It's well known and the reason you are here, I think, is because some donors have targeted funding for abstinence based interventions and have focused their prevention efforts almost exclusively on that issue. This is coupled somewhat with a concern that promoting condoms might lead to increased risks and more sexual risk taking behavior. There is a lot of emotion, a lot of heat, maybe not a lot light around the topic and a systematic review is one way to look at what do we really know. So there are strong calls for looking at the evidence, and what are benefits of evidence-based interventions.

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So, the question we addressed for this study is what evidence or effectiveness is there for abstinence interventions in developing countries? This is part of our project, which is collaboration between The World Health Organization and the Johns Hopkins Bluebird School of Public Health. The goal of the project is to examine the strength of evidence of effectiveness of a variety of HIV interventions in developing countries while systematically reviewing the literature.

What do we mean by systematic? I have seen a number of presentations here this week calling themselves systematic reviews, and I think there is some latitude in the way that the term is currently being used. The goal that we have is to try to avoid any bias or post-op analyses by being explicit in all of the decisions that are taken, avoiding any opinion-based approaches, and have producing work that might be reproducible subsequently. So therefore, the project uses systematic methods that are written in advance, describing each step of the process with quality assurance that is built into the process including double coding and resolution of discrepancies between coders, detailed coding instructions and coding forms that we use to systematically extract data from the studies that we find, and search and inclusion criteria that are all predefined and used in a very rigorous way.

What do we mean by systematic review? Well, for sake of brevity, I won't go through this but just to say that for a topic that has a lot of emotion, it is very important that we have a way to systematically remove some of that emotion and maintain our

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objectivity when we are looking at the literature. And that is what this is an attempt to do.

So, what is it that we looked at in this study? We defined abstinence interventions as any programs or other planned efforts that are intended to increase the rates of abstinence. These can include abstinence-only interventions or they can include interventions that encourage abstinence along with other risk reduction behaviors such as condom use. The topic specific inclusion criteria were an intervention that encourages abstinence for the purpose of HIV prevention, not for pregnant prevention, with specific outcomes presented that would include abstinence, delay of sexual debut, incidences of HIV infection, and et cetera, and it had to be published between January 1990 and December of 2004. We did also meta analysis across the studies to generate emerge effect size estimation to generate confidence intervals for the effects that we found. [APPLAUSE]

Here is just a quick flow chart to give you somewhat of an idea of the amount of work that is involved in doing real systematic review. We started off with 436 potentially relevant articles and after going through and screening them carefully, we wind up with 10 that meet our inclusion criteria. And what did we find? The 10 studies are mostly conducted in Africa that meet the inclusion criteria - two in Zambia, two in Uganda, one each in Namibia, Tanzania, South Africa, and Nigeria, and then one each in India and the Philippines. They used largely randomized controlled designs, which is sort of interesting, because a lot of the literature that we are looking at is not characterized by randomized controlled

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designs, eight use these designs, two used non-randomized designs. Of the outcomes only six measured actual behaviors. A lot of others measured knowledge, attitudes, and other sort of - and beliefs. But only one study among the whole group tested an abstinence-only intervention. And all the studies, it is important to note, were conducted on adolescence only.

One of the things that we do in this particular project as well is to assess the rigor the studies that we are looking at. We have constructed an eight-point rigor scale that's an additive scale with one point awarding for each item. The items that we used are listed there below, again for sake of time, I won't go through reading them but I would like to point out that these studies scored very high on the rigor scale in general. In fact, of the different interventions we looked at the average score for these studies was the highest. The reason being that for the most part they were randomizing classrooms and they were randomizing not individuals but classrooms and because they were randomizing classrooms they also had relatively high follow-up rates in participants subsequently. So there is a bit of eschewing for more rigor on these studies. More rigor than, I think, that they actually really deserved, but that is an anomaly of our scale. You can see here that two of our studies received a score of six points, which is actually pretty high, with the bulk receiving mostly five points.

What did we find? On condom use, we found three studies that reported changes in condom use, one had significant effects, but a meta analysis showed no effect across the studies. On abstinence, we found six studies that reported changes in abstinence

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behavior, three had significant effects, and a meta analysis showed significant impact across the studies but the effect size was minimal. Specifically, in studies in Zambia, Namibia and Nigeria looking at condom use following interventions that promoted abstinence, as well as other risk reduction behaviors they found that you can see relatively weak effects with fairly wide confidence intervals in a nonspecific result. The merged effect was weak and the confidence intervals indicate that we have an insignificant result here.

For abstinence, looking at studies in Zambia, Namibia, Nigeria, Uganda and Tanzania, we found three of them with insignificant results but two primarily in Uganda and Tanzania, who did have significant results and the one in Uganda is the strongest of all. Owing that particular study merged effect model for abstinence was 1.4 which significant but still a relatively weak effect.

So, conclusions. What can we say about what we know about abstinence in interventions to promote it? In fact, we know relatively little. The rigor of the studies that we looked at was in general fairly good but I think it was a bit skewed toward the good. Few of the studies actually measured real behavior. There was interesting information presented in some studies on knowledge and attitudes and some of that leads to the conclusion that efforts do promote abstinence really needed to be coupled with or a consequent to efforts to change gender attitudes first.

Only one study that we looked at actually assessed abstinence only. All studies were on in school youth with behavioral

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outcomes, which makes it possible to assess the impact on adults. No impacts were found on condom use, either as in a beneficial way but it also didn't seem to subsequently make sexual activity more common and increase condom use.

So what we can say is that, in general, the interventions that we looked at had significant but minimal impact on abstinence but again, only for young people. Thank you

BABATUNDE OSOTIMEHIN: Thank you, Kevin. We will take all the questions together after the session and we will move quickly to the next presentation which title is "A Cow Dies with Grass in its Mouth: Fishermen's Response to 'Zero Grazing' in Kisumu, Kenya." This is to be delivered by Anjali Sharma, who works currently with the Kenya Medical Research Institute and have done so for five years. Her main occupation is rapid ethnic graphic studies within understudied populations. She also did art that I should remark about, she is telling me. Anjali.

ANJALI SHARMA: Thank you. Good evening. It's truly a pleasure to see so many of you out here when I know you could be right next door watching Steven Lewis instead.

I made this presentation with the help of my colleagues at the Kenya Medical Research Institute and at the University of Washington. Funds for the study was provided by the NIH, STITMCRC project grant.

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Kenya is in East Africa and has a HIV prevalence of seven percent. In Kisumu Province, which is this part right here, has a prevalence of 15-percent, and Kisumu District, which is the red, has an even higher burden of disease. So it is postulated that the fishermen who lived and work on Lake Victoria in Kisumu District amongst those are most at risk for HIV/AIDS. However, there has been no systematic study that examines what these behaviors are, why they are [inaudible] and even if there indeed is a high HIV prevalence in this population.

So we talked to 12 groups of eight to 12 men, fishermen. And we took teams that emerged from these focus groups discussions and discussed it with 17 key informants. Key informants are people on the industry who are very knowledgeable about what's happening out there and are willing to talk about it as well as the introspective about it. Most of the quotations that you will see come from these key informant interviews.

Separately, we also tested for STI/HIV in 250 fishermen. Just to give you an idea of the men that we talked to, all of them were questioned, all but one was of Luhyal [misspelled?] ethnicity and this is important to remember. In general, it seems that the key informants were older, more likely to have, you know, blessed education, be married, but

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they earned lesser than men who were in the focus group discussion.

To understand these men's sexual behavior, it is important to understand how their work and leisure activities are organized. And essentially what happens with the fishermen is that they have periods of really heavy work fishing, whether it's during the day or the night, interspersed with leisure-time activities and the ones I'm going to focus on are drinking, smoking marijuana, and looking for ladies. [LAUGHTER] The reason why men can look for the ladies is because they have the time to do so. They have the money with which they have no financial plans to spend and they have fish with which they can approach the women. They consume alcohol and marijuana because it's easily available in small packs, very cheap. And they need it to feel brave and be strong when they bring the hardware, particularly if they are doing this at night.

So currently, most programs talk about ABC. The fishermen have not benefitted from this for two reasons. One, these programs have not implemented well in this area but secondly, because its really not so relevant within the prevailing cultural, economical, and gender frameworks, as I will go on to show you. One of the key informants explained that abstinence was incompatible with local traditions. This is because traditionally among us Luhyas, Luhyas people, most of

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our customs end with sex whether it is the planting season or when you want to harvest, everything ends with sex.

Additionally this group of people practice bridal [misspelled?] inheritance. This means if a woman loses a husband, then a male relative from her husband's side will marry her or cohabit with her and that relationship is marked with sexual intercourse. If there is no such male relative, then it is the fishermen who are coming from other beaches who can serve as anonymous planters.

Work and social structure, as well as inequitable access to resources, also influence sexual behavior in this group. This is particularly true for young women, single mothers and widows. So if a new female wants to enter into the fishing industry, she will continue searching for fish to sell until she finds someone close to her to provide the fish. He will start by giving her small quantities of fish but will tell I want you to be my lover. Now, this woman will comply because even at home, she has been told if she to succeed in this business then she has to form a relationship with a fisherman.

Conversely, a woman might initiated a relationship with a boat by putting a net on the boat then having sexual relationships with the boat owner, and then if the fishermen wants to, you know, collect the money for the fish, she might simply arrange a rendezvous with him. So women then turn to these relationships because they want to get the fish to sell,

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fry, smoke or dry. They have little money to buy their fish and they need to compete with middlemen or log-filled traders on the beaches.

Conversely, men,, particularly if they come from other beaches, will form such liaison to have a ready buyer as well as to gain some homely comforts. So the one who gives the fish is the doublac [misspelled?] and the one who receives it is the jamacie [misspelled?] and most respondents say that this relationship is a sexual one. But this doesn't mean that everybody is in this relationship. There are couples who have decided in their homes that they will not have other sexual partners and they remain like that faithful to each other.

Still, most people are of the opinion that when a fisherman sees other nice women, he forgets the children back home and the wife. Even the woman. You could have five boats and I have one, you get along with my wife, and have sex because you are giving her money. So there are multiple accounts of multiple sexual relationships irrespective of marital status particularly among those in the fishing industry who are on larger beaches or away from their own beach.

So, condom use is inconsistent for all the usual reasons. Sdditionally, for ritual sex, condom use is not acceptable. We asked when the condom has been tested and it has been proved to be effective, how can we encourage people to [inaudible] to use it? One key informant said, "Had people been

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thinking about protection, these diseases like AIDS could have been wiped out. People here they do not care. Men go on admiring faces and think asses [misspelled?] without caring about the implications." Others said, "[inaudible] dwellers have an assumption that AIDS is like any other disease, like malaria or just like the way one can be on a journey and involve himself in an accident." Another one said, "initially people took AIDS seriously because people were dying and getting infected. But now, it is as we say, a cow dies with grass in its mouth. If you think of it, it can be considered as an accident, just as if your boat has capsized in the lake."

In other words, some fishermen anticipate and accept it that you do the risks inherent in their every day and routine activities but they cannot stop living their life because of the fear of death. However, they can enjoy their life to the fullest because each day could well be their last.

Separately, we found HIV prevalence of 26-percent in the representative sample of this population of fishermen. Now, these results are commiserated with the quality definings that I just presented and urge us to look for more workable strategies for HIV reduction. I can see I'm running out of time but if I'm maybe allowed one more minute. I'm just summing up.

Now the communities have innovated ideas such as rotating funds, diversification of livelihoods, cooperators with saving and loan schemes, creative behavior change,

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communications, and building local dispensaries that treat sexual transmitted infections. This is all to reduce to the threat of HIV/AIDS among their people. However, they need financial and technical support to succeed.

So what can we do? Kisumu Province has high HIV prevalence. It has funds to treat only about a sixth of those that need ART so according to what the fishermen themselves are suggesting we need to improve access to livelihoods and basic health and social services particularly for widows and single mothers to prevent new infections and save on the funds required for treatment and comprehensive care.

I would like to thank my colleagues, the Beach Management Units, the fishermen, and you for your kind attention.

[APPLAUSE]

LAURIE GARRETT: Thank you, that was lovely. We have a name change, but otherwise the same presentation brought to you by Godpower Omoregie, who is a behavioral scientist with the Society for Family Health in Abashai [misspelled?] Nigeria. His presentation is "Like Mother, Like Daughter: The Influence of Perceived Mothers' Values on Daughters' Attitudes Toward Sexual Abstinence in Nigeria."

GODPOWER OMOREGIE: Good afternoon, ladies and gentlemen. I will go to straight to present. I also want to say I'm honored and elated that one of the co-chairs this afternoon is the chairman on National AIDS Committee in Nigeria. And it's somebody that I cherished. I want to thank him for his visionary leadership in pushing the AIDS agenda forwards in Nigeria. Thank you, sir.

[APPLAUSE]

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I present this on behalf of my other colleagues Altonia Dalacare [misspelled?] and Dr. Augusta Onconia [misspelled?].

Now what we are talking about in terms of like mother, like daughter is a fact that we all know the importance of the fact that we need to encourage to abstain from sex in order to prevent them from contracting HIV. Now, the [inaudible] information in Nigeria and in most South African countries, I don't say we got without problems including HIV are important concerns. The young persons 15 to 24 years or 20-percent of the total population in Nigeria.

About one million deaths right here in Nigeria are due to teenage mothers. Infections from abortion are responsible for 72-percent of all deaths among teenagers 40-percent of the [inaudible] in Nigeria are infected with HIV. The family as the basic unit of society is the learning environment for our duty sense with values including those leading to sexually [misspelled?] are installed. Discussions about sex without [inaudible] particularly guilt are not considered culturally as acceptable.

Our objective of this study was to identify the additional disposition of in school female [inaudible] towards sexual abstinence. We also wanted to find out whether a daughter's attitude toward sexual abstinence is influenced by her mother's value and beliefs, which we officially defined as subjective [inaudible]. The method that we used to study [inaudible] quantitative and qualitative measures of data collection where as soon as we sent back minister to answer to one in school female to date in Alisraymo [misspelled?], Lagos states Nigeria.

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Ten focus group discussions were conducted by trained moderators among in school female [inaudible]. Simple structure five random sampling we took utilize. Instruments were designed using specific variables and tested for reliability. More [inaudible] we used skills in defining the various variables in terms of their construct. For example, martial relationship were measured in terms of relentlessness, which included blood relationship, fluidness, and confidentiality. Communication was measured in terms of dialogue and feedback. Connectedness was measured in terms of bonding and congeniality where they looked at self-efficacy, personal attitude, and subjective know. [APPLAUSE]

That analysis collected analyzing the statistical political sciences and qualitative data was analyzed and concurrent responses were noted and reported.

This is just the age of the respondents that formed the study. The mean age was 14.7, was tested for significant disease objective and personal attitude. Here, we are saying that it's where the subjective norm of the mother's [inaudible] it definitely affects you know the personal attitude of the daughter.

Now what were the results that we found out. we found out that mothers value or believer intention correlated positive with the personal attitude of the mothers towards sexual abstinence and this was you know very, very significant because we did find out that where the mother believes in - what the mother subjective norm, no matter what the demonatic [misspelled?] pattern in this society is, for instance if the norm in societies believe in abstinence and the mother subjective norm does not believe in such practices, the

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daughter is most likely not to believe in abstinence as, you know, a sexual behavioral. The results showed that female [inaudible] from the kids with mothers are more likely to practice abstinence only if the mother's subjective norm and values, that is if the mother believes in abstinence.

We also tested you know subjective norms on personal attitude. And we find out to be very, very highly significant. The results here again studying the personal attitude of [inaudible] sexual abstinence is dependent on the subjective norms as reported on the value believer intention scale of their mothers towards sexuality. That's slightly emphasized or that's, you know, its slightly emphasized over what I said before. That when the mother's you know subjective norm that is what she believes in is different from what, you know, with what the norm is or what is the desired norm in this society. The daughter is most likely to copy or to take after the mother's belief or the mother's attitudinal disposition. This is in formed, you know, during socialization process, like we all know.

Conclusions, what we are concluding is a mother's society [inaudible] process correlated positively with personal attitude of mothers towards sexual abstinence. Secondly, mothers play an innermost rule in shaping the attitude of their daughters towards sexual abstinence. Daughters who are properly mentored by their mothers are likely to pass across such values to their daughters in future. Values and beliefs are easily embarked through effective mother-to-daughter communication.

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Recommendations, social [inaudible] programs should be addressed from the primary units of the society, the family. Programs would aim at strengthening parent to child communication within the family. Finally, prevention of HIV/AIDS and STIs honoring only pregnancy and all die due to certain productive problems can be achieved through effective intrafamily communication.

So generally, we are saying that mothers have a role to play in terms of, you know how, helping us to use abstinence as a preventive measure from you know, from people contracting HIV. And that's why I will say that its important that mother's role within the family should be strongly emphasized and this is within the context of the fact that it's, you know, very, very clear that mothers play important roles in the society's own process of their daughters. Thank you very much for listening.

[APPLAUSE]

LAURIE GARRETT: Thank you. Our next speaker founded an organization called GRIP Intervention Program, which is in Nailsprat [misspelled?] South Africa. Barbara Kenyon concentrates on abused women and children as her target group.

BARABARA KENYON: Good evening or afternoon. GRIP ran a two and a half program with young boy children between the ages 13 and 18 year which stopped at grade eight and nine in the Jaleacha [misspelled?] area of Mhluzi area of Mpumalanga, South Africa.

We targeted three high-risk schools believing that the HIV prevention skills and gender sensitivity skills given to the boy child would empower and impact upon the girl child. GRIP used four

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different methods and programs whose core messages were the ABC programs.

The participation in the boys in the community work in our beadwork and grain and vegetable garden, soccer sports days, and holidays counts as great. They highlighted the fact that the boy child really do seek extramartial and life skills activities.

We really wanted it to work, but it failed. Preimposed dialogue highlighted the following fact that the boys' HIV knowledge on transmission was contradictory. The boy child's risk-taking was still high and they knew no one who had died of HIV or AIDS. So every Saturday, they go to funerals of young people who have died of TB, pneumonia, cancer or serious disease.

The cultural norms and mixed messages within South Africa impacted repeatedly upon our program. Contradictory messages like how can you be faithful and abstain at the same time, no clear belief on contracting HIV through sex, denial of HIV by the elders, and peer pressure to be 100- percent man, the boy child has to have or to be seen to have many girlfriends. The boys also said that some that some of the girls encouraged sex and mocked the boys who tried to abstain. [APPLAUSE] Girls are also allowed to prove fertility by having a child in the early 20s.

Ethnics and societal context in which polygamy and causal relationships are not only culturally and religiously sanctioned but also to a large extent socially acceptable, and this makes a mockery of the "be faithful" message. [APPLAUSE]

Of the ninety boys that we talked to only two of them was still living with biological fathers in their household. The

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remainder of the boys had women head of households and stepfathers. I quote from one of the boys: "The condoms are deadly devices that carry the disease as the lubricant that is seen as HIV worms when fold with water." Both sexes avoided condom use as a show of love. We noted that both of the boys and the girls are not wanting to catch HIV but circumstances of transmission are complex to them.

The Family Health International 2005 says that transmission of HIV and other STI infections will persist despite approaches emphasizing ABC as long as non-consensual sex remains wide spread. No prescriptive program like ABC or whatever can be successful unless long-term development programs are put in place to correct the poverty, xenophobia, and discrimination and security. [APPLAUSE]

I quote James II, verses 15 to 16: "Suppose a brother or sister is without clothes and daily food, if one of you says to him, "Go, I wish you well, keep warm, and well feed," but does nothing about his physical needs, what good is it?"

Currently laws pertaining to women's and children's rights are not inclusive both culturally, socially, politically, and legally. Much more work needs to be done to make the efforts of the holistic attention to the country to be more effective in lessening the transmission to HIV.

High unemployment and other sort of things enhance the gender-based violence. We need to look at how to empower both sexes that there is not this issue of powers and that kind of abuse of structures, which encourage transmission of HIV. High unemployment, under-resourced school, all lead to a diminishing middle class and a widening gap between the haves and the have-nots. Our boy children

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have many dreams but they cannot dream and this leads them to apathy, anger, and crime. If we empower schools and resource the learners to access to computers and challenge the teachers to teach plus engaging in more micro- and macroeconomics then no hope that the children have presently of a working future that might improve the adherence to any of the ABC approaches.

What did not help recently was a popular leader whose court case was an example of not abstaining, not being faithful, and not condomizing. [APPLAUSE] That set South Africa back a long ways. Leaders both government, sports, and business need to be seen as a collective example of good morals and values. We cannot expect it go from bottom up. Good morals need to come from top down as well.

The circumstances from historical cultures have not been addressed [APPLAUSE] which also perpetuates abuse and fear. Women's buying [misspelled?] and concepts of masculinity also need attention. It was strange in the very same trial that I spoke of earlier the women were probably the most vociferous defenders of the alleged accused. And that says something for where our society is presently in relationship to societal and historical context.

We need to mentor reform and review the concept of masculinity. [APPLAUSE] We have no answers nor solutions at present but preventive programs that do make lasting changes to permit transmission need developing. We have opposed and wish that funders do not chase good money after feel good, not evidence based programs that swoop in and swoop out. It's no good. We feel that the ABC program is no good plus others that are all that, that transmit the

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knowledge but actually, knowledge alone has not changed sex behavior to a safer sex commandtrium. Thank you

[APPLAUSE]

LAURIE GARRETT: Thank you, Barbara. Your comments reminded me of a poster that was downstairs yesterday based on surveys of teenage boys in South Wazutala [misspelled?] Natal. If I recall the data off the top of my head clearly, the majority of the boys self-confessed to having beaten, coerced, or raped a girlfriend. And they were under 17 years of age. So, clearly a long way to go to build up male esteem and behaviors.

The conference organizers very wisely asked Beatrice Were to do a sort of wrap-up discussant position. It's hard for me to think anybody who would do a better job. Beatrice has played a fundamental role in one of the most important NGOs in all of Africa Tosso [misspelled?] in Uganda and is now with Action AID. Beatrice.

[APPLAUSE]

BEATRICE WERE: Thank you. I find this task overwhelming. And by the look of the size of the numbers in the room, I can imagine the expectations. And I want to thank the team of experts.

The task that I have this afternoon is really to do an analysis and about its tis all of us to think through the ABC approach and whether this is addressing African issues. Ladies and gentlemen, allow me to begin on a note that if it was addressing our issues in Africa 25 years into the epidemic we wouldn't be seeing increasing number of women being infected. [APPLAUSE]

I do have any better evidence than to demonstrate the facts that the ABC approach has failed and that we should all be

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challenged to think beyond this approach. [APPLAUSE] Speaking as a woman activist, as a woman who abstained, as a woman who was faithful when I got married, but still got HIV, I don't think there is any better evidence than hearing it from the horse's mouth.

[APPLAUSE]

I would like to say that the ABC approach begins on a failure note when it protects on a lot that assumes control that women have a degree of control, that they can abstain when they're young girls, that when we get married we choose to be faithful which most of us do, but it also plays a lot of burden on women. A woman can only account for herself but not for the actions of her partner. A woman can only account for her own faithfulness, not for the actions of her co-wives if she is in a polygamous relationship. And when we choose to use a condom I don't mind what instances but for most of us we know how difficult it can be to influence the decision. Where does the power lie?

Twenty-five years into the epidemic the ABC approach has ignored the powerlessness, the gender dynamics, the difficult choices that many women in Africa have got to make. The other dimension to this approach which was well articulated by the speakers is the fact that the real cultural context that we live in in Africa where male pressure patriarchy where the control over economic tools that enable us to buy a condom if we want to still lie in the hands in men. We have heard over the last three days that male circumcision is another break through, another tool to empower men to reduce women's choices. [APPLAUSE] the social framework, the cultural values, and all those things that have discussed still

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continue to entrench male patriarchy and reduce women's power especially in times of decision making. The fact that women must remain in Africa cannot even make a decision on when to have sex, how to have sex, where to have sex. How can we say the ABC approach addresses our realities?

Their approach again assumes all - let me just say this differently. From my own experience, the ABC approach has tended to hasten stigma towards women. It has even been worsened when the C over the last three years has got struck off through programs that have tended to promote the moralistic approach to prevention. [APPLAUSE] By implication, through these programs especially the A, B approach, which we know, has become a nightmare, a devil, a tool of murder in Africa.

What we see for women like myself is a new wave of stigma. For women who are infected, when we stand up to say we are infected today, what happens is the questions run through people's minds. She was careless because she didn't abstain. When she got married, maybe she was promiscuous, she was unfaithful by implication. If she did, let her join the risk group and try the condom. Increasingly these programs are fueling the epidemic on the African continent.

The other issue that comes out very clearly from the discussions from the presentations is the whole issue around women's economic status and the dependency on men and the desperation for survival. Women having to make these difficult situations every day. The ABC approach ignores these underlying factors that make women very vulnerable and the issues of poverty that most women in Africa find themselves in. Unless we address poverty, unless we address

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the underlying effects, we cannot talk about the ABC approach in a realistic manner. Twenty-five years into the epidemic, this is the greatest injustice I have ever seen.

There are issues that we saw coming out especially from the fishing community. There is this issue of complacency because people do not seem to feel that we are making progress. The fishermen continue to see death in their daily lives. In Wamzia [misspelled?] do that mean that they don't see the condoms that they do not know how to abstain, that these women cannot be faithful? The analysis speaks for itself. Why are they complacent? The question is to you, to both you and I. Are we making progress. Doubtful. If people can behave in the manner that we have seen, should we therefore continue preaching these programs? Should we therefore be thinking about ABC and beyond?

The other issue that comes to my mind and also from the analysis is looking at what comes out from the family values, the experience from Nigeria. From my own analysis, what I see from here and again asking myself a provocative question from we have not in the past is the whole issue about the family as a source of empowerment, education, and information. However, what is most important for me in analyzing this whole decision is what about the role of the fathers. What about the role of men? [APPLAUSE]

The world bandament of passing gun values being left to women. And how far can women go when these children get married, do the women remain with the power after they have extend for bride price. Who makes the decision? Do their mothers - are their mothers with them especially when they are girls to make sure that they are supported

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to deal with the difficult decisions around having safer sex. If they are boys, are their mothers anywhere near to tell them that valuing your partner when she says no is a terrible thing. Who has the power? Where are the men? [APPLAUSE]

Allow me, ladies and gentlemen, to also question the - I don't remember which discussion but in terms of the messages that are postulated but its still about the values. It's about the recommendation that the family is a source of information and it is an effective way of passing on messages. But what kind of messages do we pass on in these families? And who is passing them on? What sort of messages, are those messages that we do not want to limit the private parts in Africa. Are they still the messages where we are ashamed to talk about sex and sexuality. Are we still talking about the conservative messages of shame and silence and fear into address sex in this entirety? Are they messages that allow young people the right to information or deny them the right to information while regulating them to the risk of HIV? So we need to check what information the children are getting.

The other that I mentioned, again, I would like you to allow me to mention here is the risk in marriage. Increasingly we are seeing a growing risk in marriage. A growing risk to HIV, more married women getting infected because of domestic violence. And the fact that in Africa martial rape is not recognized 25 years into the epidemic. This is what is happening. Therefore does ABC work? Is it still relevant for a continent which has 70-percent of the infections but still denies [inaudible] risk martial rape.

[APPLAUSE]

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Allow me to extend it to another angle, which the presentators did not touch on. I feel very strongly that the programs of ABC but mostly the abstinence only and faithfulness has unleashed stigma denial, has entrenched it in Africa because of the fear of addressing sex and sexuality. It enables those leaders that want to keep their heads in the sand to keep them there and even keep them deeper into the sand. As a person living with HIV, I feel very strongly that these programs are responsible for undermining the meaningful involvement of people with living with HIV. This is something that we cannot afford to lose 25 years into this epidemic. [APPLAUSE]

Therefore, where do we go from here? And I would like to make four recommendations. One is that in Africa leadership needs to move beyond their rhetoric. There has been too much rhetoric for the last 25 years. This conference is about time to deliver. And time to deliver and my first call goes to our own leaders that are embracing moralistic programs that undermine human rights, that do not recognize the vulnerability of women, the exports programs that have been known to fail in the United States over the last twenty years to Africa. [APPLAUSE] And it is high time we as citizens of the world and more so African citizens that we held our leaders accountable. We cannot allow Africa to be wiped away because our leaders are trying to be politically correct. [APPLAUSE]

I have been going to leadership where one of our leaders we know, we call him the Buff in the shower, is that so? Is that a term in South Africa ,I think it is. I would like to take it another leg and challenge ourselves as women and challenge all women leaders in

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this room and at this conference that 25 years into the epidemic some of the women leaders have not used this spaces that they occupy to challenge denial, stigma, and they have actually nibbled the programs that failed women, the fail Africa, to thrive. We know that in some countries where women are raped every minute, where violence against women is a big problem, where the infection rates are on the increase, we got women leaders who have the guts to say antiretroviral treatment is not the solution to Africa. [APPLAUSE]

This same leadership caused, you know, caused a cheer from some of us who are at Angus when the assembly work very hard on putting targets into the Angus document. Today as we speak in Toronto, we have [inaudible] one of the smartest booths where garlic and olive oil is what is on that booth. And I would you like to visit that booth if you want to know what kind of leadership we have in Africa. The question to ask ourselves do we have the right leadership to cause an impact on this crisis. Do we have leadership that is in denial, stigma, window dressing, and rhetoric? We need to stop and ask ourselves.

Only the truth shall save Africa. We must get out of shame. We must stand up however uncomfortable the truth might be. Let us face it. We have work to talk about AIDS and we can't avoid to talk about sex and sexuality whether its in our families, whether its in the corridors, we are going to talk about it.

Finally, ladies and gentlemen, let us stop and utilize the power of leaders and advocate for evidence-based prevention. I thank you very much.

[APPLAUSE]

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LAURIE GARRETT: Look, Beatrice. [APPLAUSE] I knew you would sock it to them. [LAUGHTER] I just want to point out two quick factoids. Since the discussion has been brought up about leadership the former vice president of South Africa and head of the South African Aids Commission was involved in a rape most of you followed the story of Jacob Zuma [misspelled?] and you may recall that he said in testimony admitting that he had taken the woman, who was HIV-positive, "well, I took a shower afterwards." What message did that send to the men of South Africa? That a: you can get away with rape. He was acquitted and b: that you can take care of your risks of acquiring HIV through the active rape by taking a shower.

The other factoid I wanted to point out any of you that might have not been in the first late breaker session this morning in Track C, a paper by Schaffer, et al, very important showed that the incidences of HIV has been steadily rising in Uganda since 1999. And Uganda is cited as the great case example of success with ABC so this data is a warning perhaps.

I'm going to yield the chair now to my esteemed colleague from Nigeria.

BABATUNDE OSOTIMEHIN: Thank you, Laurie. And I just also want to thank Beatrice for such allictadation [misspelled?] I think it could not have better said.

I just want to say something before we take questions. That is the fact that in 1994, a good number of us and I'm sure some of you in this room, gathered in Cairo and we signed the ICPD document which in my view was a milestone in the areas of women's empowerment and ensured that women, if we had followed that route, would have

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been able to take position of their lives and be able to empower themselves in order to protect themselves, not really against sexually transmitted infections and HIV/AIDS but also that could make empowerment and all of this gender issues that we are talking about today. Unfortunately, somewhere down the road HIV/AIDS hijacked the entire process and we disconnected with productive health from HIV. Now what we are here talking about at this conference and certainly what Beatrice had eloquently talked about is for us to step back into that mode and ensure that we empower women sufficiently to be able to take care of themselves. Also to recognize that men are probably more vulnerable than they think they are and put in place men programs that address men so that they can be more responsible.

After I have said my piece, we will take a few questions. We have about 15 minutes and so we will take maybe about five questions and I want you to be as brief as possible so that you can yield the floor. We have 30 minutes, okay. We can take more than. So we can yield the floor to the next -

LAURIE GARRETT: Can we put the lights up so that we can see each other in the audience?

BABATUNDE OSOTIMEHIN: - presentation.

LAURIE GARRETT: Can we bring the lights up a bit?

BABATUNDE OSOTIMEHIN: Now as you come to the mic to ask your question, please identify yourself and your attribution, where you come from. Thank you.

JOSHUA: Thank you, Mr. Chairman. My name is Joshua from Kenya. I work with the National Aids Council. Mr. Chairman, I want

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to begin by congratulating our presentators and your chair for the work that we have heard this afternoon. I have two questions. First is the how do we reconcile the permission [inaudible] as given with the presentation from Nigeria. Our friend from Nigeria did say that the correlation of 30-percent is significant. And I know from my statistics 0.33 was too low to say that was too significant given stuff like Kevin, so how can the two gentlemen reconcile that information between the [inaudible] of change and that they were trying to measure.

Second question is on Beatrice. We heard her loud and clear and we stand with her. But I thought there is a different between ethnicity as a program has been, has not want and those are different between the way it has been implemented because I will say in Africa there were no cases even before HIV and AIDS was there where societies were not encouraging people to abstain whether boys, whether girls and were highly regard where girls and boys that remain virgins. Are we saying those cases are not there. I want to stand this afternoon and say I have many cases though not documented where girls and boys weren't wanted in society because they remained virgins and too much. Thank you.

[APPLAUSE]

LAURIE GARRETT: Babatunde, do you want to take the first one?

BABATUNDE OSOTIMEHIN: No.

KEVIN O'REILLY: I will.

LAURIE GARRETT: Go ahead.

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KEVIN O'REILLY: Okay. I think the easiest way to address the discrepancy between the information that I presented and what our colleague from Nigeria presented is a difference between behaviors and belief and attitude. The focus in the presentation that I gave was only on the behaviors themselves. And as we know behaviors are more difficult to affect. I think as we heard from the eloquent discussion that we had at the end of our presentations, having the right attitudes and having the right beliefs doesn't necessarily mean that you are going to be protected and going to be able to act on those behaviors. So there is a gulf between the two and I think that the difference between the Nigerian presentation and my summary of the evidence elucidates that particular gulf.

GODPOWER OMOREGIE: I also want to add that we never said sufficient level of 0.33 is very significant. What we pointed out if you look at the slide very well is that it's all significant at 0.001 and not 0.003. I'm surprised that has come up. Thank you.

BABATUNDE OSOTIMEHIN: Thank you. In any case, I think Kevin was talking of the meta analysis. And this was a fixed study that was very important so it's not the same. Yes.

TOM DAVIS: Yes, Beatrice suggested that we be not politically correct so I'm prepared to do that. Given that I looked at the PHS survey data from nine countries in sub-Saharan Africa and the majority of youth 15 to 24 were

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abstinent in the past year. [APPLAUSE] the majority of married people only had one sexual partner in the past year. so given that, how can we claim that ABC is impractical and can not be practiced if the majority of people are already doing it? Secondly, - I'm sorry. Tom Davis with Food for the Hunger.

And also a question for Kevin O'Reilly, I'm really glad you actually presented some scientific results. I think we need to be looking at actually studies to make a decision on this and not rhetoric. But you said some donors have focused almost exclusively on abstinence and given the U.S. public law, this is 108-25, it shows that third of U.S. foreign aid assistance prevention of HIV goes to abstinence and being faithful, 50-percent goes to prevention not related to sexual behavior, the remaining 17-percent goes to prevention efforts not related to abstinence or being faithful such as condoms. That means the majority is going to things other than A and B, 67-percent or sorry, 63-percent. Also, the U.S. government is the largest single provider of condoms in the world. We distributed 612 million condoms in 2005. Annual condom procurement has gone up steadily under PETPAR so given that how, who are these donors who are focusing almost exclusively on abstinence and the prevention efforts. It doesn't seem to fit the data. Thank you.

[APPLAUSE]

BABATUNDE OSOTIMEHIN: Kevin.

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KEVIN O'REILLY: What you say is true. The U.S. government provides the largest amount of condoms and the U.S. government does set aside monies for non-AB activities as well. However, the reports that we constantly, I mean that is what we hear from Washington. And I can only believe it. The reports that we hear from the field however are often that as it's percolated down and applied at the field level, U.S. government funding does not translate into increase in condom availability in some places. Whether it's true or not, I don't know. But those are the reports that we hear. And I think that is what leads to the controversy that we are hearing in this room today.

MALE SPEAKER: [Inaudible]

KEVIN O'REILLY: Can't hear you.

TOM DAVIS: You did say that space on reports are antidotal reports, not based on actual data that says we are not providing condoms. And AB are definitely parts of that strategy and you said we are also promoting being faithful. It's not an abstinence-only program.

KEVIN O'REILLY: That is true.

BABATUNDE OSOTIMEHIN: Did you want to say something? Did you want to say something?

BEATRICE WERE: I would like to use Uganda as an example to answer the issue about the U.S. government being the biggest provider of condoms. I think what is important for people to understand is that those of us which are linked this policies, usually people misunderstand the fact that we appreciate that the U.S. government is the biggest provider of, first of all treatment,

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for instance, underpaid for. More people than ever before have been enrolled on treatment. We have seen [APPLAUSE] that the U.S. provides condoms, but let's get the figures right. What is available from statistics is that three condoms, three condoms are provided for Africa per month per year. [LAUGHTER] So are you talking big volumes? Let's hope not. [APPLAUSE] we need to talk about these [inaudible], three condoms per month in Africa per year. And that is, you know, we need to be analytical anyway when we are talking this.

The other thing is from when you look at Uganda, if you look at - if you do an analysis, which we have done because we have been tracking this for quite some time. In 2004, the U.S. provided for most of the funding and a paper and I hope there are spots in this room who can allude to this, 50-percent of the funding went towards AB; 2005, 60-percent, around close to 60-percent, went toward AB; 2006, about 60-percent again towards AB. So increasingly, we have seen more funding and a paper go towards AB. Therefore if we look at the volume of families we need to look at what goes where and also who gets the funding. It's the moralistic faith based organizations that stigmatized the condom, the push for Ab, that bad mouthed the condom, and is this where the U.S. taxpayers' money should be going. Advisement for those from the U.S. in the room. [APPLAUSE]

TED CRANDEN: Hi, my name is Ted Cranden [misspelled?] I'm from north Iowa, one of the states in the United States. I don't have a good answer for that last question. [LAUGHTER] I want to take the interest where is - challenge with my question, which is how

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long are we going to pander to the term "be faithful." As Ms. Sharma and Ms. Kenyon pointed out, being faithful to the traditions in their respective areas is not what be faithful is in a fundamentalist, western, monotheistic regimen. It isn't being faithful. Having a second son take a widow as the next wife is being faithful to a tradition in Africa and in other parts of the world. The whole term of be faithful is a sham. It's particular to western monotheism and not to the rest of us. How long are we going to pander to the very existence of the term "be faithful"?

[APPLAUSE]

BARABARA KENYON: I agree. That was what one of the boys actually came up in their simplistic ways. That the societal norms and our cultural norms are often at odds. And what the, what we could say in one culture from America is what is normal for us and societal correct for us is not necessarily the same and prescriptive to everywhere in the world. Traditions do need to be respected. And there are always ways to work around that.

MADALINE: Thank you. First of all, I wanted to begin by saying that it seems that room is particularly hostile to the anti-condom or to the AB-focused approach. I wanted to talk or thank rather the people in the room who are equally enthusiastic about the A and the B approach for their faith in human nature. I think that those of us and I consider myself one of that group, who don't believe that A and B are the most effective. Its simply because we - we all agree, I think, everyone here agrees that abstinence is without a doubt the most effective way of preventing the transmission of this virus. However, I think that most of us feel

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that it's not realistic and until gender and cultural changes are reality and AB focus approach isn't a revival means. So just to say thank you to those of you who do have faith in human nature.

[LAUGHTER]

Secondly, I just had a question just opposed to the Nigerian colleagues, I'm sorry, I'm Madeline from Thank You [inaudible]. I work with the Canadian Red Cross. And I was wondering in regards to your data you mentioned that age - the average age was 14.7 of the people of who you were in communication with. and I was wondering if you felt that that was an age at which the youth were really experiencing sustained and concentrated pressure to engage in sexual behavior or if you will that pressure really begins later on in life and therefore if perhaps 14.7 isn't the best age to begin analyzing their belief in abstinence because it has not really put to the test so to speak so far. And also whether or not you could speak any assurances of anonymity that would were given to the participants of the survey so that we can know that the data really is reliable and they weren't feeling pressured and may have changed their answer as a result of that.

GODPOWER OMOREGIE: Thank you very much for your question. I will start from the last point you raised. The participants were not pressured at all because it was a self-administered questionnaire. That give them you know the leverage of responding objectively to the questions asked. And ethnically in Nigeria during research is a longer, it's less than 15 in all, in some, particularly that some has to do with sexual behavior. It's something that you know you don't get easy with. So the age bracket I'm not say I know such

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[inaudible] in those stats you know before then given, depending on the population you are looking at. But we look at 15 to 24 because conventionally that is you know how you go about having sex behavior of the early sex that you want some committed, ethnical, and false.

MADALINE: Thank you.

GODPOWER OMOREGIE: Sure.

HEINER GOLDSOAT: Thank you. My name is Heiner Goldscoat [misspelled?] from the Medical Research Council in Uganda. I'm one of the co-investigators of the study which was quoted a few minutes ago which this morning in the late break I was displayed in great details on my colleague Leann Schaffer. I beg your pardon but I need to make a correction -

LAURIE GARRETT: Please.

HEINER GOLDSOAT: - about effects, which were displayed, and what we heard here. Uganda has been successful in reducing the epidemic and the prevalence and incidence in the area which we have reported this morning, has been falling throughout the 1990s. Since about 2000, the prevalence and incidence is no longer falling but we haven't said that it is steeply rising. And just give truth to the owner, I would like to correct this. The message is the same. We all need to reemphasize the prevention efforts in this country. And I think this is going to be true for many other parts of Africa. So, the basic message is the same reemphasize of the epidemic but it is not correct to say that incidences are steeply rising. This would be a disaster and I hope we can stop it before it comes to that.

BABATUNDE OSOTIMEHIN: Thank you. Number two.

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TIM SHIM: Thank you. Tim Shim with the International Compliance Prevalence Federation. I think I sense a general agreeable within the room that abstinence-only approaches AB but particularly abstinence-only is ineffective and its fundamental flawed. I think we all accept the evidence. And I think we all agree where we - those of us who believe in effective public health approach accept that there is no evidence true evidence based for abstinence only. And indeed, often people who abstain from vaginal sex through abstinence often end up in taking part in anal sex or oral sex and there put themselves at greater risk of HIV.

But what my question is I have been very heartened by the fact throughout this conference we have had these discussions about ABC and that we are coming to that general acceptance of the need for us as people who care about HIV prevention, as people who want to see an end to the epidemic and want to see the debate move forward, I think that we need to then also providing our own territory. I think we need to be building a movement around saying we have the evidence that shows that ABC doesn't work and we need now to be gathering the evidence as we are already been - as is happening to say that instead what does work is comprehensive sexuality education. [APPLAUSE]

I just want to, I just want to add that as an organization IPPS truly promotes with its partners comprehensive sexuality education and you can get more information about that on our website but I wanted to pure [misspelled?] a question to the panelists was, do you believe that comprehensive sexuality education can be the alternate and if so how can we build that social movement so that

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next time when we come to the conference room we can be showing evidence base for why that is much more effective?

ANJALI SHARMA: I have been asked to speak so I don't think ABC in and of itself is flawed. It's just, it's not enough. So comprehensive education and on sexuality would be excellent. I think it depends on country-to-country to open they are and at what age and how much do you say. But I think at this point, more governments would be open to that than not. However, I also want to go back to what the fisherman was saying that the lives are such the way we do business, the way we relate as men and women. All these things, also contribute to sexuality and how sexual activity takes place. So I don't think there is one answer. I think we can all stand behind sort of an integrated approach which has been tailor the suit the country, the ethnic group, age, class, caste, that one is talking to.

BARABARA KENYON: I would also like to add that a lot of the ABC programs and they do not engage the traditional healers of whom there is a large part of our all society I would say in Africa. And so it's not comprehensive in dealing with all the medical role players that are involved and that can be used to create a more holistic prevention process. Nobody has ever, as far as I know, has embarked on working with traditional healers in culturally seeing how to use their beliefs and their knowledge in helping us fight the transmission.

[APPLAUSE]

MALE SPEAKER: Well, thank you for an enlightening presentation. I think that in the midst of this criticism, we need

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to be careful not to generalize. I'm aware there seems to be an excitement particularly with the Nobel Conferences where people tend to become more permanent by rebellious or so. I think this needs to be - we need to sober up and to look at issues more in prospect in its context.

Firstly, I think that particularly as a man, I feel that men are becoming an endangered species. [LAUGHTER] Particularly as an African. There are a number of things, which were mentioned about the rape case that involved Jacob Zuma in South Africa. Jacob Zuma defense is that the court of law acquitted him of rape. That is the first truth. The second truth is that after the trial, he publicly apologized for some of things that he said in court and some of the things that he. Now what is important to note there is that our leaders are as human as we are? At this conference, at this particular conference, when Bill Clinton speaks, we give him a standing ovation, but he is no different from what Jacob Zuma did. [CROWD BOOING]

BEATRICE WERE: Wait, you know people [interposing]

BABATUNDE OSOTIMEHIN: I think -

BEATRICE WERE: I think people - I think you need -

BABATUNDE OSOTIMEHIN: - I'm going to stop you there.

LAURIE GARRETT: But I think everybody needs to hear -

MALE SPEAKER: I think to be -

LAURIE GARRETT: - what everybody is saying.

MALE SPEAKER: I think you need to give me any opportunity to speak. If you do not agree with what I say -

BABATUNDE OSOTIMEHIN: Phillip, look, cut it. Phillip-

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MALE SPEAKER: - in spite. It is not a problem if you do not agree with what I say but you need to be tolerant -

BABATUNDE OSOTIMEHIN: Yeah. I know.

MALE SPEAKER: - and understand what I'm saying.

BABATUNDE OSOTIMEHIN: Carry on. Finish.

MALE SPEAKER: You see this is the problem.

BABATUNDE OSOTIMEHIN: I said finish what you were -

MALE SPEAKER: That you want us to agree - you want me to agree with what you are saying.

LAURIE GARRETT: No. We want you to finish.

BABATUNDE OSOTIMEHIN: No. I said -

MALE SPEAKER: [interposing] the same task is not - we are not dead.

BABATUNDE OSOTIMEHIN: We want you to finish what you are saying.

MALE SPEAKER: As an African man, I have never raped a woman. As I stand in front of you and I feel offended every time that we criticize [inaudible]. I have never raped a woman. I have never abused a woman. And I never will. As a person living with HIV, I'm involved passionately in changing the perspectives that you keep referring to, internal temps. It is quite offensive for people to just generalize in their criticisms for no particular reason. And I think that it is important for all of us to realize that as much as we are leaders and we are activists in this field, we are all part of

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humanity. We are all humans and we need to focus more on issues that continue to build us. If I have an idea that does not work, it should not be killed. We must learn from the activities and the concepts that we have employed. Thank you.

[APPLAUSE]

ARSHI SINGH: Thank you I'm Arshi [misspelled?] Singh from - I'm from the south Asia region so I just wanted to bring in a different prospective because we are talking about Africa. To begin with, I was just curious whether anybody in this room can actually tell me if they know a mother who encourages her daughters to go and have sex. You know. I have also yet to see a woman, a gay man, and injecting drug user or a sex worker supporting the ABC approach. And I think these key populations are actually the key to the work that we are doing. And I'm sure we all understand this.

To refer to my colleague who just spoke and the very few colleagues that were here who actually are you know agreeing to the ABC approach being effective. I would like to know how the ABC approach helped poverty baby in India who was punished for preventing child marriage by being gang raped. How [inaudible] in Pakistan who was gang-raped by the village council because her brother was having an affair, could have been helped by the ABC approach. How Ingina [misspelled?] in India who was raped by her father-in-law and then was ordered

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by the religious leaders to leave her husband and live with her father-in-law could have been saved by the ABC approach?

I think the impression is that maybe we living in the south are all barbarians and we need to be saved by a western right-wing fundamentalist ideology. Thank you.

[APPLAUSE]

GODPOWER OMOREGIE: Again, thanks for your point. I think something that we needs to get right is the fact that nobody is saying we should, at least my presentation didn't, say abstinence alone you know is the answer. But what is very fundamental is the fact that we need to do all approaches, I think from the Emegal's [misspelled?] conversation, quite persuasive and approach that gives the people the option to choose from is the best approach. And if people want to abstain, fine. But the fact that you know you want to say the cause, well, abstinence is not working which parts I don't really subscribe to, is the fact that we need to know which approach, you know, best suits concentration and specific cultural contexts. And that is what should be applied. So we should look at maybe an approach that keeps obsoletes or if that is what somebody called a comprehensive approach. For example, in our program in Nigeria we promote all three approaches and most special institution to date, there is that you know talk that many of them are promiscuous but from comprehensive subjects who don't, many of them actually

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abstaining but because its socially desirable to say I have had sex even those who have not had sex will claim to have had sex. So we need to balance you know all these - what we are saying is that an approach that provides options for people to pick from is the best approach. Let's look backwards, people who do it [inaudible], then fearful or use condom. Let's allow people to choose an approach that better suits their cultural and personal institutions.

[APPLAUSE]

BABATUNDE OSOTIMEHIN: Every group meeting must come to an end. We have only time for one more question. So, I'll take that from microphone one.

ELIZABETH MCGRAW: Yeah. Thank you very much. My name is Elizabeth McGraw. I'm program manager for the AIDS Control Program in ASAIDS and Minister of Health in Uganda. I wanted to just make a correction of the increase incident, which has been said already. But I wanted is to share my experience as a program manager since '93 about the issue of ABC. The panelists made a very good discussion, presentation, and then, of course, Beatrice. You did a very good analysis but I would suggest that we don't dispel completely the ABC approach. I have liked what is coming out as a recommendation.

This needs to be expanded probably to include other preventive approaches because if we take for instance Uganda all these years, we apply the ABC, in three as a trinity. You

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can't remove the A. You can't remove the B. You need to use all the A, B and the C.

Now, take, for instance we studied condom consumption in 1980s, where our level of consumption was even less by seven million. When I came to the program in 1993, our consumption for condom was about seven to eight million. Today we are buying 120 million condoms a year for consumption which means there is quite a lot - which may have been changing peoples sexual behavior. Here what I would say is also the consistent use of the condoms. As we expand on the ABC, we need to ensure that the condoms for prevention are consistently used. You find a community where condom is being kept to keep cigarettes, which as smoked very dry. You find a community where men are working in the soles factory and they are using the condom to protect themselves from getting injured.

So here, let us not dispel completely the ABC strategy. Can we expand on it? In the absence of microbicides, in the poverty in which we are living today, what will be the recommendation of the panelists for programs, interventions, in the 25 years down in the epidemic, even if the ABC does not work. We want that recommendation to come out from the panelists.

BABATUNDE OSOTIMEHIN: Thank you very much.

[APPLAUSE]

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BABATUNDE OSOTIMEHIN: I am going to yield the floor to my co-chair to make concluding remarks. And then we shall round off.

LAURIE GARRETT: Well, thanks all, for sitting through this. I think it's very important and maybe a little less than we got here in this room. When you talk about abstinence, you talk about faithfulness. You talk about condoms and you talk about sexual norms. It becomes a heated conversation across cultures, across genders. It's important that you not just talk, but you learn to listen. For all of you who did, I hope you enjoyed it and got something out of it. Thank you very much.

[END RECORDING]