

**Understanding Adolescent Sexuality & Sexual Health  
Promotion  
XVI International AIDS Conference  
August 17, 2006**

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**MARY NDUNG'U:** Good morning ladies and gentlemen. Thank you for coming to this session. We're going to talk about adolescent sexuality and sexual health promotion.

My name is Mary Ndung'u from Kenya, from an organization called the Positive Youth Initiative where we help youth infected in the first stage of HIV and AIDS. And for this section I'm going to be the facilitator.

We have three panelists. I'm going to introduce the first panelist who is Salorne McDonald, the First Vice President of Trinidad's Youth Council from Trinidad and Tobago.

He is also the Behavior Change Communication Manager, PSI Caribbean, working with HIV interventions for the youth for 15 years. That's Salorne.

Second panelist is Bruce Dick. He's worked with the youth for 15 years and currently he's with the World Health Organization. Before that he was the Senior Advisor for UNICEF in New York.

He's also head of the health section of Red Cross, and previously he was in the London School of Tropical Medicine. And before then he dealt with pediatrics and public health in South Africa.

The third panelist is Henry Luyombya who is representing the Toronto Youth Force, and he's from Uganda

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and a member of the Leadership Program Committee for AIDS  
2006.

In Uganda he worked with the youth, the AIDS Support  
Organization that is TASO. And currently is a Research  
Assistant with Committee for Accessible Aids Treatment.

So we're going to start off with the first panelist  
who is Salorne McDonald from Trinidad and Tobago. He's going  
to talk about, "Understanding Adolescent Sexuality and the  
Need to Focus on Adolescents living with HIV." Salorne  
[Applause].

**SALORNE MCDONALD:** Pleasant good morning everybody.  
Thank you very much for taking the time and the energy to  
join us this morning.

And the reason for this session is such that we have  
always tried as young people to have our issues understood.  
And then came the advent of HIV and AIDS. And then we needed  
to have another host of issues understood.

This morning myself and my fellow panelists are going  
to try to explore some of those issues and questions that  
have to be raised and need to be looked at.

In looking at adolescent sexuality and understanding  
it, we need to understand that our sexuality is such a  
potent, powerful invasive part of us that we often have no  
idea that it's at work and that it's here.

It's the reason why we wear certain clothes, it's the

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reason why we look a particular way in the morning when we fix ourselves, it's the reason why we're comfortable or uncomfortable around groups, parties, or whatever the case might be.

And the formation of this, we have gone through a process. It's been about learning, unlearning, hiding, and showing things that we've been told either it's positive or negative.

We've wrapped children in blue and pink blankets for the longest while to tell us they're boys or girls.

Yet when they grow up we reinforce that blue is a boy's color and pink is a girl's color by our own social sanctions.

How many men in the audience own a pink shirt? Can we show by a raise of hands? One, two, three, four, five, six, and I know there are more than six guys in here.

When we're growing up we're taught that if boys fall down and hurt themselves they don't cry because that's not acceptable. But if girls fall down and hurt themselves, fine, "That's okay, you cry sweetheart."

So we taught this young man, "Keep your pain. Shut up. Be quiet. If it hurts it's okay. You'll get over it. You're going to be a man."

As they grow older we push them. And as we grow older we are pushed and have been pushed into several

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directions in terms of what's more male, what's more female, what's more masculine, what's more feminine.

And we created these two alien creatures and put them to live in this beautiful world together, and deal with each other. Then came HIV and AIDS. And we had to ask a couple of questions.

Reach across and just shake someone next to you's hand for a bit. Just shake their hand. Reach across. Just say, "Hello, Hi, my name is John, Mary, Jane, Frank, Belinda, Carlisle, Rosemarie," whatever the case might be.

Now reach back and shake someone else's hand. Come on, do it. Good. Wonderful. That's human interaction. That's what we hear about. That's what we live about. Good.

Now if we go to the world of symbols we'd say, "The people we just shook hands with, you just had a very personal intimate interaction with them. And you've shared some body fluids."

Let that sink in, and now in this activity we'd say, "One of the risks of sharing body fluids is HIV." Good?

So we devise methods - ABC and all these other methods - that look at HIV prevention - safer sex, keep your own body fluids, don't let anybody else's body fluids get into you because you don't know if they're infected.

You know what's beautiful about this room and this assumption? All of you just partook in that activity. We're

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already born HIV positive. So what prevention message could you have used then?

Is HIV prevention going to be relevant to you now? Is it? Is it? No it's not. So then we need to look at removing the flesh and look at AIDS prevention.

In looking at that there's one critical understanding that we all must have. And there are some questions we need to ask.

The standard prevention program message is, "Discriminate against the adolescent who's already living with HIV, who was born positive and who has been living positive up until this time." What do you tell them, "Abstain, don't do it?" What do you tell them, "Use condoms to prevent yourself from HIV?"

HIV prevention then becomes irrelevant. And we need to look at AIDS prevention. The things that keep your T-cell count away from that critical number.

We need to look at prevention that keeps more opportunistic infections away from this young person. Yet no agency - no health care agency, no global agency - has looked at the difference in programming that becomes necessary for adolescents living positively.

Is there a difference between HIV prevention and AIDS prevention? Ask yourself the question, "What do we need to do? What do we need to formulate? How do we address the

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issues of this young person? How do we look at prevention and care as it relates to this young person and prevention? Who teaches the adolescent about puberty and being positive?"

There are a number of PLWHA and support organizations that deal with adults. There are a number of NGO's and whatnot that care for children.

Here's the catch. Here you're a child. You've got pediatricians, and everybody to look after you. Here you're an adult. When you're between here you're adolescent. What exists for you? What have we done? Where have we looked? What has been devised?

Anybody can chime in at any point and give us the answers. No? I'm still waiting. All right. I'll continue.

The home environment of an adolescent living positively is sometimes a challenge. Let's say both your parents and they're alive. And they're already dealing with the issues of standards, stigma, and discrimination.

How has it been getting you into a school? How has it been moving you from a primary elementary education into a secondary teen setting of education?

How are the issues at home about dealing with your being positive and wanting to play sports? And how people feel about that? What are issues? What is the mechanism that exists if news of your sexual status gets out into your school environment?

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What are the mechanisms to deal with that? What's the legislation to deal with that? Where's the training for caregivers, and teachers, and school counselors that deal specifically with this group of issues? Have we got any? No.

What are the new versus the normal teen issues around things like being included, following trends, and peer group acceptance?

Remember, we don't live in the perfect world where acceptance of anybody based on color, eye color, hair texture, and whatever else exists everywhere.

Enter HIV which people have a great fear of already. How do you deal with the issues as a young person 14, 15 years old who has found someone that you're attracted to and you want to start dating? Who teaches you that? Who prepares you for that?

Third, what are some of the issues in terms of preparing you for your regimen if you need medication? Who looks at those specific adolescent reproductive and sexual health issues that have to do with positive young people who are adolescents? None exist.

And we need to ask these questions simply because we are no longer in that place where we can safely assume we'll either be dealing with adults or we'll be dealing with children.

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We're not there. And unless we start addressing some of these issues, we're going to find ourselves in a very ticklish position.

Our current population of adolescents is greater on earth now than at any other point in the history of societies in this world. Preparations for disclosure or non-disclosure are very serious factors.

I'm a teenager. We hear all the talk about, "You're going to grow up, hormones are going to come in, you're going to like people." And these are the things we discuss. Where's the manual that says, "Okay, if you happen to be positive, disclose before the first kiss. Okay. No, maybe not. Disclose after the first kiss, because kissing is safe. Okay, hold on until things may get a little closer and it starts looking like it's heading down the sexual pathway."

How does an adolescent deal with those issues? Sexual and reproductive help information, messages, and being positive. We've all seen the, "Don't let HIV in. Don't let AIDS in. Don't let this in. Don't let that in."

All of our prevention messages run on the assumption that we're dealing with HIV negative, folks, who you don't want to be positive.

The health care deals with adult case management, child case management. However as you very well know, being an adolescent I'm already having trouble accessing youth-

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friendly health care is a gigantic issue, and an issue which has not yet been addressed in many of our states.

How will we know to look at dealing with SRHR issues with someone who's pregnant, and 15 years old, and HIV positive?

How do we deal with the issues of, "You're 15, you're 13. Your parents have spoken to you about all the do's and don'ts. And you go out and sit in your classroom and listen to someone who's come in to lecture on the dangers of HIV and AIDS, and where you can go to access health care.

What are specifics of your situation and how are they addressed?

Then we of course have to look at the medical side of things and what - even though this may not be a real word, I invented it about 2:00 this morning - the medical social issues of adolescents living with HIV and AIDS.

And I can't belabor this point enough. If we aren't looking at the in-between and the transition of the young person from childhood through adolescence into adulthood, are we assuming that this child - who is HIV positive - is never going to get to adolescence?

And if that's our assumption, are we being fair? Are we respecting that young person's right to be? Are we respecting that young person's necessity for care?

Or are we just shelving our own comfort with the fact

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that we'll never need to deal with that because quite possibly they're not going to live that long anyway.

News flash. Adolescents living positively have been with us since the start of the epidemic. So there's no question of, "We don't need to think" there.

The fact that no one has yet seen it fit to jump in at this point and start planning realistically for what's going to happen is alarming. And it's something that we need to address now.

I want to leave with three questions. How do we promote the health and sexuality of an adolescent born with HIV? How do we help to cope with the transition?

Teen years - as parents of teens and those who remember what it's like to be a teen - are already turbulent and full of trials.

How do we help these transitions in the face of this new block that needs to be carried? And what's the importance of promoting the health and sexuality of adolescents born or living with HIV? Thank you very much [Applause].

**MARY NDUNG'U:** Thank you Salorne for those insights that you've given to us. I'm going to introduce the next panelist. Bruce Dick is going to talk about "Review of the Current Evidence of What Works for Prevention." Dick?

**BRUCE DICK, M.D.:** Okay. Thank you very much and

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thank you very much to the organizers for inviting me to make a presentation here.

I'm going to be talking very much not about young people who are living with HIV - I think the evidence for that we have to build on.

But I would like to talk about the evidence faced much more generally for the prevention of HIV, and hopefully to raise some issues that we will need to take into consideration as we move into this very important area.

Before I start I'd like to really thank the Toronto Youth Force for the lovely t-shirt that I have [Applause]. And they struggled a little bit to find the fat old man size, but they did. And I saw this as a real example of youth/adult participation.

But I wanted to also very seriously say a big congratulations to them and to the Global Youth Coalition on AIDS.

With the gray beard, and the balding head, and the fat tummy come many AIDS conferences over the years. And we've always been trying to move beyond the token young person on the stage saying, "Please get young people to participate," to trying to generate something much more active.

And what they've done during this conference with the pre-conference, with the mobilization, with the information,

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with the organization that's taken place, they've really set the bar at a whole new level.

And Julio Frank[misspelled?] was in one of the earlier sessions when they pushed him to make a declaration. He said he was going to double the number in the Mexico conference.

And they'll certainly have some quite work on their hands to improve on what's been done during this conference. So a big hand to you all. I'm really [Applause]...

And I say young people have been amazing at this conference, wasn't like that when I was a kid.

Okay. Let's move on. What I'd like to do then briefly is to set the scene a little bit to say something about evidence. You know we talk a lot about evidence but we maybe need to be much clearer about what we need evidence for and maybe also what we mean by evidence.

I'd like to say something about the findings from a big review of the evidence that we've just completed - focusing particularly on the evidence from developing countries. And then I'd like to end up with a few caveats or challenges or conclusions.

So one of the things we've heard a lot about in this conference is that there's much more money in countries for programs on HIV. And it's been very good at this conference in fact that we've had - despite all the discussion about

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treatment - that we've also had a lot of discussion about prevention.

But of course there's increasing competition for these resources. Those current programs for young people are very under-funded in general, and even the money that is available is not very well spent.

I think we still have much too much of what I call the Hobby Shop Approach to programming. For I heard someone describe it the other day as Spray and Pray, so we need to move beyond that.

And even though young people are at the center of the epidemic - and this is true both for generalized epidemics and for concentrated epidemics - there are still people saying, "Do we really need special attention to young people?" "Duh," as my young people would say [Applause].

So we also have very clear global goals and commitments that governments have signed up to over the last ten years or so at the ICPD Plus 5, at the UN General Assembly Special on AIDS, and more recently at the high-level meeting.

But we also know from the UNAIDS Report that the progress towards achieving these goals has been very slow in most countries, that again people are still questioning, "Should we really invest in prevention amongst young people? Is there really evidence that this works?"

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And then I think we're also faced with this problem that people frequently confuse moral opinions with evidence. And as Judy Arbach[misspelled?] says in one of the chapters of the publication I'm going to talk about, "People frequently confuse lack of implementation with lack of evidence."

So we need the evidence. We need to know what works so that we can raise funds and spend the funds wisely. But as I said we also need to be clear what we mean by evidence and what do we need evidence for?

Now those of you who've been following the tracks on prevention will be well aware that there are very different perspectives to thinking about evidence - from randomized controlled trials to what I heard last week when I was having a beer in the bar.

And of course the very important range of looking at evidence between quantitative and qualitative methods.

And secondly we need to be very clear about, "Do we really need the same level of evidence for different kinds of interventions?" And I will come on to talking about this because this is one of the issues that we grappled with in this review that we've just carried out.

And then thirdly we need to constantly remind ourselves that just because there isn't scientific evidence for something doesn't mean that it doesn't work. But it does

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mean that we better get the evidence.

So then we need to think, "What do we need evidence for?" And my sense is sometimes that these different issues get quite confused.

We need evidence of course that young people have specific needs and need special attention. We need evidence for different kinds of outcomes.

So we need evidence for looking at decreasing HIV incidents, and we need evidence for decreasing some of the behaviors which underlie HIV transmission, and some of the determinants or risk and protective factors that underlie those behaviors.

We need evidence for specific interventions such as needle exchange. And we had a very good presentation on that yesterday - harm reduction programs and condoms.

And we need evidence that specific behaviors will contribute to the prevention of HIV, and that we know how to do it with them.

We heard the day before yesterday I think about the continuation of ABC to other letters of the alphabet. I had somebody the other day saying, "ABCD." I said, "What's the D stand for?" And they said, "Do it yourself."

So we need evidence also then on not only does the intervention work, but can we actually do it? So the move from efficacy to effectiveness, taking interventions to

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scale, it's so exhausting hearing people saying, "Does prevention work," when such a small number of people are being reached with the prevention interventions.

It always reminds me of immunization in the 1970's when people were saying, "How come we've got these measles epidemics still when we've got measles immunization?"

And then they discover that maybe 5 to 10-percent of the children had actually been immunized. It's another, "Duh."

And then sometimes even though things are very common sensical, we need the evidence to prove it. And I would say that much of the findings of this study that I'm going to talk about are examples of research confirming common sense.

So I'd like to talk then briefly. I'm going to go through this very quickly. There are copies of the publication at the UNAIDS booth, or there are CD-ROM of it, or you can download it from the Web sites of WHO, UNFPA, UNICEF, UNAIDS, or the London School.

So just to say that this is a collaborative effort where we've been trying to get consensus between the UN organizations -- people complain a lot that the UN doesn't work together. This is been an attempt to do that.

And it's involved many researches from many different countries. And I would say from quite different perspectives as well. So I find myself speaking on behalf of all of them.

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So the objectives of the review were first of all to try and inform the choices that policy makers and programmers have to make in terms of trying to achieve the global goals on young people in HIV that they had committed themselves to.

And that we want to then to provide a detailed review of the evidence for the effectiveness of interventions to prevent HIV amongst young people in developing countries.

And finally we wanted to develop a standard methodology through which interventions provided through different settings could be assessed, and could be assessed in a transparent way.

This as I said is the publication. There are a few of them left - afterwards if you want copies of them - at the booth. And there's the CD-ROM that you'll be much more grateful for in terms of your baggage allowance.

But there are essentially three sections, one section providing the background, introducing it, saying why we need a specific focus on young people, looking at prevention in general.

And then there's a section that looks at the methodology, looks at these settings that we've identified, and makes some conclusions and recommendations.

So in order to do this we have to go through a number of steps. We first of all have to be quite clear about what outcomes were we talking about.

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Secondly, we have to select the main settings through which interventions are delivered to young people. Then we have to categorize to different types of interventions that are delivered through these different settings.

So if we talk about schools, or if we talk communities, there are many different types of interventions that are delivered through these settings. And clearly we need to differentiate between these types if we want to look at the evidence.

And then we challenge the authors of the different chapters to say, "What sort of threshold of evidence would you need for that particular type of intervention if you wanted to recommend it for wide-spread implementation?"

We then looked at the research that was available for each of these different types of interventions. And although we scanned many, many more, there were 80 studies that were reviewed and included in this overall review.

And then based on the evidence that we got from these research projects that had already been carried out, we classified the interventions as, "GO," if the threshold of evidence was completely met; "Ready," if the evidence was partially met; and, "Steady," if it wasn't.

Now I'm getting a flashing light already, so I'm going to gallop along a little bit.

In terms of the outcomes we very explicitly looked at

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the global goals which deal with decreasing prevalence, which deal with decreasing vulnerability, and which deal with increasing young people's access to specific interventions in terms of information, skills, and services.

And these were the settings that we reviewed. So I'm just putting this up then for each setting. We needed to try and look at a different typology.

And you'll see here for Interventions for Geographically Defined Communities that we looked - here's the four different types of interventions that we looked at in that particular setting - interventions that were targeting youth specifically or interventions that were targeting youth as part of the general population.

And then we further split up those groups so that we ended up with four different types of community intervention. So that's just an example what I mean when I talk about types.

And then of course we wanted to look at the threshold of evidence that would be required for us to be able to say, "This kind of intervention should be widely implemented."

And I've listed here the kinds of things that we needed to talk about. And I'll just briefly give you two examples.

One example in terms of interventions for young people in communities where in terms of feasibility—and these

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other characteristics - there was a sense that this wasn't something that we needed a high level of evidence for.

A low level of evidence would certainly support us in being able to say that these kind of interventions could go to scale.

On the contrary this is an example of interventions for young people most at risk where we know these kinds of interventions are difficult to do and sensitive. And so we needed to - this would require a medium level.

So we also then have to have some kind of categorization for the evidence that we were looking at. And these are the sorts of characteristics that we were looking at. And we based a lot of it on the work by Habish[mispelled?] and Sesabiktora[mispelled?] in terms of looking at a hierarchy of evidence so that we could say whether the evidence itself was strong, or weak, or medium.

And then as I said, "We allocated each of these interventions to go. Stop asking for more evidence. Just take these interventions to scale and monitor them carefully."

The "Ready," where we're saying, "Widely implement them but make sure this is strong evaluation component;" "Steady," where we were saying, "No, this is not ready for prime time. This requires more research and development"; and, "Do not go. This isn't the kind of intervention we

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should be supporting."

So you'll want to know what sort of interventions we found even though my little red light is flashing. In schools then we found that they were "Go" interventions if they were curriculum-based, if they were adult-led with or without the invokement of young people. And if they have the characteristics of effective programs that Doug Kirby[misspelled?]" - who edited, who wrote this paper - has identified for interventions in schools in developed countries.

And those mostly deal with how the curriculum was developed, the content of the curriculum, and of course its implementation.

The health services - we found that really we could only increase young people's use of services if we trained the service providers and we did something in the clinics, and we reached out into the communities to generate, demand, and create community support.

Again, this is common sense, but now we have the evidence to support it.

And in terms of geographically defined communities, there was clarity that where we worked directly with young people through existing structures, we're ready. Of course we need more evaluation, but we should certainly be widely implementing such interventions.

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And for young people most at risk, again we need more evaluations because frequently - even though young people represent a huge proportion of groups such as injecting drug users and sex workers - in fact the data is rarely disaggregated.

So we need more evaluations, but certainly we should not hold back from implementing these kinds of programs.

Now I'm going to just very quickly identify three caveats. Firstly, none of the authors thought this was the final answer.

As I said, "There are lots of ways of looking at evidence." So we've just put this forward to have it on the table for discussion in terms of saying, "This is what we think," and to try and be transparent about how we came to the conclusions that we came to - that the evidence base is very variable.

We have much more evidence from schools for example where it's relatively easy to carry out research than we do for young injecting drug users, or young sex workers where frequently it's difficult to carry out research.

And often the people reaching these groups are more interested in getting on and doing it than they are in doing research.

And then there were a number of groups that I've listed here that we didn't deal with in the study. And I

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would like to emphasize the last group - the care support and treatment for young people who are living with HIV and AIDS.

This was clearly something at the beginning of the study we wouldn't look at because the evidence was so fragile, but we're starting this up and we have an important meeting in November to get this going.

Then finally a few challenges about the evidence - how to interpret the findings from multi-component interventions. We've been saying for the last 15 years, "There's no magic bullet. You've got to something in schools, and something in the services, and something in the community, and change the social environment, and something in the media."

And now people are beginning to do it. It's very difficult to tease out which of those is really having the impact.

How to take into consideration the fact that all young people are not the same? And we know that at one level - at a programmatic level - this is very important.

At another level if we're trying to reach policy makers, and we say, "Oh yes and don't forget about girls, and don't forget about boys, and don't forget about younger ones, and older ones, and ones that are married, and not married, and live with their parents," then they'll just go back to immunizing little children. It gets too complicated for

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them.

That the issue of context is very important for us to keep thinking about, that we still lack good research in developing countries - particularly research that includes some element of costs.

And finally is the whole issue that we didn't deal with in this study because again the evidence base in fact is quite fragile. And it's a different kind of approach - the whole issue that we will have heard in many of the sessions about structural interventions.

So finally then the implications for action. We have a comprehensive and transparent approach to reviewing the evidence in a range of settings, we have guidance to programmers and policy makers in terms of saying, "Listen, the 'Go' and 'Ready' interventions should just be done."

With the "Go" interventions monitor coverage and quality carefully, and with the "Ready" interventions make sure that it was a good evaluation component. But do it.

And for the steady interventions we're saying, "Not yet." But we need to put some serious research and development effort into it.

And that's in the next agenda for the researchers to say, "We have a research agenda now in terms of moving the steady interventions to "Ready" and in or "Do not go," and the "Ready" interventions to "Go."

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So in conclusion, we have goals, we have increasing funds, and we have increasing clarity about effective interventions.

We need no more excuses about, "We're not going to do this because we don't have a very good evidence base." I don't think so. I think we have a very good evidence in fact.

We need more careful evaluations of the "Steady" and "Ready" interventions, and we need much more evidence informed action for the "Go" and "Ready" interventions that have been identified. Thank you very much.

**MARY NDUNG'U:** Thank you Dick for those insights about the effective interventions. I'd like to invite the third finalist who is Henry Luyombya.

He's going to talk about, "Great Involvement of Youth Living With HIV and AIDS." More often than not you know about the greater involvement of people living with HIV and AIDS.

But to make sure that they use interventions - and they use living with HIV and AIDS I involved - we have to really understand the GI principle. So I'm going to welcome Henry to talk about it. Thank you [Applause].

**HENRY LUYOMBYA:** Thank you very much and good morning.

This morning I've been told to talk about the greater

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involvement of young people living with HIV and affected by HIV.

I don't have a Power Point presentation. All I want is to have an interactive discussion. But before I begin my discussion, I want to highlight a few things.

We've come 25 years into the epidemic. Almost all the presentations we've had since we came to Toronto we could have had before. But the problems still exist - young people, even up to this second, who are still getting HIV.

Some are us, we're still dying. And what is the problem? Is it time to deliver? Are there people who are still contracting the virus? And how about those ones who are dying when some of us are gathered here in Toronto?"

Time to Deliver. I saw that as a very good theme for this year's meeting. But to focus on the young people - especially those living with HIV.

I think now is the time. We need to highlight - we've heard of the research evidence. We've had very many presentations on involving young people - young people trying to work with others. But after here, what's next?

I would like to also take this opportunity to thank the Toronto Youth Force and the Global Coalition - the Global Youth Coalition on HIV - for helping young people from all across the world come to this conference.

Like someone said earlier, "Toronto's youth force -

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we've had about 1,000 young people from across the world." And this is the largest.

In Dublin[missspelled?] young people represented at that conference were about 50. In Barcelona, it increased to 200. Two years ago in Bangkok, that one moved up to about 450. And so we are glad that the representation of young people is about 1,000.

But what we need is not only young people coming to the conference, but making an impact. And also after when it get back to our communities to create an impact. Very many of us cannot access the conference.

What is our role when we come to the conference, attend sessions, and then go back to our communities? How about young people living with HIV. So I'll start my brief discussion on what it is to live with HIV.

I've lived with HIV for over four years. And we might be aware that stigma exists almost everywhere and many of us who could have heard about the deeper principles great involvement of people living with HIV.

However, if we put into a context of young people, where is the role of young people in the deeper principles, young women, young people who have sex with men, but the drug users, commercial sex workers?

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Does the deeper principle catch up for all this categories of young people? So I want us to reflect on some of these issues critically.

And as we get back to our communities might as well discussing adolescence and how to promote their health not forgetting the critical role young people living with HIV can play if we're to turn this epidemic around.

I'll firstly talk about access. Through the Toronto youth force, I will have had a few key messages, one of them being access. We need access to information. But some of us we have the information but we're still getting infected.

Some of us have treatment, but we are still getting reinfected. Some of us in our countries we have the resources. We have the drugs, but people are still dying in poor settings.

We need to tell the truth. We need to talk about sex and sexually disease and adolescents living with HIV. How about the monies? We need the dollars. Young people, we could be key in working with other partners to ensure an HIV free world.

Human rights, stigma and discrimination, some people are not being allowed to access education in colleges because of their HIV status. Some of us, we're begin denied jobs, employment.

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And I'm sure some of these issues we'll be seeing over the next couple of sessions or we must have had in the sessions during the conference.

But what is the problem? We come to such meetings to get solutions. We've seen some places where things have worked. What can we learn? What are the best practices we can take back to our communities?

I'm from a country called Uganda where I helped co found an organization called Uganda [inaudible] after Uganda hosted the international conference of people living with HIV in 2003.

I saw this is a great step forward in having young people living with HIV trying to advocate for our rights, but that is not enough. We need access to treatment. We need access to information to be more involved in the community and address issues of prevention.

I'll also talk about stigma as a big, big issue if we are to talk about greater involvement of young people living with HIV. Stigma has affected us in many ways. We might be aware that stigma prevents disclosure, status, and as such it allows the epidemic to spread underground.

So what is our role as young people? Firstly we need to avoid reinfecting ourselves and in also infecting others, be critical in prevention and also advocacy for care and treatment.

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Education, in one of the sessions earlier in the morning, someone talked about being aware of the problem. Twenty-five years down the road many of us could have heard about HIV, if not all of us.

But still we have some misconceptions. We are aware somehow, back then the knowledge levels are still limited. What is our role when we get back to communities and work with the young people?

If it is in research programs meant for young people, how are we involving the youth in program designing, implementation, in decision-making and also in monitoring and evaluation.

Some of use could be seeing young people as opportunists. We don't want to just come, attend sessions of [inaudible] to go back to our communities. We are key. I may not again talk about how young people are affected, the new infections.

We might all be knowing that. But this is very serious because some of us don't have the information. When we get back to our communities, we still think HIV doesn't exist. We still think there is a cure for HIV.

We still think you can get cured of HIV by sleeping with a virgin and that's a big issue. So when is the time to deliver? When shall we deliver to young people who still have [inaudible] infections 25 years down the road?

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If we are to deliver prevention and effective strategies for prevention and care and support, where is the role of young people living with HIV. Forty million people across the world living with HIV. Some of us might think these statistics are doctored.

But to me, this is a personal comment. I think even this number could be greater because many of us don't know our status. So some of the statistics are not captured and that's the problem.

We might be aware that HIV is a funny disease. You can get it today and you live on for some time and in the process you could be transferring the virus to another person and that's terrible.

So what is the role young people can play critically in trying to address the [inaudible] and the challenges and also try to be involved in advocacy for care and support, treatment and also prevention.

Sex, sex is a big issue. Some of us in society, we see young people as they're not supposed to have sex. Much as sex might be very important, but how you have sex is more important.

So I would say that if a young person living with HIV they have options if they chose to have sex [inaudible] themselves. And then the other young people, let's give them access to free information.

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We've talked about the ABC. [Inaudible], give us the condoms if we chose to use them. [Applause]

And young people, for the young people, it's not all about condoms, consistent, correct condom use very important.

In some of our societies, some of us will say, "I'll use a condom today. Next time I will not. Maybe for a partner I'll use a condom. For this one I'll not." That's a problem.

How about access to voluntary counseling and testing? What is the role of dozens who have already tested positive? We are key in responding to the epidemic, sharing our stories, having chance to speak at such meetings. It can help us reach out to the communities.

But that is not enough. We still see people dying. How can we transfer the knowledge, the lessons learned and have meaningful action? That's why we're discussing adolescents sexually [inaudible] health promotion.

In the first presentation, we have had looking at an adolescent who is living with HIV and was born with HIV. Much as our main role is to prevent HIV, now this person is already born with HIV.

Does ABC strategy for prevention help this young person in adolescence? What do we need to ensure that this person doesn't get AIDS? Do we need to work on AIDS

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prevention since HIV prevention cannot be? What is our role there?

In summary, I would like to still emphasize that young people's involvement in programs that relate to HIV mostly young people living with HIV is critical in responding to the epidemic.

And we've heard some evidence from Dick in a few other sessions you could have heard during the conference. But still if we don't have access, if we don't have truth about the reality, if we don't have the monies, we need the dollars to fund programs.

And remember young people we are key in responding to the epidemic. Evidence has shown that when we work with young people a lot can be achieved and it's not only young people coming to Toronto advocating for our issues, but also need to work with other partners.

And not forgetting that critically the [inaudible] principles that greater involvement of youth living with HIV, all affected by HIV, can go a long way in helping us in achieving time to deliver.

In summary, what is my final word? My final word would be to transfer the knowledge through all the media that we can use, through workshops down in the communities, and the role of the media is very important to report correctly on young people and our views.

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And then the personal role; you and me, what is my role, when we get back to the communities, to report on young people. How do we share the knowledge? We've already heard young people will be more than double at the next AIDS conference in Mexico.

Should we aim at coming and attending conferences, going to Mexico? Yet we have the monies to have the technologies. Our major aim is to prevent new infections and also care and support for those ones already living with HIV.

So in a nutshell, let's reflect on our personal role. What is our role in helping turning the epidemic around, not forgetting the children as we advance to adolescence, and before we get to adult [inaudible] what is our role?

And then how can we work with the young people with the youth partners so as to prevent HIV? I thank you for listening. [Applause]

**MARY NDUNG'U:** Thank you Henry. If you have any questions for either of the panelists feel free to ask. Number three?

**FEMALE SPEAKER:** Yes, thank you. My name is [inaudible]. I am a volunteer with the female [inaudible]. Thanks to all the panelists that [inaudible] good presentation from each one of you. I have a question for Bruce Dick. My question is what do you mean structural intervention? I think you didn't have time to describe that

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and I would like to hear more about structural intervention.

**MARY NDUNG'U:** Bruce?

**BRUCE DICK, M.D.:** Do you want me to talk? Sure.

I think these are the interventions which deal with the underlying practice that we have heard about so often during this conference and through our work which really underlies this disease.

So it deals, there are interventions to try and deal with poverty. There are interventions to try and deal with the lack of education, particularly getting bills into schools. There are interventions of trying to deal with discrimination, not only of people who are living with HIV, but the discrimination and marginalization that exists for many of the groups who are at the center of transmission.

So it's that I am talking about sometimes they call up streams. Some they may have different words, environmental. But they are the interventions that in fact make it so difficult for young people to get the information often and to get access to the services, and to have opportunities to develop life skills.

**MARY NDUNG'U:** Number two?

**COLLEEN:** Hi, my name is Colleen. I am the Chief Youth [inaudible] for 2006. I have a comment for each speaker. Henry your voice throughout the pre conference, the main conference, in the forums, the discussion, the media at

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the pavilion, has been so inspiring.

And I, for me I am going to go back and I am going to talk to my youth about what you said and what your challenges are and get them talking because you've been one of the strongest voices here and I applaud you for that.

**HENRY LUYOMBYA:** Thank you.

**COLLEEN:** To the second, to the doctor, I understand that there is going to be a youth friendly version of this report developed. Is that correct?

**BRUCE DICK, M.D.:** [Inaudible]

**MARY NDUNG'U:** Repeat your question please.

**BRUCE DICK, M.D.:** So absolutely, and in fact we had a satellite. I hope you all made a declaration at the youth pavilion first of all. If not, you should go to the youth pavilion and make a declaration of what you are going to do for young people.

Anyway, the, after the satellite that we had a couple of nights ago on this, the young people took Joyce Mathi [misspelled], who is the Assistant Director General of WHO in charge of this area, got her to the youth pavilion and they and she have committed to developing a youth friendly version.

Because one of the things that [inaudible] who was also on the podium then made very clear is that this provides young people with very strong backup for their advocacy.

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It's a very good document for youth advocates, but at it is it's not so digestible, in fact those of you who've read it.

I mean it's designed for researches, not, and to get the message across them from policy makers and programs. So the short answer, having given you the long one is yes.

**COLLEEN:** Thank you, and the first speaker, I agree with you entirely. There are not, the way HIV and AIDS is educated with prevention to youth is not useful and productive to youth who are born with HIV.

I have been working with a youth for over a year and a half and there is very limited support for him and I will be delighted to get your contact information to pass on to him.

He has told his story anonymously to a publication I worked on called *Bloodlines Magazine*. Those magazines have been lost in transit but I encourage everybody to go on line at [www.redbashroad.org](http://www.redbashroad.org) to hear a personal story of the exact issues we've been talking about, and I want your information to give to him so you can be his role model and he can communicate with you because you're amazing. Thank you.

**BRUCE DICK, M.D:** Thank you very much.

**MARY NDUNG'U:** Question one?

**MALE SPEAKER:** I am [inaudible] representing the Fifth Organization of the Islamic Medical Association of Management. There's no doubt now that HIV/AIDS are sadly

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become a chronic disease mainly rampant in economically developing countries and my plea is that [inaudible] poverty and ignorance.

My plea is that we should all [inaudible] to ensure that these developing countries are empowered. What am I, why do I say that? The developed countries [inaudible] they are going to spend 0.7-percent of their annual budget on AIDS.

But as of now, as of today, only part of [inaudible] countries have met that goal. My talent and my plea is that those across here who have the contacts to try and persuade the developed countries to increase their budgets for AIDS to developing countries so the mandated 2.5-percent recommend by the [inaudible].

If we do that, the youth will have jobs. When I was growing up, my grade school teacher taught me that an idle brain is the devil's workshop, a good member of the youth who fall victim to the weaknesses of the budget resulting in that [inaudible].

It's because they don't have meaningful [inaudible] and [inaudible]. If you can keep them fully engaged or working on the farm or developing their intellect, you will find that the prevalence of AIDS will reduce, and if the women who are compared to succumb to sugar daddies have enough funds in their hands, they will not succumb to any

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advances by these older men and then people who are in a position to hold them for ransom.

**MARY NDUNG'U:** Thank you.

**MALE SPEAKER:** So I, that is my plea ladies and gentlemen. Thank you.

**MARY NDUNG'U:** Thank you. Other questions please?

**MARGE BEAR:** Marge Bear from the Journal Reproductive

...

**MARY NDUNG'U:** Please be a bit brief please. Be a bit brief.

**MARGE BEAR:** I'll try. I wanted to support the first speaker when he started off by talking about the importance of recognizing that we are all sexual beings, whatever our HIV status. [Applause].

And it seems to me that the core of the solution to this epidemic remains attention to safer sex and to make that a social norm for everybody, whatever our status. And it seems to me that the ABC message has sabotaged that by trying to reduce it to something far more simple than it is, and that sexual behavior is much more complicated and needs, we need in this conference in the future to give it much more attention.

Condom use for example, has practically fallen off the agenda of the AIDS conference. In the prevention plenary it was not a topic of a speaker who had expertise on condoms

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and the increasing use of condoms.

And I'm going to be publishing a mass of papers. I've been flooded with them, showing that young people are taking their lives into their own hands that condom use is increasing among even the most disadvantaged young people, is increasing across the world.

And this success that young people bringing about themselves and practicing safer sex, and dealing with unwanted pregnancies using condoms and emergency contraception when they're concerned because they have missed the condom one day, is increasing, and this success is not getting any press anywhere. So I would like to see us giving that much more media attention. Thank you. [Applause] /

**MARY NDUNG'U:** Thank you. Ms. [inaudible]?

**LAUREN PICKLETT:** Can you hear me?

**MARY NDUNG'U:** Yes.

**LAUREN PICKLETT:** My name is Lauren Picklett. I am a freelance journalist and a teacher in a high risk population in the United States. My question is for Bruce.

To what extent can the findings of study Ready Go be expanded to the prevention discussion in the United States or other quote "developing nations" unquote?

As you may know, funding for prevention programs, particularly in schools in the States has become a huge issue and a political hot potato. And I guess my further question

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is does it matter if the relative perceived risk of the group within developed nations matter as far as prevention programming goes?

**BRUCE DICK, M.D.:** I would just say that we decided to focus very explicitly on developing countries because frankly you have a huge amount of research in the U.S. and a fairly large amount of research in other so-called developed countries on the kinds of interventions that we've been talking about.

I mean if we think of school-based interventions, you have Doug Kirby here who of course actually wrote the paper of the chapter in publication. But he's done a huge amount of research here in this country.

But it's an interesting question nonetheless, and it's a question that in the press conference from yesterday that we had about this, one of the journalists asked Judy Albach [misspelled] who was there, who is one of the vice-presidents for [inaudible] and she said that the most useful thing for her about this publication, in terms of the U.S., was to be able to take it to the people who are providing aid for overseas for other countries from the U.S.

And we will all find this from the so-called developed countries, that it provides very clear guidance for them about what sort of interventions they should be

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supporting, and that there's an evidence base for this, and that these are not just based on moral values and opinions.

**MARY NDUNG'U:** Thank you. [Inaudible]

**KATE UPPENDER:** Hello, my name is Kate Uppender. I'm from the U.K., I work with the BSO. I just wanted to say that I think the report offers a fantastic opportunity as you say to be able to make clear messages for organizations about what they're going to scale up and what works.

But this morning in the plenary, we heard from a 13-year old Canadian girl who's in school and not receiving sexual health education. And I know in the U.K. that's a reality as well.

And I'm just interested Bruce in your comments about the barriers for developing countries seems even greater. And if we can't get it right in Canada and in the U.K., how can we expect countries with limited resources to take the messages from the review and actually make it a reality for young people around the world?

**MARY NDUNG'U:** Thank you.

**BRUCE DICK, M.D.:** No, I mean it's an excellent question and I don't have any simple answer for it at all. And in fact, there was a very good review done by Action AIDS and a number of other organizations in U.K.,

They had a very catchy title which just at the moment escapes me, but basically showing that, you know we've been

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saying this for a long time in fact that we need schools based health, sex education, health education in the schools.

We've been using the developed country evidence for the most part. Now we have it from developing countries as well. But it's not getting done for many reasons.

Now, the evidence is only one of the things that are going to make this happen. Schools are really struggling in many developing countries. It's very difficult. But what we need to know is what we should be aiming for. And I always like to say that we need to make it very clear that simply providing a lecture on the reproductive tract of the dog flesh is not going to help young people develop healthy sexual lives.

So, so we know what to be aiming for and we know we have an evidence base. We need one level much stronger political will, and we know that this is hugely lacking in many countries, not so far from here, but other countries as well, and of course we need money for this.

We need money for these areas of programming, as much if not more so, and it was interesting yesterday when Kevin DeCock was doing the plenary, and he made the point that we are not going to treat ourselves out of this epidemic.

And that unless we focus on prevention we are only going to land ourselves in a mess, so we need serious funds for this as well. And of course in many ways it's not nearly

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so sexy as some of the other areas that many people are putting money into.

So it's a good question. I don't have any simple answers, but at least we have an evidence-based, and at least we know what we should be aiming for when we develop interventions in schools and health services and through the media, et cetera.

**MARY NDUNG'U:** Two.

**GEORGINA MCDUGALL:** Hi, my name is Georgina McDougall. I am a registered nurse at the hospital for sick children, and I would just like to say thank you for bringing out the point that there is a huge gap for adolescents. We treat children and the transition to adulthood. There is a huge gap.

I do appreciate that I work in a resource strong environment, so I do have the luxury of being able to do a lot of the things that you were talking about.

Disclosures, you know, talk with the teens about how to disclose to their partners, teen meetings so that we can discuss issues and to bring about the point that the teens are struggling with hearing the message in school that you don't want to get HIV, knowing they already have HIV, hearing their peers discriminate against, "Oh my God, I wouldn't want to be friends with anybody who has HIV" and yet carry that burden with them.

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So we help them to try and work through those issues. I would like to take the opportunity, because I certainly don't have all the answers on caring for adolescents, if there's anybody who would like to network, I would be more than eager to meet with you and exchange emails, cards, whatever, so that hopefully by 2008, adolescent issues, as well as children as a whole, does make it more to the forum. [Applause]

**BRUCE DICK, M.D.:** I think this is so important, and yesterday I don't know if any of you went to it, there was a very interesting session that was entitled *Providing Care, Support and Treatment for Children and Adolescents*, something like that. And I think adolescents were mentioned once as being an issue that we need to deal with, and all the rest of the focus and fact was on children.

So I couldn't agree more, and in fact I may say it, that I hope in Mexico we can seriously deal with this. And we're going to try and kick off at least with this meeting in November to be much clearer about what we can do to provide care, support, treatment, and of course, prevention for young people who are living with HIV and AIDS, and for both groups, both those who have become infected in early childhood, and for those who have become infected during adolescence.

**MARY NDUNG'U:** [Inaudible].

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**SABRINA:** Thank you. I'm called Sabrina [inaudible], pediatrician who looks after adolescents with HIV in a developing country, Uganda. I would like to thank all the panelists. But I want to say one thing that adolescents who live with HIV need to be supported to adhere to their therapy.

We're talking about prevention, prevention of early and unwanted pregnancies, prevention of STIs, but we're not looking at prevention of resistance virus.

I mean we are putting our patients on first line therapy and not supporting them adequately to adhere to their first line therapy. Sooner or later they are going to fail on their first line therapy and there'll be no options.

I want to encourage people from low resource countries that youth friendly services that are excellent should not be the enemy of the [inaudible]. With the little resources that we have, we can still start something small and do it properly.

**MARY NDUNG'U:** Thank you, [inaudible].

**MARY TURKO:** Hello, my name is Mary Turko from Dartmouth Medical School in the U.S. I am affiliated with a youth-directed, youth-targeted project in sub-Saharan Africa and four different countries that uses youth sports for development.

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It's called Grass Roots Soccer. And one of the benefits that we've had is being able to get financing to do evaluations to gather evidence about the efficacy of our project and also to publish the evidence and in *AIDS and Behavior*, an important journal.

The problem that we have found however, is that getting the money to do the research, to gather the evidence is an impediment. We had to work very hard to get a small Gate's grant to gather the evidence.

That cost as much as the intervention. So my concern, my serious concern, I guess directed to you Dr. Dick, would be, did your report address how the financing will come forward for gathering the evidence.

And if not, where will it come from? And if it doesn't come, will your report work against those of us trying to evidence-based medicine work for prevention and treatment, but not having the money we cannot prove that our projects work. So where will the help come from for financing the research?

**BRUCE DICK, M.D.:** Well, what I sincerely hope that the answer to your last question is no. I think now one of the things that we have managed to do with this report is to identify clear research agenda exactly in terms of the areas that you're talking about.

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And interestingly enough at the press conference the whole issue of sports was also brought up yesterday by a couple of people who were asking questions. Gary Barker who's doing a session at the moment, has done a very good evaluation of some sports-based interventions in Latin America.

I think now we need to come together and we need to be going to the people who are funding serious research to say there's an evidence base for this and we need to move with this and we want money for interventions.

And there are research questions here that we've identified very clearly in the report and we need answers to these questions just as we need answers to vaccines and microbicides and treatment and all the rest of it. S

So I think we, we're not going to get this money by sitting back and waiting for it as you've discovered. But I think we need to mobilize ourselves much better to go and get some serious funds to support exactly this kind of research and to answer the questions that we still need answered.

So it's a good point, again I don't have any simple answer I am afraid but a very good issue to have raised.

**MALE SPEAKER:** Thanks. Just in answer to that as well, to add to what Dick has said, in Trinidad and Tobago, we the youth undertook something very serious.

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We analyze our national budget and the youth policies and HIV/AIDS policies that we developed for five and ten year periods, and we found that there's something in common with all of the Caribbean, as well as some of the other lesser developed nations.

There is financing allocated by a global fund to address youth issues and targeted youth interventions and the research that's necessary to look into how to develop those interventions.

So as a possible answer, I think that reviewing those national plans in country to make it more localized perhaps where you are is an answer. It has worked for us thus far.

**MARY NDUNG'U:** Thank you. We're almost done now. I think we're going to take three more questions. Question three please.

**SHAPIRO:** Hi, my name is [inaudible] Shapiro, and I'm a young person from Canada. I just want to congratulate you all and a really great presentation. It's been very, very informative. I just had a few questions.

For Bruce, I was wondering, the U.N. and so many international organizations are trying to find evidence and trying to make these recommendations for why, for program implementation that is widespread.

And I feel like there might be a problem in terms of, a big lack of cultural sensitivity, where these studies are

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taking place, and where they're being evaluated, and who they're being designed to be evaluated by for the implementation in developing countries, where things can be very, very different.

So for example, I was recently in Kenya and I was working in a youth center and you see there that there is such a big generation gap. So you have money being allocated for education of youth and a youth friendly centers, but then you have the older people there who actually don't understand the message and can't deliver the message properly to those youth that they are supposed to be supporting.

So really, there's been a lot of talk about calling to action for youth and what youth should be doing, and I think especially in resource limited countries where the media is so new, and a lot of these outside influences are very new, and the ideologies of children compared to their teachers or their parents, is just so different.

I think there's really, it's very important to have an emphasis on what youth can do for other youth and how, we can reach out to each other and support each other, and I think that a lot of times the funds are allocated. Say okay this is going to go for peer education.

And if it's in a resource poor place, you have the money going into the person who runs that youth center or the

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few adults who are running that place, and the resources don't get down to the ground, and it really ends there.

And the head of the youth center is driving a nice car and the kids are getting AIDS. So I think it's, I'm wondering what your impression is about that multigenerational problem. I don't know your name, I'm sorry, the third person who spoke. I just want to congratulate you. You were really, it was incredible to hear you standing up and I think what you're doing is so important because a lot of youth don't realize that there are other youths that are living with HIV/AIDS.

And they think it's just this big bad evil thing that everyone's telling them to be scared of and they don't realize that there is something positive afterwards. And I think if people don't see people living with HIV/AIDS and living positively, they are not going to go and get tested because they feel like there's no life after the diagnosis.

**MARY NDUNG'U:** Thank you.[Interposing]

**SHAPIRO:** It's so important what you're doing.

**MARY NDUNG'U:** I think this is going to be the last question.

**FEMALE SPEAKER:** Thank you. I work in Kenya and I'm struck by the fact that all of our speakers besides the Chair, are young men, or men, and in sub-Saharan Africa HIV in some countries, young women are three times more at risk.

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So just an observation, but I sill applaud you all for coming forward and speaking. I think in the future I would like also to hear young women speak equally.

A question actually for you about you challenged us to make our adolescent friendly health services more catered for those adolescents that are HIV positive. And in that I would like to pose a question about how you see the debate around testing that has been presented at the conference, routine testing, opting in or opting out and any opinions about who you see would have the rights to that information, if an adolescent that was less than 18-years old did go forward with an HIV test. If you see that their parents should have, or guardian, should have the right to that information, so any comments on testing?

**MALE SPEAKER 3:** I think voluntary counseling and testing is very key in trying to respond to epidemic and we might be aware that it's financial point not only in prevention, but also can support.

Although in many of our settings we either charge the user fee to get tested in Sub-Saharan Africa, or the service centers are not nearer to where young people are and so it's a big problem. However, voluntary counseling and testing I know is key in responding to not only prevention but also care and support. Thank you.

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**MARY NDUNG'U:** Thank you. Briefly question three, ask the question just briefly.

**MALE SPEAKER:** When listening to the younger speakers, I was reminded that there are many specific aspects about adolescent sexuality and how it is different from adult sexuality.

Does the panel have any observations about how understanding and acknowledging these differences can influence successful programming for sexual health promotion?

**MALE SPEAKER:** Yeah. On two things, the previous testing question which there is quite interesting in nature regarding whose privileged enough to have the information.

One, it's not an easy answer, but the fact is that if it is that there were difficulties with this young person getting sufficient information to be able to manage their sexuality and grow in a healthy sexual manner, then I don't think that there would have been many of the same issues of worrying about the outcome of the HIV tests, in the ideal home setting, perhaps sure.

Everybody can get the information, but remembering that if you live in a household where not everyone is equipped to handle the info about your serious status, I think that the debate on whether just let the young person know or let the parents know, is going to be one that needs more serious thought and management.

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And in terms of understanding how adolescent sexuality would affect the quality of health care, look at the fact that if you need to look at, as Dick rightly said, the, what is it, the tract, the birth tract of the dog fish, you're not going to study a mammal that lives on land are you?

If you need to understand adolescent sexuality and address the healthcare issues you must have the facts. You must look at how an adolescent is biologically different from an adult.

Some people argue the difference that you know 10-percent and a 15-percent hormonal difference isn't great, but trust me, it is enough to make the changes as well as the psychosocial issues.

There are societies where you cannot walk out as a young person, pick up a condom and go anywhere with it because your parents are going to be called.

And if you and those parents did not have a debate or a discussion on your sexual issues, your sexual orientation, what's happening to your body, then how do you expect them to go over okay if you just gloss over the issues of adolescent sexuality without looking at the differences.

**MARY NDUNG'U:** Thank you. I give you two minutes. Speak out loud.

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**FEMALE SPEAKER:** I'm Isabelle from Mozambique. I have one question for [inaudible] your name. I would like to know how you do in your country to disseminate [inaudible] and the rights of young people living with AIDS. Thank you.

**MALE SPEAKER:** In my neck of the woods we've adopted what we call very specific, we do it, we say it, we want it approach. Our young people living with HIV they all belong to organizations of people of different social status; from different communities.

We pull together our national policies and look at what they say with respect to youth. And what we've done, is that we've developed not only a policy document, but we've outlined what the finances are.

We've also been doing the advocacy with regards to, we show up at parliament when our ministers go to speak, so they have to speak to us and they have to see us. We turn up at all the medical conferences with our young med students who are 17 and 18.

So we understand what's being said, and we understand how to attack a lot of the technical issues. And we also look at the fact that we don't just want young people at the table. We want to be eating from the same table at the same time that all the, as we say, the glitterati and the important people and the technical people. So we push for

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full inclusions and equal bilateral on level involvement; not just sitting at the table.

**MARY NDUNG'U:** So thank you very much for your contributions and the contributions from the panelists. If you have any questions, you are free to see them after the session. We just want to wrap up with these three questions.

When you go back to your communities think about how you're going to work it out together with the youth, how you can promote the health and sexuality of adolescents born with HIV. Let's not just think about the ones who are HIV negative, and how we can cope with them to go on with the transition from being a child to an adolescent to growing up with HIV, and what's the importance of promoting the health and sexuality of adolescents born or living with HIV. Thank you very much.

[END RECORDING]