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**International Women's Summit:
Women's Leadership on HIV and AIDS
Town Hall Meetings: Women Initiated HIV Prevention Methods
World YWCA Council
July 6, 2007**

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FLORENCE MANGUYU: You may already have seen her.

She's Daisy Mafubelu, who is the assistant director general in charge of family and community health at the World Health Organization in Geneva. Before she took this position, she was the head attaché at the mission in Geneva for South Africa. And that was a position equivalent to a minister. Daisy Mafubelu's career in public health started at the same time that HIV was discovered, 1981, and she has served in the South African government in various capacities before joining the WHO.

So Daisy, I hand this over to you to moderate the session. If there should be more people, this being a Town Hall, we opened it to the public. If more people should come who would wish to express themselves in Swahili, we shall allow them, and that's why I am standing here today with my friend and sister Daisy. Thank you. Daisy?

DR. DAISY MAFUBELU: Ladies and gentlemen, good afternoon. And thank you, Florence, for that opening remark. Thank you, Pauline, for your hard work. You've been running up and down to make sure that this Town Hall meeting becomes a success, and it is indeed a success. And as Florence has indicated, where you have two or three people gathered together

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in the name of HIV and AIDS, you have a [inaudible]. So we proceed on that basis.

I wish to welcome all of you in this meeting. That brings us together, several organizations, from all walks of life to talk about something that matters most in today's world. We are here to talk face to face with the consumers of healthcare. We are here to see how you and I can change lives. How can we change communities? It is time for us to do a reality check. We are all here because of sexually transmitted diseases of various types, in particular the HIV infection.

We need to know what can we do as women, and I'm glad to see that we not only have women but we have men and my brothers, you are welcome, and we're glad to have you here because we need you along this journey at women when we look at we can do as women to prevent the spread of HIV and AIDS.

We know that there are several technologies, interventions and advance for prevention, which you may know that they range from abstinence to being faithful to using a condom. These work in situations and certain places, but we also know the realities of the lives of women and girls. We know the realities of the lives of men and boys. It is well known that consistent use of condoms can prevent sexually transmitted disease, including HIV and AIDS, but research as well has shown that consistent use of condom is universally

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difficult and it's also very difficult to achieve with regular partners. It is exactly where we need these, because there are women that are in regular partnership, that are in stable relationship and we heard yesterday from some of the speakers at the opening ceremonies that these women can sometimes have a false sense of security thinking that because they're in these stable relationships, because they're in a marriage, therefore they are safe.

Child marriages and adolescents is a case in point. Young marriage, adolescents are exposed, and they are exposed in a situation where they think they are in a faithful relationship. Sometimes they're in those relationships with older men that may have a sexual [inaudible], and therefore it is important that women should be able to protect themselves.

So women have [inaudible] in the past for prevention but in today's world, although there are not many options, some of the options are still being developed. There are some tools, there is some technology. It is there to protect women.

However, women still lack access to several things. They lack information to make appropriate decisions. And when they have information, they lack technology to act on those decisions. And if they have the technology, they lack the means to acquire the technology. And sometimes they may have

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all of this, but they still lack knowledge of how to use it appropriately.

So in this context, the word lack, although it's a four-letter word, it describes a lot of things which affect so many lives. So some of the new technologies such as microbicides have the potential to be negotiated once rather than every time such as in the use of a condom. So once we can have access to those, it's power to the women to be able to protect themselves. And not only power to the women, but also, I think, power to men, because at least there's something else that does not suddenly depend on them using - women as well can take the initiative to use it.

So I want to go on and on and talk about these issues, but I have people on the panel, distinguished people on the panel that I think are well placed to discuss the specifics of these technologies, and issues around female-initiated prevention. They will enlighten us on the available prevention options on the market as well as those that are in the pipeline. They will share with us knowledge on how to be effective and take action to prepare ourselves. Plus, even if these [inaudible] are available, even if we know how to use them, even if we are empowered to use them to make decisions, we know how to use them, we need to be assertive and be able to insist on using them. So they will enlighten us on both areas.

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How can we protect ourselves? How can we protect our families?
How can we protect future generations, and how can we empower
ourselves to effectively advocate for prevention options that
women and girls can initiate?

After we've heard from our panel members, we'll have an
opportunity to interact and discuss use on these female
initiated options. So I hope that you are as expectant and as
eager as I am to hear what these great ladies and I must add
this great gentlemen have to share with us firsthand.

So allow me to then introduce the panel to you, not in
any order. I will start with Deborah, who is well known.
Deborah Landey, the deputy executive director of UNAIDS. She
has served the United Nations in different capacities since
1978 and has experience from diverse countries such as Botswana
and most recently served as the United Nations Resident
Coordinator for the Philippines before her current position.
And I know that Debbie and most of you don't really need
further introduction. She's a working testament herself to
most of the things that are happening in this field.

Then we have another with Professor Ruth Oniang'o, whom
I had the opportunity to meet and the pleasure to meet this
morning in a breakfast meeting. She is a nominated Kenyan
member of Parliament. She comes from academia, having served
as a lecturer in Food Science and Nutrition in Kenyatta

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University and [inaudible] Kenyatta University of Agriculture and Technology. She has also provided leadership to development programs, working with rural women and advocating for women's rights. We're glad to have you this morning.

Dr. Valerie Manda is the regional director for Regional [inaudible] program with International AIDS Vaccine Initiative or IAVI in South Africa. She is a microbiologist. She comes from an academic and scientific career, focusing on when communicable disease is controlled in developing countries. She has also had assignments with the United Nations, undertaking responsibilities in HIV and AIDS policies and research, particularly focusing on women in Southern Africa.

Then the only gentleman in the panel, Dr. Peter Okaalet, is the senior director for Health and HIV and AIDS Policy at MAP International, and is a member of MAP's global leadership team. Dr. Okaalet, a physician and theologian from Uganda has been involved in public health since 1980 and has been specializing in reproductive health and advocacy, policy formulation, research and implementation of HIV and AIDS programs. Peter was named as one of *Time* magazine's global health heroes in November 2005, so it's an honor really to have the only gentleman on the panel such a distinguished man in these areas.

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Then, ladies and gentleman, we also have Reverend Josephine Nguuh. I hope I'm pronouncing the last name appropriately. She's sitting amongst the audience. You're welcome. She's a pastor in the Nairobi Pentecostal Church, serving children and women. She is in charge of HIV AIDS issues in the church. She is also a member of the Kenya AIDS Vaccine Initiative Community Advisory Board. A teacher by training, Reverend Nguuh has been involved in advocacy for HIV issues affecting children, women and families.

We have Ms. Bernice Heloo from Ghana, the president of SWAA, the Society for Women and AIDS in Africa, and she advocates for women's rights and she made initiated prevention option. She has tremendous experience in women's health and reproductive health and HIV AIDS advocacy and care.

So we're glad to have all these people amongst us, but before I give an opportunity to them to start sharing with us what they have on this issue of female initiated prevention options, there's one special lady, a young lady that is amongst the audience, Judith Odhiambo, project assistant in UNICEF for male and [inaudible] initiative. So those ladies and gentlemen are our distinguished panelists that will discuss with us this female initiated prevention option, so that when we leave here, we are able to change lives.

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DEBORAH LANDEY: For that wonderful introduction. It's great to work alongside Daisy every day. She's one of our great international civil servants, and thank you very much for that. It's a huge honor to be here, to be in Africa again, to be in Nairobi, and to be a part of such a distinguished panel here at this historic summit, and I thank the YWCA in particular, I know it's been a lot of hard work to bring us all here today.

I was asked to say a few words today about why we need female-initiated prevention methods. So I thought I'd remind us a little bit about the impact that AIDS is having on women and girls. I just came back from Eastern Europe. In the Ukraine, 70-percent of all new infections in that country are female. And this phenomenon we see all over the world. In sub-Saharan Africa, 60-percent of all people living with HIV are female, and in Kenya, where we are today, and we know that enormous efforts are being made in this country and overall prevalence is in fact coming down.

Yet for every 10 young men with HIV, there are many more young women with the virus. So it is in this context in overall sheer enormity of numbers, let alone the human lives behind those numbers that brings us all here together this week, and I think that we must constantly remind ourselves of that reality.

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Before coming to UNAIDS two years ago, I had the great privilege of serving as the United Nations resident coordinator in the Philippines, which is a country with very low HIV prevalence. And I got to know and became involved in supporting a group of HIV-positive women in that country to try and help them and all the problems that they had. And most of them were married, were completely faithful to their husbands, had never taken any kind of drugs, did not know very much about HIV and never thought they would be at risk. And yet, here they were in that situation, and one of the phenomena we now see around the world is spousal transmission. In Thailand, for example, one-third of your infections are in marriage.

So this story of women from corner to corner of our planet, we can draw some lessons for it. Women, more vulnerable than men without engaging in high risk behaviors. Secondly, our efforts to protect women and girls from HIV are simply not enough. Thirdly, women are fighting a deadly virus as well as profound inequality and inequity, so women are facing a double epidemic.

Firstly, violence against women has reached epidemic proportions around the world. So conventional prevention strategies are not helping as much as we would have hoped. Abstain, be faithful, use condoms is not a formula that is working particularly well for women. I remember when I arrived

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in Botswana 12 years ago to serve as the resident coordinator in that country, and you drive from the airport to the center of the city, there are huge signposts all the way along the road, or at least there were in those days, ABC, abstain, be faithful, condomize, as they used to say in Habberami [misspelled?]. But not a formula that has been helpful. Because this approach teaches that abstinence until marriage can help prevent AIDS. But we're in a world where girls are married early or forced into sexual relationships. We tell women to be faithful to their partners, but their partners are often unfaithful to them. We tell them to use condoms, but we know that their partners often refuse.

Getting HIV from boyfriends or unfaithful husbands or through early marriage is done from one reality, women and girls lack control over their bodies in their daily lives and do not have the tools or resources to change that situation. And so women need more options. The option of when and with whom they have sex, to negotiate condom use with their partners, to have lives free from violence, to have enough resources to feed their families so as not to have to resort to risky situations.

And this is what brings us then to the topic of our gathering, and it's a very important one today, and that is the issue of effective microbicides and female condoms. Methods

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that women can initiate and will make a big difference for our lives. We all have a role to bring forward the day when women can have effective microbicides and better availability and use of female condoms. And here, I think it's very important to recognize that thousands of women have volunteered for clinical trials for microbicides and have accepted the female condom and its use. They've overcome fear and mistrust and have led the way for all of us, and they deserve our profound respect and thanks.

I think it is everyone's hope that with several microbicide candidates in large-scale efficacy trials, and a new generation of microbicides and [inaudible], that they could be available on that market in a few years' time. And for female condoms, we simply must do a better job of reducing their costs and convincing everybody to use them. So today, I'm delighted that our panelists here will be giving all of us more information on where we stand with respect to these two technologies.

Let me say that the international community recognizes that more resources are urgently needed to make these methods for women a reality. Partnerships among governments, the private sector and scientists are afoot and need to be boosted.

I think as Daisy said, there are other issues that we need to worry about and must never forget about, which is

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access to education for girls, literacy, eliminating violence, and we need zero tolerance of violence against women. And the role of men. And as she said, it's wonderful to see that we have men here with us today to partner with all of us in terms of how we move this agenda forward.

Just before closing, I would like to say that I am in here in Nairobi this week not only as a member of the UNAIDS family, of which Daisy is a part, but as a member of the Global Coalition on Women and AIDS which was set up a few years ago to draw attention to the impact that AIDS is having on women and girls around the world. This is a consortium of NGOs, public-private sector partnerships who have an advocacy function and an evidence gathering function, because so often when we talk about the impact that violence may have in terms of increasing vulnerability to HIV, or when we talk about the relationship between property and inheritance rights and HIV, people in the world say where is the evidence? Show us the evidence. And so we have chosen as the Global Coalition on Women to work in a number of areas to build this evidence base so that we can show these all-important linkages.

And thirdly, the global coalition works in countries and provides catalytic funding. So for example, last year, we did a groundbreaking study in this very country of Kenya on the relationship and the intersection of violence against women and

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HIV infection. So that's what the Global Coalition on Women is all about, and we are delighted to be here. Two of our members of the Global Coalition are the International Partnerships on Microbicides, and the Global Campaign on Microbicides are members of the Global Coalition, and we actually support both of them, one also with some small amounts of money.

So, ladies and gentlemen, I sense that in this conference, there is a sense of hope that with our individual and collective actions, we can and we will and we must change the course of this epidemic. We are gathered here with a sense of huge urgency and that this epidemic is having an absolutely unacceptable impact on women around the world and that now is the time to act, and I hope this morning's session is a part of that crucial action. Thank you very much.

[APPLAUSE]

DR. DAISY MAFUBELU: Thanks, Debbie, for sharing these aspects, for reminding us conventional prevention strategies are there, but they are not always helping much, so we need to do more. Now, in doing more, and ensuring that we can prevent our children from getting infected, I've asked Valerie to come and share with us what is it that we can do to prevent infecting children in case everything else has failed and we women end up being infected. And what about vaccines, Valerie? What can you tell us?

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DR. VALERIE MANDA: Good afternoon, everyone. My name is Valerie Manda. And thank you, Madame Chair Daisy, and distinguished fellow panelists and guests. And I'd like to thank you and welcome you to the session. And my chair has just reminded me that I have seven minutes in which to share with you a topic that I feel very passionately about, which is kind of complicated as well. I hardly know where to start. But please stop me when I go overboard, because I could talk all day about AIDS vaccines.

I will focus my talk on vaccines and not prevention of mother to child, and just introduce in a small way how we work with the PMTCT program. It's a great honor and pleasure for me to be here today, and we say very often in our organization, the International AIDS Vaccine Initiative, that this is a marathon and not a sprint, and as you know, if you're marathon runners, I think we're in the home of the greatest marathon runners in the world, that it takes a lot of preparation. It's a very hard drive, and especially when no one is cheering on, and sometimes people, like today, are opting to have lunch and not come and listen to more information that is available and accessible. But it's a marathon, and we're looking toward the final goal, and our final goal, our mission at IAVI is to develop, to ensure that there is the development of a safe,

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accessible, effective, preventive HIV vaccine for use throughout the world.

And as I was preparing for this discussion, I sent a frantic e-mail to Pauline. Where is she? Saying, tell me, what sort of audience is this? Is it going to be young girls, and how are we going to focus such a broad discussion to a young audience. But I'm very pleased to see that a lot of people who are in the field are here today to support our mission and this discussion on female initiative preventive strategies.

YWCA, I believe, has a lot in common with IAVI. We all believe very strongly in partnership. IAVI was founded on partnership with organizations such as World Cup organizations, UNAIDS, the World Bank, and many other private public partnerships. We are a not for profit organization, and the focus of everything that we do is AIDS vaccines for use in the developing countries, for use in countries and in people that need it the most. And this is probably the only way that we differ, that the engagement in the whole process from concept to implementation includes voices such as yours today in the contribution of this whole process from concept to implementation. We believe very strongly in engaging the south, from research, policy and even up to implementation. So I'd like to believe that we have a lot in common with the YWCA,

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except we're not young, well, we probably are young and we're not all women. So I'm very pleased that as much as we haven't engaged in this discourse on agenda-faceted approach, we have always considered the full spectrum of the population, including girls and especially girls.

And I'm very pleased that we have Dr. Peter on our panel, because as much as I believe in girls, I think boys are probably just as important, if not more important, and that when we talk about female-initiated control, we need to carry with each girl ahead as a boy ahead.

Women have always taken the forefront, I believe, in ensuring the health of families and in vaccinations. If you recall, immunizations, for those of you who are mothers or those of you who have young children remember, going to a clinic was something that you did with your mother or you took your children for regular vaccinations. Under five clinics are filled with mothers and babies. We have to learn something from that, and we have to learn how to build on that particular aspect of vaccines as we go into research and development of HIV vaccines, because it's a sensitive subject. And everyone that I meet, when I say I work with International AIDS vaccines, first of all, says when is a vaccine coming? And then the second thing is, it's so complicated. How do you translate it? Can you tell me more about it? And it's very

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complicated to do so, and I will not attempt to do so with this forum.

But what I will share is three broad areas in which we work and hope that we can have a dialogue maybe later on and if you wish to have more detailed information that you may send me an e-mail.

And the first broad area is the research and development itself, which is the core of what we do. The core work that we're here for, and it's the finite program is to research and develop an AIDS preventive vaccine. And we believe we have a new an innovative way of doing this.

We do this differently from traditional vaccines such as the pneumococcal vaccine or the meningitic vaccine, or even perhaps dare I say the HPV vaccine, because the model that we use has two arms. One is a sociopolitical arm of developing and implementing a vaccine, and the other is for the research and development. So I start with that one. How do we differ? What do we do in research and development? What's going on right now? When is a vaccine coming? These are all questions that are very difficult to answer in this short space, but what I can tell you is that IAVI has moved forward 14 new candidate vaccines from its inception in 1996 to date in several countries. And vaccine design research, as you know, as with all other drugs, takes place through several stages. The

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initial stage, of course, is the idea. The scientist has an idea, a theoretical concept based on scientific knowledge, research, and takes it forth through a number of steps. The first step, of course, is in the laboratory, in a wet lab laboratory. And here we're looking at what proteins on that virus if introduced to an HIV-negative person would incite the body to elicit a response that would be protective? That is our research question.

And in order to do this, it involves identifying the correct protein or antigen. That process in itself has taken us through I think, I don't know how many scientific partnerships alone in the world. There's an entire consortium right now, more than 100 scientists throughout the world, working just on broadly neutralizing antibodies. These are the antibodies that we'd like to say, if I could compare, if you would allow me, a lock-and-key concept. That we have a door that's locked and we want a key to open it, and when the door is opened, it would correlate to the body responding to a foreign antigen, recognition of a foreign antigen, and that lock would be the one to block the entry - it's actually the reverse. It should be locking it but we want to unlock the puzzle. That's the paradox.

Identifying and broadly neutralizing antibodies is the greatest challenge that I think that scientists are facing

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today. It's probably second only to identifying the actual antigens, the proteins themselves that would, if given to a negative subject, would elicit that response. So there's the two arms of the equation. One is the antigen, what is the antigen? The other is what is the antibody?

And then finally, I would say what would you use to measure the entire process? Has it actually happened in the way that you wish it to happen? And here, I really wish, Pauline, that I did have a slide, because I think I'll probably cause more confusion than enlighten them right now.

But let me just go on and say that is the idea behind the entire R and D process, identifying the correct antigens that would go into a vaccine, into a bottle, and identifying in the body the exact response that we could measure to say that this actually works, and that involves clinical trials. These trials have taken place in animals already. A lot of them have passed that initial, pre-clinical, as it's called a pre-clinical phase, and they're now at a clinical stage, which means that the trials are taking place in human subjects.

As far as clinical trials on a global scale are concerned, there are a number of clinical trials that are taking place, and the first results will probably come in 2008. To date, after 30 years of this epidemic, we only have one HIV vaccine candidate that has gone through the entire stage from

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concept to trial and has completed phase III trials in 16,000 subjects in Thailand. This was the first vaccine candidate based on the surface antigen called GP120. This of course didn't work. After all those years, 10 years in total, one concept to the end, 16,000 volunteers, 0 efficacy. Zero. So based on that, the idea now is not to wait 10 years with each concept. The idea is to run in parallel a number of different concepts and develop strategies in which the whole process can be rather shortened, but remain scientifically of high standards and of ethical standards.

I think the second effort of our work that I'll touch on very quickly is the policy work, and as we go forward with these parallel streams of trials that are taking place in many countries in the world, right now in South Africa, there's a drive to recruit almost 3,000 to 4,000 subjects on two clinical trials. Healthy, HIV-negative, young and old people, volunteers who are exposed to risk will be recruited in a drive that will see some results, preliminary results, in 2008.

And in preparation for this, as much as we know that it's a long process, and that's following if there were, best case scenario, a candidate that actually worked, or produced some positive results, it would still take a couple of years before it goes into licensure. It has to go through a process of review of that data and analysis to be sure that it is

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efficacious before it can be registered and then for it to be manufactured and be on the market. That whole process in itself would take at least two to three years. And this process involves receiving a market commitment from the private sector that they can manufacture this, because in the first place, the reason IAVI was born is that everyone who was conducting research was conducting it from laboratories in the West, and as you know, research is often driven by donors, as programs are, by donor desires and by donor needs and whatever their mandates are. And at the time, there was very little finance for HIV vaccines. There was not much interest either, because in any case, if you developed it, you wouldn't make a profit from it as a scientist. You'd have shared intellectual property.

Secondly, which governments would pay? How much would it cost? And today we're struggling with HPV vaccines in that they cost much and we're going to probably need an initiative or some drive from a number of partnerships to bring the cost down so it's accessible. Similarly for HIV vaccines. The whole research and development takes an enormous amount of money, enormous. And that in itself requires some sort of financial commitment and that is what determines how much effort is put into it. So we do need more finances, we do need

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more funding in order to accelerate even further and bring more candidates on board and explore all these possibilities.

So part of the work we do in policy is preparedness, preparedness for all outcomes. Matching scenarios, if we had a positive, something good comes up from the next trial that takes place and adds in a construct that is based on genetic engineering, it is not any part of any replicable HIV. The HIV vaccine is safe, has been shown to be partially effective in animals studies and in nine human studies. If it did come out to be positive, meaning good results, what next? So there's a lot of policy work in that area. And in that area, we talk to governments, policymakers, partners like WHO, UNAIDS, and to yourselves to find out how do we implement it? What are the challenges of implementation? What can we learn from Hepatitis B, HPV? What can we learn from ART rollout? There were many challenges in just rolling out treatment, and I think even if we had a vaccine today, we wouldn't be able to implement it, because the structures are still wanting, and we still need to focus therefore, on health systems development and in developing policy towards that.

And if it didn't work, of course, it means that we have others. And IAVI's strategy in 2005 took this into consideration. For the next five years up to 2010, we have a number of different constructs, but we are ready to move into

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place if what is available to [inaudible] it didn't work. So yes we're going to learn by doing and also learn from HPV access.

And then finally, advocacy. Advocacy is a very important part of what we do. In Southern Africa right now, we do a lot of work in communities, and I'm very proud to say that we are involved at every single level and I've seen young boys and girls develop the most incredible plays and dramas and dances promoting clinical trial participation, in places like Uruntu and Cape Kahn, in places like Soweto. We had traditional healers come in recently with our Board of Directors, coming in to say we support the conduct of clinical trials, we will encourage members of our community to participate in clinical trials. And I'd say also where PMTCT's concerned very briefly that in Zambia, the clinical trial design is such that we use discordant couples. So a couple, most of the time, and especially in Zambia because I think there's a very strong influence on premarital counseling through the church and through many other initiatives. Most couples go in for testing together before they get married, young couples. And we've taken advantage of this system to elicit from this population of people coming, what their status is. And when one is negative and one is positive, we call that discordance in couples, and that in itself is a great cohort.

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It's the only cohort in the entire world that we have access to and that we are going to be soon starting - in July - a phase II trials with a specific IAVI construct that will enroll some 500 to 2,000 couples, discordant couples, to test a vaccine candidate on. And we hope that through that mechanism we will support and encourage PMTCT and PMTCT Plus and we leave that to our other partners.

So I think there's a whole lot of stuff to say in one, but may I just conclude in saying that we support the comprehensive and holistic programming. I personally support a futuristic thinking and mindset. I believe strongly that we have a lot of challenges still in front of us on just basic prevention. Last year alone, 4 million people died from HIV and AIDS, and this is despite the billions of dollars that are pumped into prevention and treatment. And for every one person that goes onto treatment, seven more are infected. So we're running the marathon backwards, as far as I'm concerned, and I'm sad to say. It does sometimes feel that we're running and not winning, and the key, of course, is women.

Women have the greatest chance and opportunity to influence change, and so do men, but we do need to speak up, and we do need to spread the word, and I cannot believe that an organization such as for example the Girl Guides, with 10 million young girls on board can still say that women are left

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behind and girls are not receiving prevention. We need them to have some action. We need more people on the ground doing, and not only saying but doing what we need to do. We need more people going in for testing. We need more people, especially girls, going in for PAP smears. And everything that is written in documentation needs to be practiced.

And I'm disappointed sometimes that even active members on our community advisory boards, with all the knowledge that we share still come back and convert and become positive in front of our faces, as we are talking about these efforts. So it means something is missing. What are these social drivers? As much as I'm a scientist, I'm a simple woman, I'm a younger - I'm part of the YWCA. My career started with Girl Guides. And I think we still need to do more. We're not doing enough. Personally I think I can challenge all of us here. How many of us have taken a test this year? It doesn't have to be, maybe one. And two, I haven't had my test this year. How many of us have taken a test this year? How many of us have gone for a PAP smear?

Madame Chair and distinguished guests, I challenge you in your work to practice what we all preach. Let's all go for tests. Let's encourage others to go for tests. Let's go for PAP smears. Let's encourage our daughters. Let's talk to our families. Can we sit down with our families and also have

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scenario setting? What if you were positive today? What are we going to do? How can we plan for this?

Simple solutions as well as the more sophisticated solutions are what we need. Microbicides, you'll hear more about it. We're looking forward to results. We support other preventive technology. We support all new prevention, new and old prevention technologies that are available. We support treatment in a holistic manner. And then finally I'd just like to thank all the organizers for this opportunity, and I think it's been a wonderful occasion for me to concentrate for once on the female initiated and controlled. IAVI has not put women in a separate bracket. Women and girls are there right at the top with boys and men, and as a girl, a woman, and a mother to a son, I am proud to say that I believe that women are already in the front. I do believe women are already in the front, and I think it's a question of recognition. And my dream is to not have to separate women and men, and to say this is a female initiated and controlled, but men should be just as concerned as women about women's issues and gender need not be about women, but about women and men together, focusing on whatever weaknesses are still existing in our social structures. Thank you very much.

DR. DAISY MAFUBELU: Thanks, Valerie, for your passionate presentation and my apologies that I robbed the

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audience of hearing more of what you have to offer. I appreciate you also - we don't have much time but we need to give the people time to interact, and I'm sure that Valerie will also share in the open session about any questions that will come up. And in one way, I'm glad that something is happening, so therefore in terms of vaccines that we can see the light at the end of the tunnel. And I'm very hopeful that that light at the end of the tunnel is not an oncoming train that is coming to crash us but it's light - a ray of light that will bring hope to so many people in terms of vaccines.

Now once we know that vaccines are still way off, what else is there currently to help us? We do have cervical barriers, microbicides, male and female condoms. I will now invite Pauline to tell us more about this. Pauline works with the Global Campaign for Microbicides as a community trainer and facilitator. She's from Kenya. She works with the African partners to strengthen partnerships between communities and microbicide research teams. She has been involved in HIV and AIDS advocacy, policy and capacity building for civil society. And most of all, ladies and gentlemen, she's been force behind bringing you together in this Town Hall, so welcome, Pauline.

[APPLAUSE]

PAULINE IRUNGU: Thank you, Daisy. Good afternoon.

[Inaudible].

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AUDIENCE RESPONSE: [Inaudible]

PAULINE IRUNGU: Yes, I cannot talk alone. I need to interact with people. That's why I'm a community trainer and facilitator. I want to call upon to Bernice to come and join me because we women don't normally walk alone. They walk together, when they go to deliver and when they go to the market. So I want her to stand right next to me so I can do what I have to do.

Bernice is from Ghana, and I want her to give us the section on female condoms, so that I only talk about microbicides and cervical barriers and I can touch on male condoms. We want to try to make male condoms female initiated too. That's why we're going to talk about male condoms.

So I'll start off by talking about cervical barriers. This is very old technology. It's not new technology. But we're looking at making it be received as new technology so that people can use it, because we love new. Even when we go to the shop, what is the newest design? That's what we want. So we love new, we'll make old technology new technology.

What are these cervical barriers? These include things like diaphragms, those things are very old. They are some of the oldest contraception that we know, that we used, our mothers used, then we said, we don't want them. We want something new. So they're inexpensive, they're cheap, because

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you can have a diaphragm for two years before you throw it away. You can clean it, you can re-use it, you can use it for a long time. You can put it in and then remove it. So it makes it really cheap even for a woman who doesn't have much resources, because she only needs to clean it well and keep it. And it comes with good packaging. And there are variations. It's not just one design of a cervical barrier. There are cervical cups that are smaller. Some of them are placed where you hold so that you can remove them. But all of these work towards protecting the uppermost parts of their vaginal canal. That is the entrance to the womb. That is what we call the cervix.

I remember Florence asking, what is the cervix and where is this cervix? That's why they are called cervical barriers. So don't be intimidated by cervical barriers, [inaudible], but it just means you're covering that top part. Why do we need to cover that top part of the woman's reproductive organs? It's because it is very delicate. It is not made for very strong bacteria, very strong microbes to go up there. It's made so that it covers the entrance to the womb. And it has cells that are prone to infection. So infection is more likely to happen up there than the outer side. I think the outer side was made to be punished. Don't you think so? Yes, that's why we have vaginal sex.

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These gadgets are mainly used for family planning, but now we want to use them for HIV prevention. We want to combine them with microbicides. That's why the next thing I will talk about is microbicides. What are these microbicides?

Microbicides are very simply substances or products that you apply in your vagina and possibly through the rectum, so that you can protect yourself against HIV infection or infection of other sexually transmitted diseases. They are not yet available. They are under research, and that research requires women to participate. They most probably will come in the form of gels. What is currently being tested is in the form of gels, like - and many of us are familiar with spermicides, so they are most likely going to look like that. They could also be coming in the form of creams that you apply in the vagina. When you suffer from candida, the first thing that the doctor prescribes is go ahead and apply this cream in a tube, so we're not strangers to that cream.

It will come in the form of sponges, vaginal sponges. The microbicide will be loaded into that sponge, which is also a form of a cervical barrier, and pushed into the vaginal canal. There will also be in the form of a ring, a vaginal ring that you go to your doctor, they insert that ring, it rests at the uppermost part of your vagina and it stays there. It lets the drugs get into your system slowly and protect you.

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But they should only exist within the vagina. The research is looking at they shouldn't go into the rest of the body, because what would that mean?

Research is happening in African countries. Research is happening in developing countries. And that makes things complicated, because it means it's targeting women who many times don't have many choices. That's why the bulk of HIV infection is within these countries. Some of the countries in which research is happening for microbicides is like South Africa, Uganda, which is neighboring, Tanzania. Preparations are underway to start here in Kenya, Nigeria, and many others. I think for the purpose of giving us a picture of where we are in terms of microbicide research. We shouldn't think that it's happening out there far away but it's really happening close to us, especially for us who come from this part of the world.

But it's also happening in developed countries, that is in the U.S., in Europe, in Asia. So it's actually a global effort, because it's women who are saying we need more protection. We need more devices.

The challenge of these trials for microbicides is that they enroll or they require participation of healthy HIV negative women, and HIV AIDS is related to stigma. HIV/AIDS is loaded with fear. So before a woman can take a step and say, I want to participate in that research, they are really brave

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women. But many times there's an unrecognized - oh, these women, they are really brave. We just take it for granted. Okay, thank you for participating. What does that mean for them? Do they require support? We need to provide more services as friends, as families, we need to encourage them, as opposed to discouraging them and asking them don't you think that you might end up with something really bad happening to you? Because that happens.

So we need to encourage these women. As women, we need to talk with them. We need to give them more information. We need to organize programs that support them. Sometimes when they go for this research, they are found to be HIV-positive even before they can start on the research. What happens to them?

So those are some of the things that we need to deal with when we are talking about the microbicides. Another challenge that faces microbicides is there is not enough resources invested in doing research. And two, there are very little resources invested in doing community education, community advocacy, so that even before people go into a research center, they know why are we going here. Or even, where should we go to seek any other service in case we found we needed more services? So more funding is needed to target women, to educate women, to do advocacy, to do community work.

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They have to worry about microbicides, when they will become available, how expensive will they be? All these - the reason why I'm pulling them out is because they require the voice of women. They require the voice of grass roots organizations to push governments, to push donors, to put resources into research for microbicides and support services that go along with research.

I will let Bernice handle female condom, but before she says something, let me just say one or two points about male condoms. Their use is mainly dependent on men. That's a huge disadvantage. But the one thing I would like to ask us to keep on thinking and looking for ways is how do we develop skills for negotiation. Because if we as women don't have skills for negotiating with the men that are in our lives, we may not be able to use a male condom, we may not be able to use a female condom, it may become difficult to use a microbicide. It might also become difficult to use any other female initiated prevention. So we need to develop skills. And I think we need to develop skills not just for women who are in relationships or who are older but also to talk with younger women and girls as early as we can so that they develop these skills. I'll leave it at that so that Bernice can say something about female condom.

[APPLAUSE]

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BERNICE HELOO: Yes, thank you. I also require that you stand here while I talk for all that time. [Laughs]. Thank you very much for the opportunity, and I'm just going to talk about something that we all might have heard about or may have seen or may even have used earlier on, or before.

Can I show? Can I see by a show of hands those who have seen the female condom, so that I don't spend my time going back to it? Okay. Yes, that is very good indeed. What this means is that knowledge about female condoms is very high, and almost everybody here and I'm sure also in the larger community, have some information about its use. Unfortunately, that's why the further we know that a lot of women really accept the female condom, its use has been very problematic. And this is what I call the conspiracy against the use of the female condoms. Conspiracy in the sense that we've never had a consistent and dependable approach to promoting the device.

In some areas where women have been tried, the condoms are not available. In Nigeria, our organization, Society for Women and AIDS in Africa sent me an SOS message saying that we have trained so many women in the use of the female condom, they are ready to use them, but where are the condoms? Can you send some over from Ghana? Meanwhile, in Ghana, some of the condoms were stacked in the offices of some bureaucrats and some donors. One donor sent a message to me and said, Bernice,

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can you quickly take these things out of my office, because they were getting [inaudible], they were not used for their intended purposes.

So all over the place, people are conspiring to mitigate the work that we're doing to promote the device. A person that we also have a lot of consensus from many sectors which is known to all of us - some people talk about the aesthetic values, that it doesn't look attractive, that it makes noise, that it smells, and anything that will really put it off of its use are the things that we hear them saying. Additionally, we have this issue of patriarchy. In fact, in the African home, the men are the policy makers. They make a policy that there is no way you're going to use a condom. And so we have to grapple with men in particular and especially patriarchy.

There have also been issues raised about women's inability to negotiate for the use of the device which Pauline has alluded to already, but this is something that I'll be talking about in the course of the presentation.

Cost is also another issue. Most of argue that why should a device for a rural woman be more expensive than the male condom? In my country, the cost of the female condom is two times that of the male condom. This is really unacceptable and we have to talk about that as well. However, we can

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overcome of these challenges, you know, which I would also describe as denial. We are in denial because some of these things can be overcome.

We can train more women in the use of the condoms and training must go with accessibility. When we train, the condoms have to be accessible. So you don't train and go away for a year and come back to bring the condoms. Or, you don't have the condoms and then you don't have funds to train the people. Let me be blunt over here. We suddenly in Ghana, I had a call from the UNAPA office saying that they had taken delivery of a load of female condoms which my organization is expected to promote. And then I asked for [inaudible] condoms [inaudible]. And we have a lot of satisfied users all over the place who are ready to motivate other people. So we should not judge this mystery device saying that it is unacceptable when we have not tried our hands at a consistent promotion, consistent name. It should be up there all the time. It must be associated with capacity building. We should also ensure that our women are using local negotiation skills. It heartens me, I get frustrated when we sometimes dismiss our local women, saying that they do not have any negotiation skills. They do. In the local communities, we know how to get the men to [inaudible] cost, don't we? We don't have to say it is [inaudible], everybody [inaudible] and blah blah blah - it is

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through their stomach. We know how to cook the best meal. You know how talk to the men and they do whatever you want. So let's document those ones and build upon them and use them for our women to really have access to the condoms.

Also, my suggestion, of course, is to the fact that we should also try with the younger generation, the younger women. Those in the high schools, those in the special institutions, should be targeted with special programs. That way, when they grow up and go into my reach, they already have this culture with them, so they would be able to negotiate properly, even in marriage. And as we know, marriage is now becoming a risky business. But when we try earlier on when the people are younger, when the women are younger, then they will grow with this culture.

I must end by just saying when a woman, an Indian woman, who was asked to talk about female condoms or promote condom use in her marriage because the husband was unfaithful said - she said, "How can I start talking about condoms when I have never done that before?" So what I'm saying is that let's talk to the younger generation, and then they will grow up to promote it. That does not mean that we should also not work with the older women. And so I want to appeal to all other people here that we must not lose hope in promoting the female

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condom as we wait for the microbicide and other intervention options. Thank you very much.

[APPLAUSE]

DR. DAISY MAFUBELU: Thank you, Bernice. Thank you, Pauline, for sharing this vital experience with us. I thought when Bernice asked how many people have seen a female condom, the next question would be, how many of you know how to use it? Because obviously, if you registered for the conference across the street, you must have seen a female condom in your bag. So the answer to that question would have been almost 100-percent. But I think it's important - I think later on she should ask how many of you know how to use it? How many have used it? Maybe not necessarily for you to use it, but you are here and as people who are going to advocate are going to teach people. How are you going to explain to a woman how it's supposed to be used if you don't know how to use it? So I think it's a challenge for us. When we leave here, we need to scrape in our bags, look for that female condom, and make sure we know how to use it, so that we have power in our hands. So thank you, Pauline, thank you, Bernice.

Now I will ask Dr. Peter to share with us the current scenario in Kenya, but not only in Kenya, in sub-Saharan Africa. What is the current scenario? What can a male tell us about female initiated and controlled options? And we've just

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heard that by the way, male condoms as well can be female initiated. So please go ahead.

DR. PETER OKAALET: Thank you. Presiding Chairperson and moderator Dr. Daisy Mafubelu, distinguished panelists seated here with me in front, the YWCA, staff and organizers of this wonderful event, ladies and gentlemen, good afternoon.

I am feeling a little intimidated. I am not normally in these kind of scenarios. Maybe that's why I was given the topic scenarios, to talk about what is happening in Kenya and also what is happening in Africa. But Madame moderator, even before I begin to talk about some of the things that are on these few pages, some of you already picked up the notes as you were coming in.

I want to say that my heart goes out to women. As I speak with you, my sister-in-law, who is sick, positive with HIV, has been finding it hard to take medication and she is not just simply refusing to cooperate, but because the virus has affected her brain. So for most of the relatives that are trying to work with her to encourage her to take the medication, they interpreted that as being stubborn, not cooperative. Hence the need for all of the things that we are hearing here and the work of every one of us to put hands together so that we can work as a team, scientists, activist, theologians, leaders, men, women.

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Men make a difference, and I think that was one of the topics for World AIDS Day 2003/2004 and I say work that we are now highlighting what ladies are to be doing and what all of us ought to be doing to support them. I have three ladies that I want to point out and one of them is here. She doesn't mind standing up. Mrs. Esther Indiritu [misspelled?]. Please, will you stand up? Esther Indiritu has her own organization in Guam. She's a graduate of St. Paul's United Theological College with a master's degree in community care on HIV and AIDS supported by Mark International and the University of Wales and of course implemented at St. Paul's. She is my hero. Give her a hand, well.

[APPLAUSE]

She's Kenyan. The other two ladies are Kenyan Mary Kiloti [inaudible]. I don't know if she was able to come. Maybe not. She's been [inaudible] for those of you who know her. A little small in body, but when she begins to speak and talk about HIV and AIDS, and trained men and pastors, she's very powerful. Another hand clap for Reverend Mary Kiloti.

[APPLAUSE]

And of course, Professor Miriam Muere [misspelled?], one of our trailblazers. All of you, maybe most of you, have met her but she's not here with us. Professor Miriam Muere received an award just yesterday. She is chairman of

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[inaudible]. She prefers to be called chairman. And also chair of [inaudible] and on the board of MAP International, Medical Assistants Programs, the organization for which I work. And she travels to the U.S., several times, to attend board meetings over here. Another hand clap for Professor Miriam Muere.

[APPLAUSE]

I have other friends like Florence. I'm sorry, we'll clap for you next time. When we talk about prevention, there are two key issues that come to mind. Are we talking about reducing risk or are we talking about eliminating risk? If you are talking about reducing risk, the approach that you'll take will of course move [inaudible] those things that reduce the risk. But because you are talking about lives that are so precious, lives of our mothers, sisters, daughter, lives of men, women, boys, I think we need to be going beyond reducing and focus on eliminating risk.

Why focus on female-initiated preventions? I was at a meeting in [inaudible] in December of 2005 where Dr. Jerry Zaloff [misspelled?] presented what I thought was the justification. And as I've been listening also to our sister Debra Landi, she's talked about it - the assistant director of UNAIDS. She's also focused on why we should focus on female initiated options. Number one particularizes and specificities

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with regard to women and girls, stereotypes that are out there. Women are supposed to serve men. They're supposed to be submissive and so on and so forth. Keep your marriage at all costs, because you [inaudible] where the husband is marauding outside there and you're not sure what he's doing and bringing home, stick it to him. Men can have extra affairs, but not women. STIs are perceived by many as women's diseases, and even women sometimes believe that themselves.

Access to information is slanted against women. We've heard from many other presenters. The ABC model is not helping women to avoid contracting HIV. Why are sentinel surveys focused only on women, so that when we are [inaudible] the prevalence of HIV and AIDS for example in Kenya, we are talking about 15 tests for women who go to [inaudible], aged between 15 and 49. And then we deduce as far as Kenya, Uganda, Ghana is concerned, this is the prevalence. What about the girls left under 15 years? What about those older than 50 years? What about the men and so on?

No [inaudible], especially when you are talking about prevention, mother-to-child transmission. The mothers who we are trying to prevent passing the infection to the unborn babies and so on, are they on mandatory treatment themselves?

There are issues with public policy: violence against women, poverty, legislation, numerous gaps between policies and

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laws. Dr. [inaudible] said justice delayed is justice denied when it comes to especially rape, incest and those other kinds of vices which men inflict upon women.

So as we talk about prevention scenarios in Kenya, now I'm excited about the role that Professor Miriam Muere is playing at the national level and beyond. You have the notes, you can read through some of the things that I have said there. But in Kenya, they have coined an acronym TOWA. T-O-W-A, Total War on AIDS. Involving men, women, boys and girls and everybody else. So you spell TOWA with a capital T and O, Total War on AIDS, and then a capital W and a capital A. Right now, as we speak, of the 270,000 plus Kenyans who need ART, only about 146,000, 145,000 are receiving it. That's about half of those who need it. So we are not doing a good job. We are moving, but I think the speed is slower than the speed of the virus.

What are some of the emerging issues in Kenya with respect to prevention of AIDS, HIV? Behavior change communication, how do we coordinate and sustain the gains that we have made? How do we get men involved in the prevention of mother to child transmission? How do we accelerate the uptake and [inaudible] of ART.

We are promoting female-initiated options, but as we talk about these options, who is our audience? If it is only

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women, then we are missing out, because we have set up [inaudible] on society. So the more men, the more boys that we also have in some of our audience groups that we address, the better for all of us.

Protect the rights of people who are infected and affected. Accelerate mitigation of socioeconomic impact of HIV. In Kenya, there's lots of debate about the condom, and for those of you who are here, there's a newspaper cutting, *The Standard* of Friday, June 29th, "Catholics, AIDS Council clash over condoms." Those of you who are Kenyan, how many of you saw that particular paper? And I'm sure it has generated a lot of debate and so on. These are people at the policy level. What about the district level, the communities, the villages, the households? What are they hearing about the condom? There's still lots of debates, but all of us gathered here of course know, condoms have a role to play in the prevention of HIV.

Talking about Kenya also, what have they put into place in the strategic plan, 2006 to 2010? With respect to prevention, they are targeting the following groups, the youth, sex workers and their clients. Again, focusing on sex workers alone without focusing on their clients is just trying to solve half to the problem. Who are these clients? Where are these clients? What are they following, in these meetings like this

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and these conferences like this, are they hearing the messages that are going on there? Or are we just putting the burden again on the commercial sex worker?

Policies of the workplace, injecting drug users. Again, those of you who are here, Kenyan, do you know about what is happening to the costs and how so many people are increasingly using injection?

Uniformed forces, even as we talk about rape, we talk about incest and so on, most of the police force are men. So when women take their complaints to them and so on, the speed with which they respond goes back to what we said earlier. Justice delayed is justice denied.

Migrant workers, the fisher folk, people around Lake Victoria, and this doesn't apply only to Kenya. This applies to Uganda and Tanzania. The left side, sometimes the fisherman demanding for sex in exchange for selling fish to the women.

[Inaudible], men who have sex with men, and the elderly caregivers. In sub-Saharan Africa, moving beyond Kenya. Again as you were coming in, you could have picked up a PowerPoint presentation sheet, "A Tale of Three Epidemics." Just take a look at that, or look at your neighbor's if you don't have a copy.

The yellow line on my chart here represents [inaudible], where the epidemic, the incidence has never gone

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beyond 3-percent prevalence. The green line represents Kampala, which is the capital of Uganda. And then the red one - it's in black and white, it's not red - it just goes upwards. It's Manzini, and Manzini is in Swaziland. Within Africa, a tale of three epidemics. Why is West Africa, in this case represented by [inaudible], showing the lowest, and Manzini showing the highest? People who write books normally talk about the rise and fall of somebody, for example, [inaudible]. The rise and fall of [inaudible]. But when I look at this graph before us, as far as Manzini's concerned, it's not a rise and fall. It is a rise and rise of the virus, or the prevalence. Why? There are so many issues that apply. Another time, Madame Moderator to talk about the programming that is focused on the drivers of the epidemic.

But I wanted to go to page five of the notes as I conclude. The salient issues in preventing the spread of HIV among women and girls, and there are three of them: biology, behavior and cultural practices. If you don't have the notes as you walk out, I think Pauline helped us to print over 100 copies, you'll find out what we have talked about with respect to the biology, the behavior and cultural practices.

I want to conclude again emphasizing also what Dr. Valerie Amanda has already mentioned with respect to knowing your status. So I have put a question there. I hope you know,

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that you actually know, your status, your partner, your risk. And other risk factors that could make you contract HIV. In conclusion, I want to say Madame Chair, AIDS is not over until it is over for everyone: men, women, boys and girls. Thank you for listening to me.

[APPLAUSE]

DR. DAISY MAFUBELU: Thank you very much indeed for raising those salient points and I'm sure as invited, if you don't have the handouts, they are there somewhere outside as you come into this room on the table. The doctor really highlighted those issues which I think are quite important and also coming from a man, we hope that you are one of our advocates out there and we can get more and more men to join us in this fight.

So, ladies and gentlemen, we normally save best for last. We've nearly reached the end, but what was the end? And at this point, I would like to invite the Honorable Professor Ruth Oniang'o, who is our guest of honor, to give us a few remarks. And we know that you are very committed out there and your job is that kind of a job that makes you get in contact with people on the ground. So what are you telling these people when you meet them? Please tell us.

[APPLAUSE]

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PROFESSOR RUTH ONIANG'O: Thank you. Thank you, Madame Chair. Good morning, everybody, because you haven't had lunch. Distinguished ladies and gentlemen, I'm happy to be with you right now, and really most of it has been said by these excellent presentations. When Pauline asked me whether she could send me a paper to read - I don't like reading other people's written papers, but at the same time, this issue is so close to my heart that I know everything I want to say from the heart and it's all here.

None of what you have said here is relevant where it operates at the village level - nothing. No one knows about those female condoms, or they have gotten one in the past, tried to use it, and it was like a nightmare. But like Daisy said, maybe negotiation - you need to understand the cultural context in which you are operating. I don't know what patience there is in the community that I come from for negotiation to have sex. It's not even love making, it's have sex. My heart gets filled with tears when a woman comes to my home, she has lost her husband, she's not sure whether she's positive or negative, she's being accused of having killed that husband, and she's being bundled out of her home so that relatives can take their land or whatever was left by the husband.

When a woman comes and her children, and they say my husband has been living in Nairobi all these years, he's never

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come home for five years. We hear the woman he used to live with has died and died of this big disease. And I don't know how to say no to him. When a chief, who is supposed to be guiding the people is known to be positive, rumor has it, and is busy going around raping, but because he's the chief, nobody dares touch him. These are the realities, I'm telling you. These are the realities.

When people in Kenya say, what did he die of, what did she die of? I think that big disease. We are still whispering. We are not even calling it by its name. When we have an HIV and AIDS bill in Parliament, we have a Minister for Health who is a woman, we still can't table that bill.

Oh, you know Kenya's statistics, prevalence has gone down. I say, yes, really? Prevalence has gone down? I'm a researcher and a statistician, I'm a professor of food science and nutrition. Ph.D. in food science and nutrition. I use statistics. But now I've become politician also, and I know I can manipulate my statistics.

As far I'm concerned, in the community I come from, I've lived near this community of over 3 million Kenyans. I'm not sure what has changed. A lot of money in this country, I'm sure it takes [inaudible] GDP on HIV and AIDS. It does not reach the people I work with.

[APPLAUSE]

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When there was all this hype about male condoms, hype in my community, they used to say, if you want to enjoy a sweet. You know sweet which we talk of? You remove the piece of paper on top of it. They were free all over the place. I don't see them anymore. I remember convincing groups to walk around with the condoms, and they didn't want to, because it would go against their church beliefs and practices. Then I started to ask them, any one of you tell me who has not touched by HIV and AIDS. Then they started to carry them around. We are saying that even the female condom, let us start with young people? I have daughters. I'm a teacher of young women. AIDS has hit at the lifeline of our time. We'd better accept that. How many times do we sit down and talk about sex, negotiating? One of the biggest tragedies around where I was was when a man died, his wife died, the son died, and the house help died. So the father and the son were both sleeping the house help. When were they talking about it? You know? Until death do us part. I think only women keep repeating that. Until death do us part.

It's a tragedy. You have homes who have no - you have villages which have no adults in this country. They have been wiped out, out of homes where I come from, there are five graves, you know? Wife, man, three children, all of them dead. This is current, by the way. I am not talking of yesteryear.

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So, yes. I remember in my younger days when we were trying different methods of birth control. Condom no good, you know. Some cream, maybe, not 100-percent. Diaphragm, injection maybe. It saddens me. I'm very sorry. I've been walking in my own community for 17 years, I'm a professor for science and nutrition and the whole idea was how would we improve these people's life with better nutrition, improve agricultural yields, get rid of poverty. And we used to measure our development by looking at child nutritional status. Child nutritional status for Kenya improving up to the year 2000. And thereafter, beginning to go down. Failure to thrive? Yes. Whatever we did before has been negated by this path. And it's like a huge elephant which we can't wrestle down. So when you talk about it in a huge forum, even in church, people just sit down where you are sitting. Feeling sorry for ourselves. How do we wrestle down this animal?

So the survey we have done. What is the biggest challenge for you, people living with HIV AIDS, affected by. [Inaudible] some funding from the Netherlands which we are looking at children who are vulnerable and affected or infected, below 8 years. The biggest challenge in those households is food, food. And we know, our survey is showing that people are taking their ARVs, selling them in order to buy

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food, food. [Inaudible] of food. Food prescription, we need to talk about food prescription.

Madame Chair, I'm sorry. I'm not talking about those creams to protect women. I'm talking about our women, and that's how they survive to take care of their families and themselves. To take care of little kids who have been left. [Inaudible]. All the while, our immune systems are under threat. We didn't put up with some funding before I become a member of Parliament, put up AZT. And they told me nobody's ever going to use those AZTs. Nobody's going to come up and declare their status. But you know, I was pleasantly surprised. I now have women who have come together, they're a group. And the only qualification to be a member of that group is that you are [inaudible] and you have been tested and you agree to be continuously tested. They stick together, so they don't have to be remarried by in-laws. You know? And they can take care of their children. Because for them, those numbers give them security, a sense of belonging somewhere, not harassment.

Church - yesterday I just met the founder of Anarella [misspelled?] is it? I told him, we need this in our community. Because if we can help ladies talk about being positive, then they can also ensure that families and women are protected. Police - as members of Parliament, we are entitled

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to have security by the way. We can go to our next police station and we are assigned a security. They tell us they cannot test our people for HIV and AIDS because the incidence rate is so high among the armed forces. It is so high.

So, what can I tell you? I'm happy that we are discussing these issues at the international level. I trouble quite a bit- I talk the same way everywhere I go. I'm aware we have many many CBOs, CBOs in this country, if I take the Kenyan example, who are struggling with [inaudible] care, with issues, until they become at risk themselves. They are vulnerable themselves, because they don't have the resources to deal with that problem. I know National AIDS Control Council has tried. They give about 300,000 Kenyan schillings, however many dollars that is, to groups only once. And the rest of it is left up to you. So my appeal, really, is this.

I'm a member of Parliament just by default, you know I've been there for four and a half years. But I used to talk like this even before, so people just assumed I was going to be a politician anyway. So advocacy is so crucial. Advocacy is so crucial. We shouldn't blame anybody. The main mode of transmitting this virus is between a women and a man. And by nature, it is entrenched in a cultural context. You need to understand it. But for me most importantly, let's assist

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people to talk at that level as research goes on at the international level or at whatever levels.

We are talking of survival over generations, that we are actually losing generations. Now I am glad we are insisting that the two people before they get married must be tested. You must be tested. So let's assume it is the man who is positive. I can see the occasional woman. No, I can see the woman saying that even if you are positive, I love you, I'll stick with you. Let's assume it is the woman who is positive. [Laughs]

Even if the man wanted to, his family would not allow him to marry that woman who is positive. I came because of this issue. It's exciting, it's passionate. And I've also learned quite a bit and I've seen the passion. I think we are all passionate about this! If nothing else, it is a passion that is going to get us to have a breakthrough. But as we continue to do this, believe you me, a lot of the work at the community level is going on without money. Money is berthed here. Even what comes to Kenya it's just left at the national level. Big cars driving around, good reports, statistics and so on, but we need money, some of this money which comes in the name of helping Kenyans to really go right down to where the action is so that people can have hope. Families can have hope. And I know that the minute in my own community - the

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minute we bring spouses together, we talk to them, they begin to understand. This message that is mostly women who are infected allow the men to go around groping this thing around. They won't be infected. It's only women who are vulnerable but the men are not. What man would want to be infected, really? Shouldn't he be using a condom also? So yes, there may be awareness, but still a lot of myths. Still a lot of myths and fresh misinformation.

Thanks a lot. I'm talking at a time when you are on empty stomachs. You need to be reenergized. But I'm happy that you organized this session and to just tell you that what I normally say is that we can't lose hope, and that each one of us, I'm sure, wherever we are, because we need different strategies, so we need to look at this in different ways. And that focus is on the different ways of women protecting themselves, and for me that social protection is extremely critical and we need to address that as well.

Thanks a lot, enjoy the rest of your stay in Kenya.

[APPLAUSE]

DR. DAISY MAFUBELU: Prof, thank you very much for bringing us down to reality, sharing with us what you see on a day to day basis on the ground, for sharing with us the challenges that you see daily. And I must say, therefore, that is a blessing in disguise that you became a politician by

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default, because I think we need more of you that would be our advocate. So another round of applause.

[APPLAUSE]

Thank you. Ladies and gentlemen, we are definitely running out of time. Much as I want to include all of you, I am restricted in terms of time. I still have two people that I would like you to listen to, but that is after I've given you a chance to raise at least three questions, put questions to the panel. And I would like to strictly restrict that to three. And not three from one person. I am restricting it to three people.

I would like to invite also Florence to help me, so even those few that would like to put questions in Swahili must be able to do so. Florence is also well known to all of you, and I know that she doesn't want me to do this, but I'll do it anyway. Florence is a pediatrician based here in Nairobi. She's in clinical practice. She's the senior consultant and policy advisor of IAVI. She's a member and past president of the Medical Women's International Association, and she's a respected advocate when it comes to health and well being of women and children - not just here in Kenya, by the way, the world over.

So this one person already who is ready to put up a question. And Florence will help me to identify and line three

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people to ask those questions. So ma'am, just say who you are and ask your question please.

FEMALE SPEAKER: [Inaudible] Swahili. Is that okay? [Inaudible]. My name is Anastasia Wajuko [inaudible]. I'm a [inaudible] Nairobi. I'm HIV positive. [Inaudible] for business. I'm a businesswoman [inaudible] between Zimbabwe, Botswana [inaudible]. [Inaudible]. [Inaudible] women infected [inaudible]. That is the only word I can say today [inaudible]. We are not going anywhere.

[APPLAUSE]

DR. DAISY MAFUBELU: Thank you, the camera is for us.

FLORENCE MANGUYU: She did mix Swahili and English. So I presume you got a lot of it, but she got HIV very suddenly when she was involved in a car accident and had to be transfused. That's how she got the disease, and now she has an organization showing people how to prevent getting infection, and she's been working with sex workers, and she wants even to teach them more. But she commended the professor very highly for what the professor says and mainly on lack of resources. She wants to talk to you, Professor, later on, and I think that's allowed. So please, get to talk to the professor.

DR. DAISY MAFUBELU: Thank you for your comments, and thank you for being brave and really doing something for the rest of the people.

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MALE SPEAKER: My name's David [inaudible]. I work in the Kenya Institutes for [inaudible] in Kenya. One is to thank each of the panelists for their words that you had. I wanted to commend the professor for your acts, that the new prevention options that you have, only are available maybe in Nairobi, and are not maybe practical in the community, that is one. I also wanted to say that we all need real support in what you are doing. We need to act together with women, not fight with women.

I am born of a woman, born of a single parent, a woman, and also I am married to a woman. I am father of a daughter. So we don't need to fight with women, we need to work together with women. And we need to seek male support, because men fight with women not because they know, but they fight maybe because of the expectations of the community. Some communities in Kenya perceive a man who fights with a woman as a hero. So if you don't fight with your woman or you usually don't have many women out there, you are perceived differently.

So I wanted to ask the professor, because I saw some other day some members of Parliament who were tested. They were tested for HIV AIDS after [inaudible]. [Inaudible]. We thought maybe if the HIV AIDS Prevention and Control Act was ascended by the president, that [inaudible] by 2006, therefore becoming an act of Parliament. That now the issue is in the

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Act itself, it indicates that the Act is already commenced and therefore become operational when the minister visits the [inaudible]. So I'm asking you, I'm requesting you, to talk to the other members of Parliament. To maybe request this of the minister to give this Act a commencement date. Because the world is not waiting now for a commencement date, which we don't have. [Inaudible] we are still waiting six months later. So if you do that, you save us a lot. Thank you so much.

DR. DAISY MAFUBELU: Well, thank you. Before I allow further questions, I would like to first ask Judith Ogiambo to just briefly share with us her experiences. I think it's important that we take this question at this point in time because it might allow you to interact even more. Judith, please.

JUDITH ODHIAMBO: [Inaudible] I hope I'll manage. My name is Judith Odhiambo. I'm a project assistant with UNICEF. We're implementing the [inaudible] initiative. Before I say anything, I would like to acknowledge Mrs. [inaudible]. She has really been a pillar in my life. [Inaudible] I just got my undergraduate degree last month. I am HIV-positive. I've been positive for four years, and I was told to share my experience in prevention as a person living with HIV and AIDS.

So I'll say, every woman, whether HIV-positive, negative, young or old, we experience problems when it comes to

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negotiation with the use of condoms. And especially if they are African, they are set up. And most of the efforts I know, [inaudible] is the female condom and the male condom. I once tried this male condom. Let me say - you can try and you can manage, but I'll say that the female condom is not an easy object, especially for the first time. It's a heavy barrier, and the fact that you have to wait for a few minutes for it to conform to your body, and then [inaudible] is also an issue, the noise and all that. But I think with [inaudible] we can [inaudible]. And then the male condom. You know, we are HIV positive. We have feelings. We ought to be in relationships. But one challenge you experience, you can't go telling everyone hey I'm HIV positive. You know your status. You want to protect yourself. [Inaudible] be protected. But it's okay, everybody here is HIV-positive. How can we tell somebody, but not my sisters who are HIV-positive, I'll tell them. And they also want to be sexually active. [Inaudible] wants to affect any type.

So we the problem of convincing men to use condoms. [Inaudible], I mean you look beautiful, I mean I don't see any sign of you being HIV-positive, so why should I use this condom? I've known you maybe for two months, and I don't see you being faithful, let's just do it. I try to convince them, you know? And I'm sure there is somebody that will say fine,

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oh let's just do it. And in the back of my mind, I'm like oh my goodness, maybe I have - [inaudible] or I've infected him. The same. Then also there are some men who do not know how to store the condom. You know, they put it in their wallet, the friction, and then when it comes to the moment, they remove it and that's usually when you determine - I can't use this one. I mean, I can see it's torn or something. And they'll tell you like, this is the one I want to use. So those are some of the challenges we experience. And then we obviously know African men, they will tell you, I cannot eat a sweet in that package, you know? We find it very hard for women who are very young and beautiful, no, to tell these men, come on, I'm here to protect you. I already I have HIV, so I'm trying to protect you, but they can never, you know? Most men, and believe me most. I remember one time when [inaudible] and this girl was saying she knew her status and then she went home and told her husband, I've been diagnosed and I'm HIV-positive, and the doctors told me ABCD. And one of the As is that we have to use a condom. And the man told her that is a virus. I don't know where you got it from, but you're my wife, I'll take care of you, and I have to. It is the way it's supposed to be, you know?

So as women living with HIV and AIDS really experience problems, as much as we want to protect ourselves and protect

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those men, who may know their status or may not know their status. But a time has come when you have to say to some individual, I don't want an infection and so - it's an individual decision. Either I will use a condom or I will not use a condom. But I think when I heard about the microbicides, I've been excited about it, because I will say this is one method that women will be able to have control over. I know when the microbicide is out there, I will be able to use it, and I will not have to say every time, I am HIV-positive, and you have to wear this thing, or ABC. I'll have control over my sexuality, I'll have control over my life, my health, and I'll be able to protect them with or without them knowing.

So I am really, really so excited. I am really encouraged. The development of the microbicides [inaudible]. So that women out there can be able to protect themselves and protect their surroundings. But one thing you have to remember, we need to empower women. We really need to educate women around issues of sexuality and HIV and AIDS. And not just empowering them, we also need to [inaudible] issues around capacity building. They need to be [inaudible]. Especially when you see sleeping [inaudible] with men. It's not just choice, it's because maybe they're not economically able, and that's why they're doing that. So it cannot be just developing microbicides. We also need capacity building, resource

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generation efforts, so that women can be able to have their own means. They can be economically independent. So I will say it's really sad. I will conclude that it's really sad that at this time and age people are still dying of HIV and AIDS. It's not accessible. Thank you.

[APPLAUSE]

DR. DAISY MAFUBELU: Thank you, young and beautiful. I want to make a plea to say, really, I'm now out of time completely. So I would like to request that you reserve your questions and request my panel if they would be kind enough to stick around so that there could be interaction with the panel. I know that there are a number of questions that you would like to ask. So I would request that you do so please. And the last person that I will ask now to also share with us is Josephine. I introduced you at the beginning. The young women's perspective on female prevention options, just to share with us very briefly. Thank you.

REV. JOSEPHINE NGUUH: Thank you so much. [Inaudible] it is a privilege to share with you what I have today, and I will be talking from a young woman's perspective. Having worked with young people, working currently with children and women and mainly women living with HIV and AIDS in the church, I'm so convinced that this meeting could not have come at a better time today. The present status is that over 60-percent

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population of the world population is young and over half of these are female. It is common knowledge that this is the age that is childbearing, it is the age that is forming families and giving birth to children, and therefore, unless something is done, we are going to pass on the epidemic. I believe that this meeting addresses a very pertinent situation, very pertinent issues that affect young women in relation to HIV and AIDS.

And people say, what can a young woman do? As young women, we can do many things, and I'll just mention a few. I'll call upon us young women to uphold morality, and I mean behavior change, such as abstinence and fidelity as one major way to control the spread of the pandemic. I'll also call upon to unite with other young women to exact a positive influence, especially on peers. I also would ask us to exercise the right of speech. We have a mouth, and somebody has said that even though it is so difficult to negotiate on sex, in the African situation, a woman would definitely know how to go about an issue that is important to her. Let us be open to know and use the already available methods for further prevention of the infection and especially the condom which is already an issue of discussion, as we await other methods to be invented.

We can also speak for knowledge on HIV and AIDS, by all means. Some of us young women, very young women, are very

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ignorant on issues of HIV and AIDS. We need to leave this bracket. Let's also appoint the old age cultural practices that [inaudible] women. We [inaudible]. Let us trust one another to speak for one another, and let us forge together to move from what is past and to move forward.

We also need to acquire necessary education and [inaudible] that we are equipped with skills and are empowered, not to be taken advantage of because of our financial needs. Young ladies, let us be [inaudible] especially those for research and looking for a cure for HIV and AIDS. My appeal on behalf of the young women, to us that are here today at this meeting, and to all that can hear the cry of a young woman. It's one, please recognize that young women have special needs. We already know that women have very special needs, much more a young woman. Also, an appeal that young women will be empowered and [inaudible] that you would be invited to participate in response to the issues that [inaudible] concerning HIV and AIDS.

Young women need to be listened to, so I'm asking that we can be heard, and that we can also learn to be [inaudible] women and men can learn to give us and here because here is something that we can contribute towards the already ongoing debate. Please protect and promote the rights of the young women. Ask them to come in and take part in the -

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