

**Plenary: Taking Stock: Current Changes  
in the Global Response  
XVI International AIDS Conference  
August 14, 2006**

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**HELENE GAYLE:** Good morning and welcome to the first and opening plenary for this XVI International AIDS Conference. I am Helene Gayle, president of IAS and co-chair for this conference. It is a real honor for me to be here for this opening plenary. Now the theme today is Global Challenges in the Global Response. We have an exciting panel of speakers and moderators to introduce them, but before we begin, I'm going to call to the stage Louise Binder and Geeta Rao Gupta. Louise is going to present a very special award.

**LOUISE BINDER:** Good morning. On behalf of the International AIDS Society and the International Center from Research on Women and the International Community of Women living with HIV/AIDS, I am delighted to present the first \$3,000 Young Investigator Prize for women and girls and HIV/AIDS to Penelope Campbell of Jamaica. [Applause].

This prize recognizes a young woman investigator from a resource-limited setting whose work demonstrates excellence in research and/or in practice to address gender related issues and special vulnerabilities of women and girls in the AIDS epidemic. Ms. Campbell, working with UNICEF in Jamaica, has successfully planned and implemented HIV prevention programs targeting high-risk behavior among key groups, including at-risk adolescents and sex workers. She has developed prevention services including drop-in center for sex workers and youth

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information centers and youth friendly spaces for adolescents to access information, services, and skills-based counseling.

The three organizations sponsored the prize to highlight the need for women to play a central role in developing an understanding of this epidemic. Penelope epitomizes the hard work, commitment, and skill that thousands of women researchers demonstrate in order to shed some light on ways to reduce women's vulnerability in this epidemic. Congratulations, Penelope Campbell.

**PENELOPE CAMPBELL:** Thank you.

[Applause]

**HELENE GAYLE:** Thank you Louise and congratulations Penelope. This is an incredible first award that really does recognize the important work and research focused on women and HIV/AIDS. I would now like to introduce the moderators, and I will turn it over to the moderators for the rest of the session. The first moderator is Dr. Lieve Franssen, who is the head of Human Development for the European Commission and the vice chair of the Global Fund for AIDS, TB, and Malaria. She is also a major funder at this conference and through the European Commission has been a consistent funder for this conference. We thank you for your leadership and support.

The second moderator is Dr. Jack Whitescarver, NIH associate director for AIDS research and director of the Office of AIDS Research. As many of you know, Jack Whitescarver has

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been a long standing supporter of AIDS research but also a long time colleague in the fight against HIV and AIDS.

The third is Dr. Nils Dauiaire who is president and CEO of the Global Health Council, a leading worldwide alliance of health professionals. Dr. Dauiaire has been, and the Global Health Council, given major contributions in their work here at the International AIDS Conference over the last few years.

Finally, Dr. Geeta Rao Gupta who is president of the International Center for Research on Women. A research and advocacy not-profit based in Washington, D.C. and a real true leader in the fight against HIV and AIDS, specifically with a focus on the issues of women's vulnerability.

So, we have a wonderful panel of moderators, a wonderful panel of speakers, and I will now turn it over to Lieve Fransen. Thank you.

[Applause]

**LIEVE FRANSEN, M.D.:** Good morning everybody. Does this work from here? Yes, okay so then I am very happy to personally also welcome everybody here today after long trips for some of you. This is a very challenging conference and I hope it will make a difference for the world. I am very proud to be here for the European Commission but also as the vice chair of the Global Fund. And I am very honored to chair this first session and introduce the first speaker.

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The session is Taking Stock on Current Challenges in the Global Response. The first speaker I am honored to introduce is Chris Beyrer. He is professor of Epidemiology and International Health at the Johns Hopkins School of Public Health. He is also the founder and the director of Central Public Health and Human Rights in Johns Hopkins. He has a very distinguished career. A lot of publications, a lot of books, research that I'm not willing to go into details about. Further full information is also available to you in the binders. He is very much involved for the moment in international training and research and authoring several books such as *War in the Blood: Sex, Politics, and AIDS*.

He will present to us an update on the epidemiology of HIV and the transmission factors and the structural and ground of transmission in the different regions and the different epidemics. Chris, thank you.

[Applause]

**CHRIS BEYRER, M.D., M.P.H.:** Thank you very much, Madame Chairperson and good morning ladies and gentlemen, friends and colleagues. I would like to thank the IAS and the organizing committee for the invitation to speak to you today. And also to say what an honor it is to address this wonderful gathering of our community.

Our topic is HIV Epidemiology and Transmission Factors on what could be called risks and risks contexts for HIV. I

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would like to begin by highlighting three core themes of this presentation. Individual level risks for HIV infection remain at the core of ongoing and emerging epidemics but the pandemic is increasingly diverse. There is evidence of declining incidents in some settings but of ongoing spread in others. For some populations and regions, the HIV/AIDS epidemic is just beginning. Social and structural risks are the context for HIV epidemic spread or control and understudy correlates of risk and protection include human rights context, access to evidence based prevention services, and supportative or undermining policy environments. The third decade of AIDS has been marked by emerging epidemics and new regions of spread across central Asia and the former Soviet Union, by MSM spread in high and low income country setting, and by ongoing spread in the generalized epidemic of Southern Africa.

What I would like to do this morning is explore these three epidemic contexts with you looking at individual level risks and at the social and structural drivers of these ongoing epidemics and to ask why despite all we know in 2006 these epidemics continue to expand. These data are courtesy of UNAIDS and show an estimated 38.6 million people living with HIV in 2005, 24 million of whom were Africans. So 4.1 million people acquired HIV last year and 2.8 died of AIDS. This conference will highlight many tremendous advances in AIDS treatment and

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care but our focus here will be on the several million incidents of new infections.

Looking at these UNAIDS data map, its clear that HIV remains highly unevenly distributed both globally and within Africa. The fastest growing epidemics in third decade have been in the former Soviet Union, the FSU, with an estimated 1.5 million people living with HIV, 200,000 of whom were infected last year and largely among IV use. South and Southeast Asia have been the most affected regions after Africa with diverse epidemics in heterosexuals, men who have sex with men, and IDU. Southern Africa, our third case study, remains the most affected region with 12.1 million infections. That is roughly a third of all people living with HIV worldwide in this small region. This epidemic already so severe continues to expand.

Before we look at these three case studies, a word of caution about epidemic trends. These data are from Pisani, et al, and they look at prevalent and incident infections by risk exposure category in the epidemic in Indonesia. Looking at prevalence, in light blue, the rates in sex workers and injection drug users looking roughly the same but new incident infections were overwhelmingly in injection drug users. We need incidence data to see where this virus is going and we rarely have it. And we still urgently need a reliable measure to assess recency of infection.

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Let's go on then to the first case study which is the emerging epidemics in Eurasia. Injection drug users accounted for an estimated ten percent of new infections globally in 2005 but for 30-percent of all new infections outside Africa. In 2006, 27 countries had reported one or more sites with over 20-percent infection in injection drug users use, an emerging epidemics include Russia and Ukraine, a number of central Asian states of the former Soviet Union, Iran, Nepal, Indonesia, Libya, and Mauritius. A number of other African states have now reported some injection drug user risks.

Individual level risks for HIV infection among injection drug users are well characterized in the literature and generally consistent across these epidemics. These risks include: needle sharing, injection frequency, cocaine injection, not being on substitution therapy, MSM, injection drug user history, and injection use while incarcerated. These individual level risks have led to explosive epidemics and here we see UNAIDS 2006 data showing the steeply rising infection curves for the two largest epidemics in this region, Ukraine, now the highest prevalent state in Europe, and Russia. Eighty-seven percent of accumulative infections in Russia are due to injection drug use and 68-percent in Ukraine.

So, what are the structural drivers of these epidemics? There are at least three: heroin, itself; lack of evidence based prevention in heroine use zones; and punitive and

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repressive approaches to IDU. Let's start with heroin. In 2000, we reported on the relationship of HIV spread to overland heroin trafficking routes out of production zones in Burma and Laos. This work demonstrated that Burma's heroin exports were central to HIV spread in the region and along heroin routes into China, India, Thailand, and Vietnam. At that time, Burma was the world's leading producer; today this is Afghanistan. This is most recent data available on seizures of opiates in kilograms and the larger the ball; the more opium has been seized. At the time of these data from 2004, Iran seized more heroin than any other state, followed by Afghanistan itself. The central Asian states around Afghanistan have experienced a 17-fold increase in opiate use from 1990 to 2002. And Iran alone has an estimated 200,000 injection drug users. Burma and Laos remained significant producers.

These are Afghanistan poppy pods and that is not a farming implement. These are UNODC data from 2006 on opium production in metric tons. Production has increased over the last 25 years except for 2001 when there was a faquat [ph] of the Taliban regimen at the time, but has continued to increase. The 2005 crop was estimated at over 400 metric tons of heroin, that is 60-percent of the global total.

So, what does this mean for HIV? Well both the Bush and Carzi [ph] administrations are on record that drug control in Afghanistan will take year to decades. So, drug treatment and

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HIV prevention have to be implemented now and everywhere these tons of heroin are being trafficked.

The second driver of these epidemics has been the limited use of prevention measures with demonstrated efficacy for injection drug use transmission in these very zones. Dr. Whodack[ph] is going to address the evidence for IDU prevention in the Harm Reduction Plenary but here we will say that the evidence supports methadone maintenance therapy, harm reduction including needle and syringe exchange, and peer education and behavioral interventions.

So how are we doing? Here we see the proportion of injection drug users in the former Soviet Union region reached by needle and syringe exchange. Overall, the rates are very low everywhere except perhaps Kyrgyzstan. It is important to keep in mind that UNAIDS recommend 60-percent coverage for effective prevention in IDU epidemics. Globally, we reach less than ten percent of injection drug users with prevention services in 2005. These limits on prevention for IDU are not simply questions of resources but are also structural. Despite the scientific evidence, the US continued the federal ban on funding for needle and syringe exchange both in the US and globally, although PETPAR will support methadone maintenance therapy for injection drug users. Methadone maintenance however remains illegal in Russia and most of the former Soviet Union and generally, limited to pilot programs across the region

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where it is needed most and as with prevention so with treatment.

A recent review looked at injection drug user access to antiviral therapy in 50 low-income countries and found that only about 34,000 injection drug users were on ARV, 30,000 of them were in Brazil alone. That's 88-percent of the total. When we talked a rights based approach to health, this is what we mean. Brazil's universal access to ARVs really is universal and does not discriminate against injection drug users. Too many countries do.

How do punitive policy environments drive risk? Incarceration may be the most extreme example. Drugs can be widely available but injection equipment is scarce. And this we have seen in Thailand, Iran, and Afghanistan in recent reports. What mechanisms are at work? Well increases in risk for HIV acquisition in incarceration, increases in syringe sharing among drug users during crackdowns, decreases in attendance at voluntary drug treatment and needle and syringe exchanges due to police surveillance, and decreases in use of services if registration as a drug user is required. This is seen from a recent report from Ukraine. This is a photo from Ukraine and shows criminalization of a drug user in a medical facility, but I would note that one important structural form has happened. Last year methadone and buprenorphine the two key drugs for substitution therapy were added to WHO's central drug list.

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Our second case study is risks among MSM. Men who have sex with men have been among the most affected groups in high-income countries since the epidemic was identified 25 years ago. Now this is still true in the US. These are data from Dr. Espinoza of the US CDC looking at the HIV infection trends in the 33 states with named reporting. What we see are significant declining trends, this is one of the epidemics that is in decline in heterosexuals and for injection drug user exposure in the US, but no decline in MSM and in this sample of 33 states, overall 61-percent of new infections in the US were among MSM.

In 2006, there is also evidence of emerging and concentrated epidemics in low-income setting among MSM. Here we have compared published reports on rates of HIV infection among MSM an estimated national adult prevalence from the UNAIDS 2006 data. Its striking that several of the countries shown here including Senegal, Cambodia, and Thailand are well known for early successes in controlling HIV among heterosexuals. But the rates are markedly and consistently higher in MSM against backgrounds of low general population prevalence. We see this in India, the US/Mexico border, Peru, Argentina, and Ukraine. These data I would argue suggests we strongly need more MSM targeted interventions.

Individual level risks for HIV are similar across high and low-income setting. Unprotected anal intercourse, lack of

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circumcision in one US study, frequency in number of partners, injection drug user risks, and use of non-injection drugs mediated to increase sexual exposure, particularly methamphetamine. In the US, African American MSM have had markedly higher HIV rates. A recent five city study found overall 25-percent of MSM were positive but 46-percent of black MSM and adjusted out to ratios for black race range from two times higher than other ethnic groups to nine times higher.

Millett et al reviewed the literature on black MSM and the hypothesis for these higher rates. And this may really have bearing on the global side, on the developing country, MSM epidemics. The data did not support that black MSM had more high-risk sex or more drug use risks. The literature do support more sexually transmitted infections, especially syphilis, and that black MSM were less likely to have HIV testing and to know their results. There was insufficient data on circumcision and one positive study each supporting sexual network factors as leading to this increased risk in incarceration as HIV risk particularly for black men.

These data are from Fritz Van Griensven with a CDC collaboration in Bangkok looking at Bangkok MSM. They used venue daytime sampling at MSM venues in 2003 and again in 2005 and found consistent increases across all age groups. HIV rates in the youngest MSM increased from about 13-percent to 22-

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percent over this two year period indicating really very high incidence among these young men.

What are the drivers of structural risks in this context or in these contexts? Well, criminalization and stigma limit MSM access to HIV prevention treatment and care. This is broadly true across many developing country regions. MSM are markedly understudied in these emerging contexts. So for example, they are not included in the Thai National Surveillance or in the National Surveillance in Vietnam or in Senegal. This is really where we have the one study from MSM in Africa. Fewer than one in ten MSM worldwide have access to necessary prevention services.

Our third case study is the southern African epidemic. Here again we see the 2005 data map. This epidemic is markedly more severe than the rest of Africa and it is the one that is continuing to expand. These data show the south with stable or increasing rates of infection at very high levels. Then the east, west, and horn of Africa again in data from UNAIDS show evidence of decline or stabilization at consistently lower rates. We do not have a single causal explanation for this divergence but there are some features of the southern African epidemic, which may help us, understand this unique epidemiology and the special challenges that people of this region face.

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These data are from the recent National South African National HIV Survey and show some of the key features: strong female preponderance, very high rates of infections overall, and marked gender differences in younger girls and women already three fold higher in boys at age 15 to 19, and reaching over a third of women by age 29.

How do we explain this? Well, individual level risks for transmission include not using condoms, blood, and now genital viral load in acute and early infection. Male circumcision was found to be protected in the first observational study from South Africa and two other trials are underway. HSV-2 and other STIs, cervical ectopy, all play a role. There is some plausibility to ARV in reducing infectiousness; clearly, this is the case in vertical transmission.

Acquisition risks include lack of condom use, viral load, lack of circumcision, ulcerate disease, and STI. There are some additional risks, which have been found to be associated with HIV infection in the southern African context. These include marriage, from a Zambia study, intimate partner violence in South Africa, early coital debut, concurrency of sexual partnerships, and labor migration from both genders in data from South Africa.

One important driver does appear to be the extensive labor migration in the post-apartheid era and the sexual

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patterns, which developed from it. This association between labor, sexual patterns, and STI was first reported by Kark in 1949. Some good ideas stick around. Lurie in [inaudible] identified a pattern of recurrence of circular migration, which increased risks for both men and women. And migrant men in their study were about 26 times more likely to be infected by an outside concurrent partner than a spouse. And this mobility in migration really is a regional phenomenon. There are some 2.5 million migrants from other countries working in South Africa and a recent influx of displaced people claimed Zimbabwe.

We put this together in something of ecological model for risks in this context. Again, with individual level risks, condom use, circumcision, HSV-2 at the core. And then moving outwards and into a relational risks like STIs, labor migration, and concurrency. A community level with autonomy of women, stigma, and VCT and ARV access. More of a political level, an overarching contextual level of human rights, and the condom gap that I am going to get to. And finally all of this really needs to be seen in the context of this advanced and ongoing epidemic stage.

There is one more structural gap that probably is important from this southern African context and that is the condom gap. We still have a significant gap between global distribution and need. For Africa, the current availability has

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been estimated at three condoms per man per year so we are about 1.9 billion condoms short.

In summary, then individual factors are key targets for HIV prevention but structural realities remain powerful drivers of these epidemics. While decision makers may have limited availability to change individual behavior, they can change their own behavior. It is indeed time to deliver on structural intervention that we know work. Where HIV spread is driven by lack of prevention services and by undermining policies which aide and abet the virus and not those at risk for it, we risk failing again to respond to AIDS.

I have several conclusions. I think one is to say that evidence based prevention services are human rights and have to be extended to injection drug users, MSM, and girls and young women if we are going to improve the structural context for reducing individual level risks. The epidemiology tells us that means going to scale with evidence based prevention for injection drug users including needle and syringe exchange programs, expanded drug treatment and prevention in prisons, recognition of the rights of MSM to services, dignity, and protection from harassment and discrimination, and sexual and reproductive access in choices for African women and girls. And clearly this is one area where we need to expand those choices to include things like microcides, oral preventive therapies, and hopefully an HIV vaccine.

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Finally I would like to acknowledge the many investigators who contribution to this talk. And I would like to thank all of you for your attention and for the wonderful that you do. Thank you.

[Applause]

**JACK WHITESCARVER, PH.D.:** To continue with the program, its my great pleasure to introduce Dr. Julie Overbaugh. Dr. Overbaugh is a member and associate program head of the Fred Hutchinson Cancer Research Center in Seattle, Washington. Dr. Overbaugh's work focuses on various aspects of HIV-1 transmission and pathogenesis and is noted for its emphasis on translational research. For the past twelve years, she has worked closely with Kenya Seattle Collaborative Group conducting a number of studies of mother to child transmission of HIV-1. Her collaborative studies have demonstrated that the viruses that evolve over the course of infection are more pathogenic in part because they have escaped neutralizing antibody control. She has made major contributions in the area of transmission of HIV to women. Her work has produced crucial findings demonstrating that the genetic diversity of the virus in women is much more complex than early viruses seen in men or in infants. In particular, her group has demonstrated that women with sexually transmitted diseases are women who use hormonal contraceptives are more likely to have diverse

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viruses. Recently her work has highlighted that women who are HIV-1 infected continue to be at risk for reinfection.

She served as editor of *The Journal of Virology* and is the organizer of several international meetings. Her work has been recognized by an Elizabeth Glaser Scientist Award and by a Merit award from the NIH. She has played an important role at the National Institutes of Health having served as chair of the NIH grant review panel on the molecular biology of HIV-1 and as a member of the Office of AIDS Research Advisory Council for which I am especially grateful. We look forward to the presentation on HIV Transmission and Pathogenesis: A Viral Perspective. Dr. Overbaugh.

[Applause]

**JULIE OVERBAUGH, PH.D.:** Thank you. I would like to thank the organizers for providing this opportunity to discuss what is known about the current understanding of the biology of HIV transmission. In the case of an HIV exposure, we know that the risk is not identical for each individual nor is the risk identical for that same person when they have exposures.

Today I would like to talk about the host and viral factors that contribute to these differences. And I will discuss what I perceive to be the challenges and opportunities in this area of HIV research.

Host factors, which I will discuss, first are of importance because the characterization of these factors may

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allow us to manipulate or mimic those that play a role in blocking HIV infection. Host genetics have been shown in many studies to contribute to susceptibility of HIV-1. This is perhaps most clearly demonstrated by mutations in the primary HIV co-receptors CCR5. CCR5 plays an important role in allowing entry of the virus into the host cell, particularly virus strains that are transmitted from host to host. The most notorious CCR5 mutation is  $\Delta 32$  [Delta 32]. This is a 32 base protein deletion in CCR5 that renders it defective. People who have this deletion are therefore not susceptible to infection by most strains of HIV-1. Other mutations that alter CCR5 levels or the levels of proteins that block HIV binding to CCR5 have also been implicated in impacting susceptibility to HIV-1 as have many other genetic markers.

Modifiable host factors are also important in determining susceptibility to HIV-1. These were covered a bit in the previous talk and will be discussed in much more detail by others. I call these modifiable because in contrast to host genetics these factors are ones that could potentially be altered by intervention. One such factor, the presence of a sexually transmitted disease, has been linked to increased risk of HIV acquisition. In men, there is more and more evidence that lack of circumcision increases their risk of HIV acquisition and I think this will be a topic of much more discussion at the conference.

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In women, several studies have shown that hormonal contraceptive use puts them at increased risk of HIV acquisition including our own but this has not been seen across all studies and therefore is a topic that requires additional research.

One of the most exciting discoveries in HIV field in the area of biology of HIV has been the discovery in the past few years of innate antiviral factors. These are proteins that are present in some cells that block HIV replication in those specific cell types. These so-called restriction factors TRIM5a and APOBEC3G act by blocking the virus after it enters the cell. Thus the mechanism of action of these proteins is akin to some of the currently used antiretroviral therapies where the goal is to stop the virus from becoming a permanent part of the host cell and thereby stop the process of producing more viral progeny [misspelled?]. The TRIM5 protein protects some non-human primate species from HIV infection. For example, the TRIM5a in cat monkeys blocks HIV replication in the manner I just described. This in part explains why cat monkeys are not susceptible to HIV-1. In contrast, the human version of TRIM5a does not block HIV-1 infection. Thus, the TRIM5 restriction of HIV is specie specific.

The human form of APOBEC3G does block HIV infection and although this protein blocks it at same stage in virus replication as TRIM5a, it does so in a very different manner.

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The stage of APOBEC3 restriction is set in the cell that makes the virus particle, the producer cell. If that cell has APOBEC, APOBEC can be included in the virus particle and if that virus particle infects the next target cell, the infection is blocked after entry by APOBEC. However, HIV has a very effective way to counter APOBEC3G and that is the Vif protein. Vif is present in the producer cell and expressed by the virus, blocks incorporation of APOBEC3G in the viral particles thus these viral particles are infectious for the target cell. Vif is there for antiviral resistance factor of the virus that counters an antiviral resistance factor of the host.

These discoveries provide a lot of challenges and opportunities for the field because natural antiviral factors provide a window into the vulnerable points of HIV-1. we may be able to use this information to design new therapies to block HIV infection by finding ways to keep Vif from countering the natural human antiviral protein, APOBEC3G, and by mimicking the TRIM5a proteins that naturally block HIV infection such as the TRIM5a found in the cat monkeys.

I would like to discuss a fourth host factor and this is actually a host factor and a viral factor that may play a role in susceptibility to HIV-1. That is the role of pre-existing HIV infection in blocking subsequent infection by different partners. A process called super infection. Here the question is, is there a difference in HIV susceptibility

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between somebody who is already infected and someone who is not. This is an important question in determining whether the immune response that develops in natural HIV infection are ones that would be desirable to elicit by vaccination.

There are several case reports of super infection published several years ago. One of the first case reports was an individual who was infected with the subtype AE virus. And about two and a half years later, a subtype B virus was detected in this individual. The timing of this super infection was quite clear because the subtype C sequences were characteristic of subtype B sequences found in Brazil. And this person has just been on holiday there and admittedly had several high risk encounters.

This raised the important question are these cases rare or is reinfection by HIV common. And there is in fact limited data that addresses the risk of reinfection or that defines when reinfection occurs after the first infection. This is a significant question because of if superinfection occurs early after the first infection it may be at a time before their HIV specific immune responses, which are shown here with lines CTL and antibody. However, if superinfection occurs late into the first infection for example, as in the case I showed you, it may be doing so despite immune responses to the first HIV strain indicating that those specific immune responses were not beneficial in protecting against HIV infection.

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We have begun to examine the incidence and timing of superinfection in the prospective HIV negative cohort in Mombasa, Kenya. This study is part of the Seattle Kenya collaborative research project. In this cohort, the time of infection has been defined by regular serology and RNA testing, allowing us to precisely define the date of infection. There are now about 80 women with greater than five years of followup after the first infection who are enrolled in this cohort. We have now examined 57 cases in this cohort. We start by analyzing viral sequences soon after seroconversion. We then analysis sequences three to five years later. For cases where the sequences differ and suggest reinfection, we analyzed sequences in-between using multiple methods.

This slide summarizes the data from one individual. The top panel shows the viral load profile of that individual and at the bottom of that panels shows the days post infection where we analyze viral sequences. The table below summarizes the results of molecular analysis by three different methods. What you can see is that the first three time points tested up through 264 days after the first infection. We detected only a subtype B virus. Starting at 385 days post infection in this individual, we began to detect the subtype A virus. This subtype A virus and the D virus were consistently detected from that point forward in this individual. Therefore, we assume that this person acquired subtype A virus somewhere between 264

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and 385 days post infection. This is a case of an individual being superinfected in that by an intersubtype superinfection, that is infection by two different subtypes.

I summarized that exact same data on this slide in a different manner to prepare you for future slides. Here the interval that we defined in that individual case is shown as the pink bar. We have now identified eight cases of superinfection among 57 women and here I show you the estimated intervals of superinfection in these individuals. The pink lines are cases of intersubtype superinfection and the light blue lines are cases where the subtype of the first and second virus was the same. The estimated interval and thus the length of bar in this diagram varies depending on the samples we had available for analysis. But what you can see is that while many of the cases clustered in the first year or so after the first infection. There are examples of cases of superinfection that appear to occur two to three and up to five years after the first infection.

I have superimposed on that data from other studies that were published where there was the estimated time of infection was provided. Here again you can see that there are many cases that occurred early after the first infection but there are cases that also occurred much later. This sample size is clearly too small to tell whether the risk of superinfection varies over time after the first infection. But it does suggest

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that superinfection is occurring once the host has had time to develop antibody and CTL responses to the first virus.

Thus, there are a number of challenges and opportunities here. The first is determined if HIV infection reduces the risk of subsequent HIV acquisition and if so, when. In those who become superinfected what immune responses are lacking or impaired? Those that are lacking maybe be important immune responses through elicit vaccination whereas those that are present are ones that probably are not important responses for developing an effective vaccination since they weren't effective in blocking HIV infection in this setting. In addition, I think its important to define the clinical consequences of superinfection so that HIV positive people can be wholly informed regarding the impact of reinfection on their disease progression and preliminary studies of small number of subjects suggest there maybe some impact on progression with the second infection.

Now I would like to turn to viral factors. These factors are important to study because characterization of them may allow us to identify an Achilles heel in the virus to target with a vaccination, microbicide, or other intervention. We know that higher viral load in the index case increases the chance of transmission whereas exposure to lower levels of virus is associated with a reduced risk of infection.

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This has been shown for heterosexual transmission in discordant couples as well as in the setting of mother to child transmission. I should say that most of these studies have focused on cell free virus levels that is viral RNA levels in plasma what you hear referred to as plasma viral load. This raises the question is the cell free form of the virus what is most important or is the cell associated virus that is the infected cell itself also important in determining transmission outcome. Both cell free and cell associated HIV levels in breast milk have been shown to collaborate with mother to child transmission. Interestingly cell associated virus remains an important correlate even after controlling for cell free virus levels.

And that data from studies in the Nairobi clinical trial, breast-feeding clinical trial, are shown in this diagram. Here the cell associated virus of non-transmitting and transmitting mothers were compared and the transmitting mothers had significantly higher levels of cell associated HIV. This is of interest because recent studies suggest that in breast milk, antiretrovirals may have less effect on reducing cell associated virus than cell free virus. Much of our understanding of the effects of antiretrovirals was derived from studies of blood and plasma. And these studies of breast milk while preliminaries suggest that the findings from blood and plasma may not extend to other compartments. Thus if we

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want to predict the impact of antiretrovirals on transmission risks, we need to know whether cell free or cell associated virus is more important in transmission and how different antiretrovirals impact both types of virus in relevant compartments.

Finally, I would like to discuss the features of the virus itself. The virus variants that are transmitted are a small subset of those present in the index case suggesting there is a bottleneck during transmission and implying that some virus may be more fit for transmission. This hypothesis is supported by the idea by the observation that transmitted virus most often require the CCR5 co-receptor for entry into cells and virus that use the alternate co-receptor, CXCR4, appear to be less favored for transmission. In addition, recent studies have suggested that transmitted viruses tend to be among those with less glycosylation on their envelope protein.

Glycosylation prefers to sugars that are on the outside of the viral envelope protein that create in effect a shield as shown here. These will vary in number and position on the protein depending on the viral strain.

Selection for less glycosylated viruses were first illustrated in a study of eight initially discordant couples comparing viral envelope sequences from the donor, in green, to the recipient in blue. Here you see that the recipient viruses have fewer glycosylation sites than the donor viruses. This has

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been shown for mother-infant transmission in a study of 12 pairs who were part of the Nairobi trial. Again, the recipient in this case, the infant, shown in blue, has viruses that have fewer glycosylation sites than the mother variance. So, selection for viruses with less glycosylation has been observed now in several studies but we do not yet know the biological basis for this selection.

Thus, there are a number of challenges and opportunities beginning with why are viruses with fewer glycosylation sites favored for transmission. What are their biological properties that impart this transmission fitness and do they have an Achilles heel? If certain viruses are more successful at spreading than it is critical that candidate interventions that target the virus be tested against such strains. And this is particularly relevant for screening microbicides and vaccines and any interventions that are designed to target and disrupt interaction of the virus with the host cell.

Because animal models are also an important tool for screening such interventions, we need better animal model system that mimic these transmitted strains. In that regard, encouraging data was presented at a recent Keystone meeting describing a SHIV encoding a subtype C HIV envelope from an infant early in infection. This is the first virus that can infect in a cat that codes a recently transmitted HIV envelope.

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There is still much to be learned about the host and viral factors that contribute to the defining the risk of HIV infection but recent discoveries such as the restriction factors, APOBEC3G and TRIM5a and other factors of virus such as their glycosylation pattern provide new insights into potential vulnerabilities of the virus. But other studies such as those suggesting the superinfection maybe more common may force us to reassess some of our old notions that HIV infection protects from subsequent reinfection.

Finally, I would like to acknowledge for the members of my research team at the Fred Hutchinson Cancer Research Center who contributed to some of the data I showed you, my long-time collaborators at the University of Nairobi, the University of Washington and Coast Hospital for their contributions to the work I discussed. And finally I would like to thank you all for your kind attention.

[Applause]

**NILS DAULARIE, M.D., M.P.H.:** The science is critical but equally critical is the social and political context in which AIDS take root and spreads. Starting with the Durbante [ph] AIDS Conference in 2000, the Global Health Council has been honored to sponsor the Jonathan Mann Memorial Lecture. Jonathan was a pioneer in the field of AIDS first working in Crowetceta [misspelled?] and Kinshasa in the early 1980's then the founding director of the Global Programme of AIDS at The

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World Health Organization, which was the predecessor of the UNAIDS, then the founding director of the Francois-Xavier Bagnoud Center for Health and Human Rights at Harvard University.

What's striking about Jonathan was that he started as a classical scientist, a clinician, an epidemiologist but he became one of the first among us to recognize that AIDS is inextricably connected to the recognition of human rights, that AIDS could not exist in a world in which human rights are truly respected, and that the abrogation of these rights provides HIV with its preferred pathway to spread and devastation.

Jonathan was killed along with his wife Mary Lou Clemens-Mann in the crash of Swissair Flight 111 in 1998. But he left behind something that cannot be stopped. We are honored today to have the Jonathan Mann Memorial Lecture presented by a giant in the human rights movement in India. Anand LaNash [misspelled?] Grover.

Anand is co-founder of the Lawyers Collective in India and director of the Collective's HIV/AIDS Unit in Bombay. He has worked extensively in the arena of legal rights and protections for persons living with HIV/AIDS, campaigning in the courts from employment security for those infected, for the rights of sex workers, intravenous drug users, men who have sex with men, and other vulnerable groups, and for the critical

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role of low price generic drugs in the right to fold and equal access to care.

He and his organization have been central to the development of a proposed new HIV law for India. I asked him this morning where his rather British name came from and he told me that was Angloization [misspelled?] of a traditional name of the guardians of the Seek Temples. Today Anand is a guardian before the temple of legal and human rights for all. Please welcome him here today to speak about human rights and social vulnerability.

[Applause]

**ANAND GROVER:** Thank you very much Nils. I thank the International AIDS Society and the local hosts and other organizers of this conference for giving me the opportunity to present the Jonathan Mann Memorial Lecture in this plenary session of the conference.

Indeed it was Jonathan Mann who more than anybody else understood the vulnerabilities of the sections of society to HIV and how the epidemiology of HIV is partly determined by these vulnerabilities as also the importance of human rights in combating those vulnerabilities and checking the spreading of HIV. The fact that over a period of time human rights have come to occupy a key place, not only in the discourse of health and HIV but also in the programs to combat the spread of HIV as also in this conference is a tribute to his astute analyses

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which are still relevant today. By this presentation, I wish to pay homage to his remarkable insights and highlight some of these key issues of human rights which are essential not only in the theoretical sense but also in the practical outcomes of formulating strategies to combat the spread of HIV in the coming period.

The first issue that I would like to take up is that of understanding of the nature of the illness generally in the context of rights. This has had a direct impact on HIV related employment law.

Historically and classically, the concept of health and ill health has been informed and shaped like a lot of concepts in Western philosophy by the Cartesian notion of duality. Thus, one is healthy or unhealthy, fit or unfit in the final stages of AIDS or not in the final stage of AIDS. Human beings generally and more particularly lawmakers, lawyers, judges, and doctors like to fit people into categories. For, once a category is formulated, it is easy to fit a host of persons or entities within it. But reality as we know is not like that.

Is a person living with HIV with pulmonary TB an AIDS case or not an AIDS case? This particular question is coming up repeatedly in the courts in India and other places. The implications of such decisions related to the employment of people living with HIV in the Armed Forces is very important and they are very serious for the individual concerned.

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Fortunately, we know that from our knowledge of HIV, that the immune system in human beings plays a critical part in a dynamic interaction with the environment. It is this dynamic equilibrium between the CD4 cells and HIV that partly indicates the state of the health of an individual. But despite that, an insistence on the part of the international and national organizations is to force dynamic states into fixed criteria. It is necessary to abandon this paradigm of fixed categories and move towards a dynamic criteria in this behalf so that justice can truly be obtained by people living with HIV.

The next point I want to address is a very important issue of opt-out routine testing. For years, testing for HIV has been based on the volunteer counseling and testing model. But from early 2004, Botswana, which is hailed as an ideal, actively promoted opt-out routine testing in its programs. The model is now being followed in other countries. The changes were heralded not only because of the fundamental change in the treatments in scenario of HIV, namely the success of triple combination therapy from 1996 onwards. But more fundamentally on account of the availability of cheap supply of first line generic antiretroviral drugs, primarily from India.

What is this opt-out routine testing model? Basically nearly all patients are tested for HIV as a routine part of medical visits unless they explicitly refuse. In contrast to the VCT model, there is very little or no emphasis on pretest

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counseling. Moreover, consent is effectively done away with. There is a quite an active debate on this issue and I am sure you have a lot of opportunities please to listen and discuss this.

Let me attempt to summarize its contours. Firstly, it is case of the proponents of opt-out routine testing that pretest counseling model that have been adopted early in HIV pandemic, may have been valid in the era when there was no treatment available. However, now that treatment is available pretest counseling model is redundant. Secondly, in the context of availability of treatment, it is important that people test so that treatment is made available to them. Thirdly, pretest counseling takes a lot of time and resources that are better utilized for testing. Fourthly, it has only created HIV exceptionalism, which is only fueled stigma around HIV. Finally, as a result of pretesting it is argued it has desolated people away from a HIV test and therefore the very delivery of treatment.

Undoubtably, the vast majority of people living with HIV do not know that they are HIV positive. It is in their interest to know that they are indeed HIV positive so that they can protect themselves by taking appropriate treatment and also protect others. Therefore, scaling up of testing of utmost necessity. There can be no two opinions about this proposition. The real question in my opinion is how this should be done and

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whether opt-out routine testing is the best option globally in the circumstances that are obtained today or in the near future. [Inaudible] questioning the modalities of opt-out routine testing does not in any way detract from the commitment to universal access.

It is clear that opt-out routine testing is conditional on universal access to treatment. Unfortunately, with the all optimism that I have on a lot of issues, I am apprehensive that universal access would not be a reality in the near future for the vast majority of people living with HIV in developing countries. At the global level, the 3 by 5 initiative was able to reach only approximately 50-percent of its target in 2005. In my country, India, where the estimate of people living with HIV in 2006 is nearly 5.2 million in the adult population. Anywhere from 500 to 700,000 people require treatment. However, the government of India's target is to provide first line treatment only to 188,000 and that is too only by 2010. As yet, there is no provision for second line drugs that will be increasingly required.

According to the UN 2006 Report Global AIDS Epidemic, the funding gap of global funds is \$6 billion in 2006 and will increase to about \$8.1 billion in 2007. What this means is that the ARV treatments will not be available for to the vast majority of people living with HIV. In that case, the opt-out routine testing is not really a practical option at all.

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My other concern with opt-out routine testing, is it does away with consent altogether which is a precious human right. According to the US Supreme Court judge, [Applause] Justice Cardoza put it in his classic statement, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." Justice Brennan of the high court of Australia pointed out that this principle is adopted in human rights instruments. The necessity of taking consent is not restricted only to treatment as is normally believed by a lot of people. It also applies to diagnostic testing. Significantly, it has been heard by the House of Lords of England that "there is no doubt that a person of full age and capacity can not be ordered to undergo a blood test against his will." The House of Lords added a warning which is very relevant for our purposes and I'm going to read it out: "The real reason that English law goes to great lengths to protect a person of full age and capacity from its personal liberty being interfered with is very clear. We have too often seen freedom disappear in other countries, not only by coup d'etat but by gradual erosion, and often it is the first step that counts, so it would be unwise to make even the minor of concessions."

So do we need to sacrifice such important principles adopted by domestic and international law for the purposes of scaling up HIV testing. I would respectfully submit that such principles cannot be sacrificed easily. Moreover, doctor

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patient relationships are inherently unequal for reasons of knowledge, skill that the doctor possesses and the trust that is supposed by the patient and the doctor. The opt-out routine testing model is wrongly as used that everyone is equally empowered. But such inequality, will a patient be able to refuse even if she is supposedly informed of her right to refuse.

The opt-out routine testing model is largely based on the experience on Botswana. What is the experience there? According to a study in the antenatal clinics in Francistown, it was found that an increase in uptake of women testing for HIV went from just over 75-percent in the last four months of the VCT approach to 90-percent in the first three months of the new policy of opt-out testing. But compare that to other countries, and you will realize that is not a great jump. In 2005 across India, 88-percent of those counseled in the mother to child prevention program went in for HIV test. In Uganda where 95-percent of those that were counseled home visits agreed to the HIV test. Of these 88 percent who were first timers. Therefore, Botswana does not appear to be a case that needs to be followed globally.

Apart from jettisoning effective consent the other change in the opt-out routine testing scenario is to do away with effectively pretest counseling. Counseling strategies were developed in the era where treatment was not available to

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people living with HIV. With HIV, a pretest counseling prepared a person not only for the test but also for consequence coping with a positive result without any treatment. They could not have possibly prepared one for treatment that became available later. As the treatment situation changed in the HIV context watered down to triple combination therapy being found effective and the drugs becoming affordable and accessible, protocols for counseling both pretest and post-test that needed to be overhauled drastically. However, that does not appear to have been done.

What about counseling in Botswana? In a report according to Dr. Howard Moffat who was the medical superintendent at Princess Marina Hospital in the capital Gaborone. He said, "People who are not sure that they wanted to know their HIV status often emerged from counseling determined not to be tested." He added, "I think that the medical profession itself played a major role in creating this fear of AIDS and this quite irrational reluctance to be tested." Thus pretest counseling which is meant to help people living with HIV to cope with life had become a tool of terror in the hands of health care providers."

In these circumstances, I would submit the serious issues arise about the content of counseling and the manner that it is sought to be administered. Certainly, it does not warrant a global strategy of testing based on the Botswana

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model of opt-out routine testing. All proponents of opt-out testing articulate that the model should be adopted on the basis of appropriate guarantees and assurances carrying across states. We recommend routine testing for HIV for persons in key occupations with guarantees of confidentiality protection against discrimination, free treatment for infected persons.

It is difficult to understand how these guarantees or assurances would especially in the context of pervasive stigma have any meaning in real terms. Unfortunately, [Applause] Unfortunately, it is impossible to control stigma because it operates in silent, secretive, and subversive ways. The law only steps in much later after the event, after the damage has been done. Even then, at best, it compensates an individual in monetary terms and cannot restore the damage that is caused to the psyche of that individual. The real challenge is to control stigma within communities and within the individuals. We should focus our energies on that. What we need is a massive investment in programs to destigmatize HIV and make people living with HIV acceptable in societies. [Applause]

The next point I want to turn to is the issue of vulnerabilities of sections of our society. This is an area we have to thank Jonathan Mann for. It is because of him that we have an understanding that communities that are marginalized by society are vulnerable to HIV. At a theoretical and programmatic level, the international community has accepted

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this thesis of Jonathan Mann to some extent. However, it is my opinion that the understanding the vulnerabilities have been limited. Communities that identified as vulnerable because policy makers today can easily draw connections between HIV transmission and the vulnerability of such communities.

However, other sections of society there are also marginalized in society on other counts such as reasons of race, ethnicity, sex, gender, caste, class, poverty. What I would term the traditionally marginalized sections of society are not seen as this vulnerable to HIV. I feel that such issues have not been addressed sufficiently.

As an example, I would just turn to the Afro American community in the United States. Although the Afro American community constitutes about 12 to 13-percent of the population in the United States, they account for more than half of that prison population. According to a detail study roughly one-fifth of the black adult males in the United States have served time and many of these of men have cycled in and out of correctional institutions for fairly long periods of their early adult lives. This, in my opinion, is a scandal of the highest order in any society. [Applause] But more so in the United States which rightly prides itself on protection of rights of its citizens. Unfortunately, this societal discrimination results in putting African Americans into prisons and translating that into high HIV infection risks,

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much higher than in other communities. Today they represent nearly half of the new HIV diagnosis in the US. Of course, the glaring question in prisons in the United States is the complete inability of prisoners to access condoms. Thus a study has noted that the overwhelming majority of prisons and jails, nearly 94-percent in the United States, do not provide condoms to its inmates.

President Bush and the United States administration has to be told yet again that the ABC policy is killing people in the US [Applause] and the rest of the world. [Applause] The US has the advantage that these questions can be looked into thoroughly by competent researchers. And money is available for that. Thus, we see on the podium people from the US and not people from Africa and Asia talking about epidemiology. [Applause]

Are we in the developing countries doing that sort of research? Is structure discrimination for traditionally marginalized sections of society reserving high infection in them? If so what are we going to do in our societies? We know that the coverage of HIV prevention, clear treatment services amongst these populations is appallingly low. In developing countries, we have to look into ourselves and ask the same questions that the US researchers have asked.

The final point I want to take up relates to the violations of fundament rights of people living with HIV and

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their access to affordable medicines by private companies and governments. Today after hard struggles in different countries over decades, the right of people living with HIV to affordable treatment is well recognized internationally. It has been possible to translate this right into practice partially because in 2000 Indian generic companies were able to force the reduction of prices of antiretroviral drugs. They were able to produce them cheaply because there was no protection of product patent in India. There was only protection of process patent. Product patent protection means monopoly production, no competition, and high prices. No product patent protection means budgetary producers, competition, and low prices.

[Applause]

Indian generic companies supply about 50-percent of the ARVs in the developing world. Even the cheap generic drugs that are available in India. The right to affordable antiretrovirals has not been translated into entitlements domestically in different parts of the world. As a result, the majority of people living with HIV around the world are unable to access ART in their respective countries. Unfortunately, the situation is going to become worse in the near future because in January 2005, in India enacted a patent law to protect product patents [inaudible]. Now as it is urged there are thousands and thousands of frivolous applications filed for patenting of drugs in the Patent Controller's Office.

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There is a real danger that frivolous patent applications maybe granted even though they are not really inventions under the Indian patent law. This would ultimately mean that Indian generic companies would not be able to supply drugs at affordable prices domestically or to other developing countries. This is true even for the first line and second line of ARV drugs and other drugs.

India is unique that it has a law that it does not allow patenting of new forms of drugs like combinations, isomers, and et cetera. Unless the new form significantly enhances what is known as the efficacy of the drug. This law is in conformity with the Trips agreement. The Trips agreement was a brainchild of the US Multinational Drug and Pharma lobby. The breaches represented unfortunately by the US government through the United States trade representative. Their agenda has been very clear from the start. To have a US type of patent law in the whole world. During the Trips negotiations fortunately developing countries were able to bargain for the Trips agreement to provide for minimum standards and allow flexibilities within these minimum standards.

Again, with the crisis of AIDS the world community agreed to DOHA declaration for countries to have the power to protect the healthy and lives of people. These are hard won victories of the developing world. Unfortunately, [Applause] unfortunately these victories of the developing world and the

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peoples are sought to scattered by the US Pharma lobby and the United States trade representatives. They are now pushing for laws in the developing countries either through free trade agreements or bilateral agreements or by other means, which are known as Trips Plus. Thus in India there is continuous pressure to introduce what is known as Data Exclusively. In Thailand, there is intense pressure being exerted to agree to a free trade agreement that would include data exclusivity and other provisions that goes far beyond Trips. In Kenya, pressure is being exerted to amend patent law so that import of generic drugs will become difficult.

These are just some of the recent incidences. Of course, all the pressure is exerted covertly through lobbying the government officials and politicians even under the threat of unilateral trade sanctions and the 301 of the US law. These measures not only challenge the serenity of each country in framing its laws but also have the direct effect of violating human rights of people throughout the developing countries. For the moment, they are being taunted because of the active and exemplary rule of civil society in each of these countries.

It is high time that we told the US Pharma companies and the United States trade representative that one voice from this conference that we shall not succumb to their money or political power. [Applause] And we will fight to see that the rights of our people to affordable drug prices are protected.

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My appeal to the government of the developing countries is not to give up these hard won victories and fall prey to these pressures. The lives of your people are far more precious than anything that the Pharma lobby might offer to you.

My appeal to civil society is not to give up the fight because the ultimate victory will be ours. Thank you very much.

[Applause]

**LIEVE FRANSEN, M.D.:** I am honored to introduce to you our last speaker for this morning's plenary session leading an infatigable activist from Canada, Louise Binder. She will talk today to us about women's experience in the AIDS epidemic. Louise is a lawyer who was diagnosed with HIV in 1993 forcing her to retire from her job in 1994. But the advent of antiretroviral therapy in 1996 helps to improve Louise's health and give to us the energy and inspiration of a committed leader. In 1997, she helped to found and since its inception has co-chaired and then chaired the Canadian Treatment Action Counsel which does strategic advocacy for access to treatments.

Over the years, she lent her leadership to many important organizations and efforts including the Ministry of Council on HIV/AIDS, the Community Advisory Committee of the Canadian HIV Trials Network, and the HIV/AIDS Ethics Committee of the University of Toronto. Most recently, she was one of the founding members of the Blueprint for Action for Women. Through these appointments and as a board member and today vice-chair

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of the provincial women's AIDS organization, Voices for Positive Women, Louise has been involved in many important advocacy struggles including the battle to save and then increase federal funding for HIV/AIDS here in Canada and the struggle to get timely access to safe and effective drugs at the provincial and federal levels.

Louise has also been a strong voice for HIV positive women and women's rights in this epidemic. She has received many awards and high level recognition for her efforts but the awards that matter most to her are the ones she has received from the communities she has served including the Ontario AIDS Network award and the Canadian AIDS Society Leadership award.

Ladies and gentlemen, I present to you a woman whose courage and leadership has been an inspiration for many of us in the fights for human rights, Louise Binder.

[Applause]

**LOUISE BINDER:** I want to begin with a word of thanks to the organizers for your invitation to this plenary session on women, girls, and HIV. Merci beaucoup.

Good morning to all of you. I dedicate this presentation to the memory of my friend Ivan Rotterman [misspelled?]. As the only HIV [Applause] the only HIV positive Canadian woman among this years group of plenary speakers I am honored by your invitation and moved by its obligations. I want to speak to you today about power, the driving force behind the

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HIV epidemic today. Where power resides, the epidemic recedes. Where power does not, the virus thrives. Today the virus thrives.

Of course the power lies where we know it lies, with adults, men, white people, people from the north, rich people, straight people, the designers and occupants of the mainstream whose interests are satisfied at the expense of those who are not, the brokers of power. Of course it comes as no surprise that HIV is thriving in women, young people, drug users, prisoners, sex trade workers, people from the South, non-whites, gays, transgendered, transsexuals, indigenous people and in Canada, aboriginal people, first nations in with and matey [misspelled?] people.

Of course, this is not new. What is new however is the legal impact of this exercise of power on the massive HIV pandemic and its catastrophic effects worldwide on women and girls. This planet is now engorged with the bodies of millions of them who have died because of HIV. For many of them death was a relief and a release because before their deaths, they had been raped, beaten, sexually abused, emotionally abused, starved, worked beyond exhaustion, sold into slavery, forced into the sex trade, imprisoned, disowned by their families and deprived of their children. Many of those who died were just girls, robbed of the childhood and adolescence and finally life itself. Not that life would have held much for them. They would

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likely not have received an education, a fairly paid job, inheritance rights, property rights, or reproductive health choices and rights. Even marriage and monogamy are no protection against this disease. Some were stoned to death; others committed suicide rather than face the social ostracism, violence, abuse, and unrelenting despair of their lives.

I will never forget the shock of receiving a telephone call to learn that my wonderful beautiful, bright, funny, HIV positive, grand Candace had just jumped from the 17<sup>th</sup> floor of her apartment building right here in downtown Toronto.

We all bear witness to the grime reality of this devastation in sub-Saharan Africa, the Caribbean, in Southeast Asia, in Latin America, and in Eastern Europe. And let's be clear. We have no reason to be smug or sanctimonious in North America. [Applause] Infection rates for women here are and have always been rising. Look at rates among women in Canada who are from countries where HIV is endemic including Africa and the Caribbean. In the United States, HIV is the leading cause of death among African American women age 25 to 34. Hispanic American women also bear the brunt of this disease. And the infection rate among aboriginal women and girls in Canada is appalling. Women comprise 46.6-percent of new infections in aboriginal people.

These are the consequences of the imbalance of power in the world. Yet, we women know full well that we are not merely

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the victims, vessels, and victors of disease as we are often portrayed. [Applause] On the contrary, we are proud survivors and leaders in our communities. We are not powerless. For power finds substance in the courage of conviction, in the determination to right a wrong, and in the willingness to swim upstream. In fact, staring in the face of massive devastation and injustice, as we are, women have been at the forefront of some of the most creative, innovative, successful initiatives designed to turn the tide of this terrible epidemic.

There are scores of examples of this and I have three I want to share with you today. In 1991, a woman from New Gandhi stood at an International AIDS Protection Conference and asked this question: "If we can put people on the moon, why we can't we make something that women can use to protect themselves against HIV." [Applause] Good question. And American community activist, Laurie Highsea [misspelled?], wanted to find an answer. She discovered that Dr. Zenith Seine of Columbia University had already put the wheels in motion by calling for a virucide. So Laurie and a small group of determined women including Adrienne Germain of International Women's Health Coalition, went to work putting women initiated HIV protection on the agendas of the UN population council and The World Health Organization.

The first research funding for an intervaginal virucide became available in 1992. The next year Laurie and Andrea

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helped form the Women Health Advocates on Microbicides. Within five years, they had launched the global campaign for microbicides. [Applause] the alliance for microbicide development was founded in 1998 and the International Partnership for Microbicides in 2002. The IPM has raised \$170 million from eight governments, two foundations, and multinational organizations including the Bill and Melinda Fund, the Rockefeller Foundation, the European Commission, and the World Bank. And I am proud to say that Canada was one of those donors. [Applause]

In spite of the initial reluctance of the pharmaceutical industry to invest in microbicides, which lingers to this day, there are now 25 candidate microbicides planned or underway, five in Phase 3 trials with over 27,000 women in 19 countries. Now that is power. [Applause] The power to potentially save 2.7 million lives over three years because one woman asked one question and determined women took real action. [Applause]

Here is the second story of courage and leadership by women. As a result of the sectarian conflict in Rwanda in 1994, 250,000 women were raped as a tactic of war and genocide. More than two thirds of the Rwanda rape survivors, mostly widows, were HIV positive, and had no access to antiretroviral drugs. So, they decided to do something about it. They contacted two American women, one a journalist, and one a doctor, who had

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recently formed the Women's Equity and Access into treatments. Together they helped formed a joint public/private partnership under the National AIDS Plan called the Rwanda Women's Treatment Access Initiative.

They provided technical assistance, training, education, and a range of medical services to women, men, and children. All aimed at building the capacity of local non-governmental organization and their clients to deliver services themselves. Government and non-government partners provided crucial services including trauma counseling, transportation, antiviral drugs, HIV testing and counseling, monitoring pediatric care, income generation programs, and food, recognizing poverty, nutrition and safety as huge barriers to successful treatment. A so-called chicken fund was implemented. It supplied several hundred women who were starting antiretroviral treatment with a chicken and two roosters providing eggs for protein as well as products they sell to buy food. The women also received training in food production and income generation to have a sustainable means of supporting themselves and their families.

The program provides free comprehensive HIV care to more than 4,000 people, 45-percent of whom are genocide rape survivors. Everyone who needed antiretroviral therapy has received it with more than 90-percent adherence success rates.

[Applause] three mobile teams provide HIV testing to 1300

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people per month in partnership with 24 non-governmental organizations. And a national peer education and training program provides self-empowerment tools for HIV positive people and their family to become leaders and community outreach workers. All of this because women survivors sought a solution and two women took action to help them realize it. [Applause]

Here's the third story. It has to do with sub-Saharan Africa's rule in Vopro [misspelled?] province where poverty and unemployment are wide spread and where the need to improve the economic well being and self empowerment of women is seen as a means to reduce violence against women including rape by their intimate partners. This in turn reduces HIV infection. The intervention with micro finance for funds, gender, equity study or IMAGE is lead by a team including Canadian Julia Kemp of the Rural AIDS and Development Action Research Program in collaboration with School of Public Health at the University of Wisslaughtervan [misspelled?] and the London School of Hygiene and Tropical medicine.

The IMAGE study combined a micro finance poverty alleviation program with participatory gender and HIV training. The micro finance portion was handled by the Small Enterprise Foundation, a South African non-governmental organization with more than 30,000 active clients, to help minimize the prospect of conflict within households and to advance women's self empowerment, IMAGE created a learning program called Sisters

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for Life. It included training sessions on gender roles, cultural beliefs, relationships, communications, domestic violence, and HIV. It also encouraged broader community mobilization to engage both men and youth. And the outcomes are amazing. After two years, the risks of intimate partner violence was reduced by 55-percent. [Applause]

Participants were able to challenge the acceptability of violence, to expect and receive better treatment from their partners, to leave abusive relationships, and to raise public awareness about intimate partner violence. This is my favorite slide of all. These benefits also reached young people at home resulting in greater openness and communications about sexuality and HIV. Self confidence was so enhanced that partner participants organized 40 village workshops, 16 meeting with leadership structures, five marches one of which you see here, two partnerships with local institutions, and they formed two new village committees including an anti-rape committee. All because of a group of women risked their lives by daring to speak out about violence and to seek a solution and one woman took action to help them find that solution and so much more. [Applause]

What do these stories teach us? Well first, that while the problem is profound and much time has been lost, it is not insurmountable. In order to sustain successful approaches to the problem empowerment strategies are essential and they are

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more likely to be successful if they are integrated within macroeconomic and cultural strategies aimed at creating improved equality. Second, they teach us that the oft-repeated myth that culture and religion are insuperable barriers to successful HIV programs is sheer nonsense. [Applause] We need enlightened and courageous leaders in every strategic area of this epidemic, in cultural and religious leadership, in government and politics, in research, in healthcare delivery, in our communities, and in our families. Third, the stories teach that projects are successful when they recognize that women's and girls' lived experience leads the way to successful decision-making and implementation. [Applause] The reality of our lives as women is that gender inequality in the economic, social, educational, and political arenas directly impacts our ability to protect ourselves from HIV infection, to access prevention services, to get the care and treatment and support we need for ourselves and for those for whom we care. HIV is the result, not the cause, of these inequities. [Applause]

So, what is the solution for women and girls? Not mainstreaming. Not ghettoization but integration. These stories illustrate that we must integrate HIV into our other health issues affecting women and neither can we separate women health issues from development issues such as education, training, employment, and economic security. We have to work at all of these areas concurrently, intersectorally, cohesively and

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urgently if we are save some remnants of this and the next generation of women and girls. [Applause]

So, what does this mean in practice. First and foremost, it means the establishment of a multidisciplinary framework at a national level to develop, implement, monitor, evaluate, and ensure accountability of a comprehensive HIV/AIDS strategy. This framework should comprise all levels of government and all stakeholders including non-governmental organizations, including health and development and cultural, religious and community leaders. But most importantly, women and girls must be at the table both those living with HIV and those over represented populations in this epidemic. They would have the veto power in this decision-making. This group would have the support to implement it decisions and the resources to do so. It would report to appropriate government officials, elected officials and have direct access to and support from them. The strategy developed by this framework would set specific targets and an urgent plan to achieve universal access to all methods of prevention, diagnosis, care, support, and treatment for HIV/AIDS related services and an accountability mechanism. And it would also support research for and including women and girls.

How do we define the elements of this strategy? Let me give three key elements. First, we require an universal understanding that the prevention, treatment, dichotomy, that

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is often advanced is completely false. They are in fact inexplicably linked in achieving a successful HIV strategy. Neither side of this equation is successful without the other. Both need adequate funding and resources. In terms of prevention, the strategy must be comprehensive. It must include targeted education and awareness, the availability of adequate and affordable supplies of male and female condoms to all the ones who want them [Applause], a comprehensive harm reduction program for drug users, decriminalization of the sex trade, and an end to violence against women and girls.

It requires generous government funding for Microbicide research starting with an immediate doubling of the present investment to at least \$340 million and support for companies to hold trials. What a prevention strategy for women absolutely cannot include is the ill conceived counterproductive and dangerous policy of ABC: abstinence, be faithful, and wear condoms. [Applause]

To my mind, this is the most blatant example of policy making by men who know nothing of the context and realities of the lived experience of women and girls. [Applause] While we are grateful for prevention funding donors including the US President's emergency plan for HIV relief must remove all strings including the abstinence until marriage condition from their funding approach. [Applause] These strings are ropes around women necks and they are killing us. [Applause]

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In terms of diagnosis, there must be no universal compulsory testing of any woman or girl, including a pregnant woman or her new born child as part of an HIV strategy.

[Applause] None of us wants to give HIV to our children but to target pregnant women is to betray them while millions of men continue to avoid being tested and avoid practicing safer sex. [Applause] No support exists in terms of the violence, divorce, and devastation of these women's lives if they test positive. It is a coward's way out and it is not even good prevention strategy. [Applause]

In terms of treatment, we must ensure universal and equitably distributed access to the best antiretroviral treatments for women and girls urgently for first, second, and third-line treatments. We need pediatric formulations. We need treatments that include drugs for opportunistic infections and co-infections. And all pregnant women should have treatment, and it must be standard of care for them, not just prevention for the child. [Applause]

In the hardest hit areas, pregnant women have inadequate antenatal care. Only a small fraction of those women have care and it is generally monotherapy which is not an acceptable standard of care. You know we would have fewer orphans to care for if we looked after mothers properly. [Applause] If we care about orphans then we have to care about keeping the mothers alive.

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We must also look past the clinic door to see if we are really reaching women. That means more than just doling out a handful of pills. It means food and water to take the drugs properly. I have heard many stories of women trading or selling their drugs for food or giving pills to family members. And it means transportation and particularly in remote areas. Many cannot make repeat visits because of lack of transportation or childcare. We must also provide care and support for women and girls who are unpaid caregivers. We need proper public health systems everywhere. [Applause]

Finally, we need levels of literacy for women and girls in matters of treatment that is absolutely imperative. Second, an HIV strategy must be integrated into reproductive health and rights services. [Applause] Reproductive health and rights includes intervention to reduce perinatal transmission, screening and treatment for reproductive tract cancer, treatment of opportunistic infections that make pregnancy riskier, provision of information on contraceptives and medications used by HIV positive women, provision of information about and access to services to prevent and manage unwanted pregnancies including safe abortions for all indications provided by law. [Applause]

And without coercion.

All HIV positive women must be given information and support to have children if they choose as well as education on

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and support for exclusive breast-feeding. Women's rights are human rights. Reproductive rights are one of those rights. Women must be protected from violence, coercion, and discrimination in the enforcement of these rights. Donors must immediately remove all conditions for funding women's health that are in fact life threatening. [Applause]

Violence is a breach of another of our basic rights and it is directly related to HIV. It includes marital rape which in many countries is still legal, female genital cutting, incense, early enforced marriage, violence related to trafficking, and sex and economic exploitation. Women and girls cannot utilize any HIV services and support if they live in fear of violence. The crisis of violence against women will continue to completely confound our efforts to solve the HIV crisis for women and girls without anti-violent laws and policies in every country. The judicial system must be sensitized and do you know I exaggerate? No, I do not. On this planet, at least one in every three women has been beaten, coerced into sex, otherwise abused in her lifetime. In Liberia, toward the end of the five-year civil war, half of all women age 15 to 70 experienced physical or sexual violence by a soldier or a fighter. In the United States, it is estimated that at least one in three women will be sexually assaulted in her lifetime. In Canada, aboriginal women in the '90s were at least more than three times more likely than their non-

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aboriginal women to have been assaulted by a current or former partner.

As long as the basic human rights have one women or girl that is trampled on then none of us is safe. [Interposing]

**LIEVE FRANSEN, M.D.:** Please can we ask you -

**LOUISE BINDER:** No religious, cultural, or political imperative is worth the health or life of one women or girl.  
[Applause]

We must also deal with development issues. We have got to get women educated even if that means that they have to take away school taxes and other costs. Every year a women is educated helps her. We have got to ensure that women get opportunities for financing, that they have property rights, and that they have inheritance rights and that these are enforced.

So now my conclusion.

**LIEVE FRANSEN, M.D.:** Louise, I am sorry. We are getting into to the next -

**LOUISE BINDER:** I get it.

**LIEVE FRANSEN, M.D.:** - session.

**LOUISE BINDER:** By now you may be saying to yourself. You have heard this all before. I understand and I agree and therein lies that tragedy. For many years now, passionate people have been doing what they can to bring awareness to the world about the tragedy of women and girls. And to demand

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action with notable exception those have fallen on deaf ears. So I say to those in power we seek neither pity nor charity. It is a practical matter. You need us to run the engines of your economies, to make and nourish families, communities, and societies. It is in your interest to right the wrong so do it. Everyday that you permit the status quos to prevail failing to challenge or change, you are complicit in mass murder.

**LIEVE FRANSEN, M.D.:** Louise, Thank you very much. If you could at least close -

**LOUISE BINDER:** I'm on the last one.

**LIEVE FRANSEN, M.D.:** - this session. Okay? [Applause] Can we please - [Applause] Allow me - [Applause].

We have some housekeeping messages please can, can you all stay and listen for a minute to the housekeeping messages.

[Interposing] Can I inform you? We love, we love Louise presentation, but we are expecting an important session with Bill Clinton and Bill Gates coming here.

**JACK WHITESCARVER, PH.D.:** Just get her off the stage.

**LIEVE FRANSEN, M.D.:** And so we need some housekeeping in this session. [Interposing]

**MALE SPEAKER:** [French spoken]

**JACK WHITESCARVER, PH.D.:** And then we can exit but I want -

**LIEVE FRANSEN, M.D.:** What do they want? What, what do the people want?

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**ANAND GROVER:** The session is very, late – the overflow  
with –

**NILS DAULIARIE:** Tell them that it is over.

[Interposing]

**ANAND GROVER:** If you make the decision I be  
[interposing] Say that I will turn off the microphone now.

[Interposing]

**LIEVE FRANSEN, M.D.:** Okay. Louise can we ask you to  
close but not even one minute please because otherwise we will  
have to cut down the microphone. Please.

[Interposing] [Applause]

**LOUISE BINDER:** Okay. To those outside the traditional  
power circle I say this we must continue to stand together and  
grow our circle because if one of us is not safe then none of  
us is safe. All of us in the HIV community owe a huge debt for  
much of the work in progress in research, awareness, treatment,  
and humanity to the gay and lesbian communities. And I thank  
them. Sadly, sadly the same cannot be said for the women's  
health and feminist communities and that has got to change and  
I trust it will.

Our conference theme is time to deliver. Time to  
deliver? I do not know what timepiece you are using but mine  
says that we are decades late with this delivery. Sadly, there  
is no way to turn back the clock and bring back the women and  
girls, the millions of Ivan Rudderhans [misspelled?] that we

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have lost. None is – now is definitely the time to salvage some of us before the last words are written on this ignominious chapter of the history of mankind. It is time to deliver human rights and AIDS action now. Now more than ever. Thank you.

[Applause]

**LIEVE FRANSEN, M.D.:** Thank you very much Louise for a very powerful presentation. Can I [Applause] –I am sorry, I have some housekeeping for the next session. Could I please ask you one second for housekeeping for the next session? I said already the next session we are really a little bit over time with this session. The next session is in this room with Bill Clinton and Bill Gates.

I have been asked to tell you to act – the room will be full or filling up, so please fill up the central seats as much as possible and leave the outside free for new people coming in.

The second message I have is please use the washrooms on the right side of room. If you leave this room, you will not be permitted to return for the next session in this room. I hope this all very clear and I'm sorry I had to cut down Louise's beautiful presentation and I'm sure we will continue the debate and the discussions in the next very productive sessions. Thank you and see you later.

[Applause]

[END RECORDING]

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