

**Conference: World AIDS Day:
Reaching Women and Girls and Enhancing the US Response
Welcome and Panel 1: Addressing the
Challenges Facing Women and Girls
November 30, 2004**

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JENNIFER COOK: Good afternoon and welcome. I'm Jennifer Cook, not Steve Morrison. Some of you may have an earlier version of the agenda. I'm Deputy Director of the CSIS Africa Program, and I work with Steve Morrison, who is Executive Director of the CSIS Task Force on HIV/AIDS. The Task Force is funded by the Bill and Melinda Gates Foundation and is chaired by Senator Bill Frist and Senator Russell Feingold. Originally the Task Force was centered in the Africa program, but now in its second phase, it's grown to encompass our China, India and Russia programs, and also includes a number of working groups on prevention, on women and girls, on the security implications of HIV/AIDS and on the President's Emergency Plan for AIDS Relief. The goal is to help build bipartisan consensus on US strategic policy towards global HIV/AIDS. We're delighted to host today's events with the African Ambassadorial Corps, and I'd very much like to welcome Ambassador Mary Kanya of the Embassy of the Kingdom in Swaziland and Ambassador Lapologang Lekoa of the Embassy of Botswana, and other members of the Ambassadorial Corps who are in the audience.

I'd also like to thank our panelists. We have several stalwarts of the CSIS Task Force. That would be Janet Fleischman, Jen Kates and Phil Nieburg, but we also have Dr.

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Connie Carrino from USAID. Welcome. We have Michelle Gavin, from the office of Senator Feingold. Especially, I would like to thank Asunta Ogura [misspelled?] of the Kenya Network who came on very late notice, but now, welcome. Thanks for coming. Janet Fleischman is going to introduce and chair the panel. Janet's the chair of our committee on Women and Girls. Prior to joining us here at CSIS, she had many years as an advocate and analyst with Human Rights Watch, and we're very glad that she's brought that passion and tenacity of that long career to the Task Force here where she's really critical on keeping our focus on the centrality of the issue of women and girls, not only through her working groups, but also getting other working groups and the delegations to the various second wave countries to interweave the gender issue into their work. Before I turn to Ambassador Kanya is going to say a few welcoming remarks. I'd also like to thank the Kaiser Family Foundation for webcasting and transcribing this event. This is an incredible service. There are a lot of other events going on this week, and especially today, in conjunction with World AIDS Day, so if you feel that you've had to forego another event to be here, we're glad you're with us, but the likelihood is that you can catch it on the Kaiser webcast, but there are no hard choices. This event and others will be broadcast at kaisernetwork.org. With that, I will

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turn over to Ambassador Kanya.

AMBASSADOR MARY M. KANYA: Thank you. Mr. Morrison, distinguished Ladies and Gentlemen and their families, may I on behalf of the African Diplomatic Corps welcome you and thank you for having taken time out of your busy schedules to join us in this conference as we observe the World AIDS Day. I would like to extend our sincere appreciation to see you and the CSIS Task Force on HIV/AIDS for [inaudible] sponsoring this event to the African Diplomatic Corps.

The impact of HIV/AIDS is relevant to all of us, but I would like to refer you to an article which appeared in yesterday's Washington Times written by Trevor Nelson, titled Money Needed for AIDS. The nation must lead the world. This year's theme focuses on girls and women. Statistics tell us that in sub-Saharan Africa, 75 percent of all people living with HIV between the ages of 15 and 24 are female. The Deputy Executive Director of UNAIDS Kathleen Cravero is reported in the Washington Times—I read the Washington Times a lot—of last Wednesday as having said "Young women are an almost endangered species in Southern Africa for several reasons." What she said is a wake-up call. After reading what she said with tears welling up in my eyes I said to my self, "How true." As somebody that comes from Southern Africa, the statement makes me remember how we have in the past few years

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been burying men, young and old, single and married who died of AIDS. I remembered how wisened girls have met their husbands and dying fathers and brothers from their deathbeds. I was reminded of how these women are keepers of their properties and inheritance whilst they mourn their loved ones. I have seen the widows, mostly young widows, distinguished by their black clothes in the streets, toiling to make ends meet, fending for the orphans. I was reminded of the recent visit I made to one of the hospitals back at home where the hospital beds are almost filled to capacity by dying young women and girls. Yes, know that it is taking its toll on the women and girls who have and are still most vulnerable to a number of factors, some biological, some cultural, poverty and economic dependence and many more. The panelists will elaborate on that. Once you address the women and girls, we should not forget that boys and men are an essential part of the solution. Actually, they ought to be at the center. We call upon governments, missionary groups, NGOs, donor agencies and all to join hands and work on strategies that match the scale and extent of the problem.

And finally, to all of you, to all of us, let us not wait for the next World AIDS Day to meet. Let us meet more regularly to share our experiences as part of the fight against this epidemic. Thank you. [Applause.]

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JANET FLEISCHMAN: Thank you, Ambassador for those important comments and important call for all of us to more than just meet today, and that's part of what we hope to energize in this meeting today, a real action and agenda, moving forward based on information we're going to get from a very distinguished panel, to talk about what the US can be doing to really look forward in terms of US policy and PEPFAR, and a strategy focusing on women and girls under each of its goals of care, treatment and prevention.

I just want to say a couple of remarks before opening it up to the panel, and I thought it would be appropriate to start out with just a story of when I was in South Africa last Spring, and I met a young woman named Queen in a township outside of Capetown called Kylichia. Like countless other women, she had found out her HIV-status when she was pregnant, and she was involved in a program reaching out to other pregnant women who needed the kind of economic and social support services that are required for them to go on and deal with their illness and deal with the realities that they were confronting with their families. And she told me how frightened she had been to disclose to her partner and to her family. She said, "I was afraid he'd leave me and say that I brought the virus to both of us. I even feared disclosing to my family, especially since my father is a

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priest." And she went on to describe the kind of circumstances that other women find themselves in, how their partners abandon them, or worse, subject them to forms of violence. She noted that women often join the group after their boyfriends or their families have thrown them out, when they have no place to stay. She said, "We look after her, find her a place to stay, give her food." And in the end she said, "HIV is everybody's disease."

I think it would be impossible to be addressing this epidemic without keeping a clear focus on the realities that women and girls are confronting in this epidemic, and we realize now that all too many of the prevention and treatment programs are failing to address the needs of the majority of those living with AIDS, especially in the worst affected countries. It is high time that we designed programs targeted to what women and girls face in a world of AIDS, and use this focus of World AIDS Day with this theme of Women and Girls to really propel action and to design important new innovative strategies to meet this challenge.

Most of the prevention messages have focused on the ABC approach. I'm sure you're all familiar with that. And while these are important messages, they are often not within a woman's power to control. People now often speak of ABC+, trying to think about the broader range of preventions that

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are necessary to adapt to the realities of women's lives. And this of course, grows out of the statistics. Sixty percent of those living with HIV in sub-Saharan Africa are women and girls, a striking 76 percent of young people aged 15 to 24 are female. Girls aged 15 to 19 are infected at rates as much as five times higher than boys their age. This disproportionate impact is clearly linked to social and economic factors that severely undermine women's ability to control their sexual lives. In a climate where sexual abuse and exploitation against women and girls is widespread and usually goes underreported, how can they practice abstinence? When married women, many of whom were child brides, have been faithful to the very husbands that are infecting them, how do the messages about monogamy help them protect themselves? And when girls are pulled out of school to take care of sick relatives, and are denied opportunities to gain the skills that would help break their economic dependency, how can they avoid survival or transactional sex and negotiate condom use? Clearly, AIDS is insidiously undermining the skills, the experience, the networks that support women and families in Africa and around the world. Women are clearly vulnerable but they are not weak, which is evidenced by the fact that so many survive and become leaders in their communities, organizing support and care for their families and the

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broader community. The point is to give them what they need to save themselves and to protect themselves: resources, education, jobs, access to HIV treatment, legal support and real options to live safely and productively in a world of AIDS.

This is a critical moment for the US and its international partners to develop proactive strategies that enable women and girls to have meaningful access to HIV prevention and treatment. Understanding the epidemic's impact on women and girls leads to logical programmatic decisions, and should be linked to clear gender-specific targets. This is our challenge on this World AIDS Day. It should hopefully be the beginning of a long campaign that really puts strategies on women and girls at the center of what the US PEPFAR program is aiming at in its target countries and more broadly in the global response, and I think we can look forward to our panel today to try to help us begin that walk and lead us in the direction of a real concerted action on this regard. So with that, let me introduce first Ambassador Lokoa, who became Ambassador to the United States in 2002. He has served as the High Commissioner of Botswana to Zambia, Tanzania, Kenya and Uganda in 1996, and he previously served as Director of the International Relations at the Department of Foreign Affairs, and a number of other distinguished

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appointments within the Government of Botswana. I present to you with that, Ambassador Lekoa. [Applause.]

AMBASSADOR LEKOA: Ladies and Gentlemen, colleagues, I stand before you a humbled man in the first instance because of the passion and [inaudible] tone with which my colleague the Ambassador of Swaziland introduced this topic today. The other reason for my humility is the talent around the table here, which is so knowledgeable about the issue that you are about to discuss that I will not be presumptuous as to try to address this issue from an internationalist perspective or scientific perspective. But to talk about the safest thing that I can do which is the experience of our [inaudible] Botswana and what Botswana is doing about the scourge. HIV/AIDS is devastating sub-Saharan Africa region, actually the southern Africa region [inaudible], which is the [inaudible] region. The pandemic is the greatest humanitarian crisis, which has seen little gains made in the region in the past decades. According to the 2004 United Nations Global Report on the AIDS Pandemic sub-Saharan Africa, which has over ten percent of the world's population is home to close to two-thirds of all world people living with HIV/AIDS. In 2003 alone, an estimated three million people living in the region of Southern Africa became newly infected while 2.2 million died of HIV/AIDS. The effect of HIV/AIDS has been

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particularly devastating among women and girls. The latest findings of the AIDS epidemic published 2004 in the Annual Report by UNAIDS and WHO indicate that close to 60 percent or 18.3 million of adults living with HIV/AIDS are living in the Southern Region where I come from. Botswana, [inaudible] and Swaziland continue to experience HIV/AIDS prevalence rates that exceed 80 percent among pregnant women. In Botswana alone, over 60 percent of the mostly affected 15 to 49-years category are women. Botswana is one of the countries most affected by this scourge. The impact of this pandemic is placing a heavy burden on the individual, especially the most vulnerable groups, women and girls. The challenge facing Botswana is to find ways to change the social conditions that deny women the ability to control practices that increase their vulnerability for contracting HIV/AIDS.

What makes women vulnerable to HIV/AIDS, generally? One, [inaudible]. Women face gender-based risks from HIV/AIDS in a number of ways. The growing proportion of women affected by this scourge arises from a mix of psychological, social and human rights factors. Women and girls appear to have a higher inherent risk of being infected through heterosexual activity compared to men. Studies have shown that women are more susceptible to HIV infection than other sexually-diseases than men. Transmission from male to female during

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sex is about twice as likely to happen as from female to male. A compounding factor here is the fact that women and men are more likely to be coerced into sexual intercourse, or raped often by someone older who had greater exposure to the virus.

Cultural factors: Women are often expected to prove their fertility as a prerequisite to marriage. In most cases, this happens even before parties are aware of their status. Social factors indicate that gender inequalities make women susceptible to HIV/AIDS. Women frequently do not have the power to negotiate safe sex or refuse unwanted sex. In many instances, women are still seen as sexual objects. The majority of them generally cannot protect themselves against HIV/AIDS because they have to rely on their main partners, who may decide whether or not to use their condoms. Those who have been infected with HIV find it difficult to share this important information with their partner because of fear of violence and abandonment as my colleague has just indicated to be the case in South Africa.

Economic factors: HIV/AIDS, lack of access to education, poverty, and economic inequality and depleted intertwined. The burden of caring for the sick, the dying and the orphaned pushes women deeper into poverty. They are often pressured into, as a result, into professional sex, or sex in

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exchange for money, or goods with older men who offer the illusion of material security. This level of economic independence deprives them of the choice as to when and with whom to have sexual relations.

Botswana has put in place some prevention strategies. Amongst them are intensifying prevention of mother-to-child transmission of HIV/AIDS, lengthening the management of sexually-transmitted infections, using the mass media and local drama groups and other artists to promote routine HIV testing as an integral part of their general healthcare. Traditional values, or the typing of traditional values to encourage people [inaudible] with these practices. Building income capacity by training program officers and coordinators at different levels, community capacity enhancement to facilitate community dialogue on issues related to HIV/AIDS, and generally promoting sexual behavior change through curricula in schools and so forth.

Botswana has also put in place one strategy which I think deserves particular mention, which is routine testing which was first introduced in my country. In 2004 the Government of Botswana introduced routine HIV testing as a measure of enhancing existing mechanisms and health infrastructure. The tests, which are not mandatory, are also made available at prenatal and sexually-transmitted disease

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clinics as a way of promoting prevention of mother-to-child transmission. Once patients have opted to be tested, pre- and post-test counseling is done. The people of Botswana have embraced routine HIV testing. Abstention increases in HIV-testing, particularly in pregnant women were observed at various government sites nationwide after the implementation of routine testing. Between April and June of this year, a total of more than 11,000 thousand people were tested. Three thousand of them were male, eight thousand of them female. Five thousand of them tested positive, the majority of them being women. These findings have had a positive impact of routine HIV-testing in the country. This has also enhanced enrollment of access to HIV-prevention and treatment statistics. This is an indication of positive behavior change, which may also reduce stigmatization of AIDS. However, routine still testing faces the following challenges: Inadequate financial and manpower resources that we have always talked about, inadequate medical facilities to accommodate more patients as a result of the new testing, inadequate medical personnel some of whom have migrated to developed countries, including the UK. Another challenge is that currently all those that are tested under the routine testing do not have immediate access to the ARV program, which is quite congested at the moment.

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The Government of Botswana has also demonstrated commitment in supporting women in the fight against HIV/AIDS by putting in place programs specific to women and girls. Education for girls is highly promoted. In Botswana, by the way, education is still free for [inaudible] and health is also still completely free. And really the challenge here is on the education. I think the behavior change, for people to take advantage of the facilities that the government has put in place for them. Psychological support in the form of counseling is provided for women, especially in home-based care. Women are educated on HIV/AIDS gender-based violence, and also receiving training on HIV and human rights. The government also provides support to orphans and vulnerable children. As part of these interventions, a [inaudible] gets additional support for schooling are provided to all registered orphans. Botswana is also adopting a human rights-based approach to HIV/AIDS and the protection and implement of women and girls by providing shelter to women and children experiencing domestic violence. I realize that I have to be quicker because. . . [Chuckles.]

I was going to talk briefly about the static region, and because my time is up, I will only refer you to refer you to the last summit of the [inaudible] heads of state in [inaudible] in July 2003 which laid the framework for

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regional action. I hope that information is available online, but just to highlight a few areas where they are going to be concentrating you know, what to deliver on HIV or to respond to the region is in the area of human resources. This involves training and skills development and ensuring access to all. [Inaudible] also want to look into better ways us sustaining the educational systems and ensuring their [inaudible]. One of the challenges in Africa—I think in many developing countries—is inadequate funding the healthcare area.

Good security: Here they will be addressing all aspects of unprecedented AIDS toward the mitigation of the impact of HIV/AIDS and issues of food entitlement and nutrition. They will also be focusing on the areas of mitigating socioeconomic impact. Here they will be looking at all aspects of policy development relating to support for HIV affected persons in their communities. This includes addressing orphans, youth employment, women and putting in place programs on HIV/AIDS.

HIV-prevention: They will be here addressing issues which have been referred to as the "corridors". This referred to the spread of the disease through migrant workers and the people in transit between, within the region. Agenda issues will also be embraced in the regional program. We are

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actually putting in place comprehensive programs and policies as a response to problems facing women, who not only account for the number of HIV/AIDS, but are also critical for all aspects of coping with the disease.

In sum, the areas that in my view we should be focusing on are human rights as in relation to how we respond to the challenge to protect women and children. I think the first one is human rights, the second one property rights, the third one, education for girls, fourth one, economic independence for woman, fifth, preventions of burdens against women and children, and sixth, doing away with cultural traditions that affect the spread of HIV/AIDS. And then [inaudible] that we shouldn't forget that boys and men need to be part of the solution.

In closing, I want to quote even though it is not traditional to do so, my colleague, the Ambassador of Swaziland. Normally I should be quoting my President or some politician. [Laughter.] but, I am humbled by involvement in this whole affair, and this is what she said in one of her interventions in [inaudible], and I quote: HIV/AIDS is a holocaust, the Black Plague of our century, wasting all continents, and races. It is not anticipated financially and policy wise. It is causing untold damage. It needs international response that puts it into perspective instead

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of using it as a political tool. More people are dying now than the people that died in the first and second World Wars." If HIV/AIDS is to be defeated, the world needs to work together to make a difference in the lives of those who have been infected and been affected, and these are women and children. [Applause.]

JANET FLEISCHMAN: Thank you very much, Ambassador Lekoa. Apologies for being the time-keeper here, but not only do we have a panel that I know you all want to hear from, but we want to be able to have a discussion here, because there are a lot of people in the audience, I know, who would like to intervene. We're going to switch the agenda a little bit because of different people's time constraints, and we're going to move now to Connie Carrino, who is the Director of the Office of HIV/AIDS at the US Agency for International Development. She has worked at the Bureau of Global Health at AID since 1991 in India, Washington and Russia. Between 1994 and 1997 she established the Division of Health Policy and Sector reform and developed teams to work in environmental health and malaria. Connie is going to speak about gender and PEPFAR. Connie?

CONSTANCE CARRINO: Thank you so much, and thank you to my CSIS colleagues, especially Janet, for setting this up, not for today, as many of you know, but as an ongoing issue,

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and it's something that has helped a lot of what we're doing in the US Government right now, and the other thank you, I suppose, for today and other days goes to the Kaiser Family Foundation, who are telecasting this event and quite a few events around town, helping those of us who aren't in every community to be able to share and know what's happening else where.

I was asked today to talk a little bit about how women, and women and girls' issues figure within the President's initiative, and to do that, I'm lucky I don't have to go through some of the data that you've already heard, but just to give what's happening in a nutshell, those young women between the ages of 15 and 19 that we were talking about that are getting AIDS much more than their male colleagues of the same age, it's about 4,000 young women a day worldwide, and that's something that, if it continues is going to put whatever donor activities we have going on and whatever money we have going into any system, just going to bring it to a halt.

The President's Emergency Plan, many of you in the room are part of, in one way or another, either through your organizations or through your day-to-day work, but just as a summary, it's a five-year, \$15 billion commitment made by the United States to fighting AIDS in the areas of prevention,

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care, including care for orphans and vulnerable children, and in treatment. It works in about 100 countries around the world, with specific focus in 15 countries. Within those 15 countries, and in Africa, the Caribbean and Asia, where we are assuming most of the prevalence exists, we have some very specific targets, and that is, over the five-year period of this first phase of the initiative, to avert seven million new infections of HIV/AIDS—that's the next slide—to treat two million people, and to provide care for ten million people living with AIDS, and the orphans and vulnerable children affected by AIDS.

I think because it's very specific, because it's very objective oriented, there were many questions at the beginning on how we would involve women, how we would involve some of these more integrated, multi-sectoral activities that we are often concerned with when we look at the issue of women and girls in development. I think what we're finding—I was asked to kind of go through that today. How does that relate to prevention? How do women and girls relate to what we're doing here in mother-to-child transmission and treatment?

I'd like to just say a few words, both about some challenges for women in these areas, specific challenges for women, and what we're seeing in responses. Our Ambassador

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from Botswana outlined it at a country level what some of these were. I think we're finding that some things work, and the important things to be aware of as you go in, to make sure that your strategies give room for this. Challenges in the area of prevention are obviously some of our gender norms. The reason you have more young women affected by AIDS than some of their counterparts is perhaps they're having relations with men who are much older. The issue of intergenerational sex is an issue hitting us within AIDS that's affecting the very young. Fear, of coercion, of not being able to have control over your own sexuality, economic and poverty vulnerability to exploitation. Many of us have seen the signs of the sugar-daddies syndrome of someone that needs school supplies or needs to feed a family, or puts herself in a position of perhaps of having put herself in the position her body being the only piece that she has to transact with economically. The types of responses are not perfect, but they're ones that are being worked on, and when it's the strongest, it's focused on men, and not just women. We have found in some countries, specifically working in South Africa on building positive male involvement, working with putting aside some of the earlier stereotypes about men, providing peer education and life skills to equip young girls and women through the community to begin to address what in

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many cases are cultural or social mores that are affecting a woman's vulnerability both to violence and coercion, but more specifically in this case, to HIV/AIDS.

Another area of prevention that affects both mother and children is the prevention of mother-to-child transmission. Before the Emergency Plan, which began in 2003, we had a smaller but incredibly significant plan that was in the US Government of providing \$500 million over a period of three years to focus on preventing mother-to-child transmission of HIV. When a woman was pregnant, it is focused on providing Nevirapine or some similar antiretroviral at birth, and dramatically brought down the cases of transmission from mother to child. What we saw by last June or so, were a series of services delivered to about 378 women that they themselves were HIV-positive. Their children had a much better chance of not getting the AIDS virus, and then they were brought into treatment programs, many of them not ready for treatment at the time, but at least ready to be tracked by programs, given to be able to be brought in, perhaps at a later date. As anyone in this room would know the obvious, that treating a child isn't going to help very much if Mom doesn't survive to take care of them.

In the areas of care, women bear the greatest burden of care. There's very little support in community-level

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studies, in countries—we had one in Kenya where any one family would have to give up at least two women in a way. They would have to leave school, or they would have to leave a job to care for other family members. This is an informal community approach to handling AIDS care, but it's one that is being taken on much more by women than by men, and it's clearly affecting the future of many. Girls in AIDS-affected families have a tendency to leave school. Many of us have seen this as we've visited communities. A lot of the girls—there will be an older sister that will take care of others. Again, as women, poverty, they tend to be more unemployed and already be at a poverty level, which sets you into a vicious cycle.

In the areas of orphans, we have right now, within the US Government, about 102 programs going in 27 countries for orphans and vulnerable children, and these are rather comprehensive programs, looking at everything from psycho/social support, to some of the education that the Ambassador talked about, to prevention, to healthcare, to different types of support for the family. Microenterprise is also something that is important for HIV/AIDS women, not only economically, but handling issues of stigma. A few of us, when we were in Bangkok for the big meeting last Summer managed to see programs that were set up so that if an HIV-

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positive woman was partnered with a negative woman in a microenterprise endeavor, which would sort of begin to develop a breakdown of stigma. Another area that everyone's mentioned so far, and I assumed would, is the concern with inheritance rights and property rights. This is something that we're finding within our programs as part of the policy level work at the country level in these 15 focus countries, that we are starting to see plans to deal with this at a legal, social and larger developments level. Before I leave care, I have to say, you know, we all got together at some point, if you think about today and tomorrow, World AIDS Day with some of our closest friends, and a group that one of my colleagues at work wanted to give special attention to, on a day where we're looking, perhaps celebrating women and girls were nurses. It has been, in fact the nurses around many of the countries that we're working that had had to deal with the care issues, the stigma issues, the impossible issues of not having drugs or care or anything to offer people who were dying, and yet stuck with it through very difficult circumstances. This is a great group of women that, many of us—I'm not a nurse—but we're thinking about, on a day like this, and should give some special attention to.

In moving to treatment, treatment is a difficult issue. I've been surprised to hear in the last 48 hours

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statistics that show that not many women, or a very small percentage of the women in treatment in different countries, and I'm kind of incredulous. I think this is something that's going to be moving over the next few years. Our own agency, the US Agency for International Development starting three very small pilot treatments, one in Kenya, one in Rwanda, and one in Ghana in 2002. While certainly not nationwide and spectacular, the 4,000 or so people who have treatment now, a majority are women, and I just assumed that would be the case everywhere. I'm finding that isn't the case. There are barriers like the fact that you often have to ask your husband or father whether you can go get any kind of medical treatment. Often it is men that have the economic resources, to be able to go after and get treatment. And then, just quite frankly, the fear of stigma is a very strong concern, like Queen, that Janet was telling about, that I had heard elsewhere, which is that you're not sure you want to admit that you have this disease or may have this disease. You may not even have it. The ensuring of access to treatment is very important, and sponsoring comes for community education in this area, workplace education involving women leaders. One very simple, perhaps what our statisticians thought would help is that as we look at prevention here and throughout our program in these 15 focus countries, in fact, what women

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development experts have always said to do, and it helps—we keep factoring data so that we're sure that we know how many of the men are under treatment or therapy. That's something to follow over the life and their test scores are something that are important to keep an eye on for the future.

I think the last few areas, ones that people are impressed, that people are not as aware of, one is research. The Emergency Plan is sponsoring research that we've started within our agency and are continuing to sponsor in microbicides on women control relative to the area of HIV transmission. It's especially important in as many couples as we have in many communities. We also have concerns also with vaccines. I don't know if any of you follow Iave [misspelled?], the vaccine consortium. You're probably hearing that there's quite a bit of emphasis now on making sure that women get into the vaccine trials and that they are set up to capture the concerns that women may have as part of the trials and that they're kind of in from the beginning.

Their violence is something that we're concerned with, and I think by having Phil here, my guess is that you're going to talk about this a lot. One of the very important areas that we've been focused on is how to handle the issue of counseling, in terms of gender violence. When women would come in for maternal health, they would often be

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the first of the couple to know that they were HIV-positive, and we want to be able to set that up so that that doesn't become the scapegoat for the family or the community on AIDS and move into violence.

Finally, the area of leadership. I walked in the room with a few examples of leadership. As you're seeing, the two announcers, I think they show the problem better than anything else. There has never been an AIDS program that has been successful unless you have strong leaders, whether it's at the large regional level, the community level, or in your cases, the national level. I think that having this consortia of ambassadors focus on the issue is going to take us a long way in both the foreign policy and national policy areas. We can focus then on women and what to do for them. Thank you.
[Applause.]

JANET FLEISCHMAN: Thanks very much, Connie. It's very helpful to get a basic sense of what we can start to see in terms of the PEPFAR program in terms of what they may be covering, and I'm sure there will be questions. Next we're going to hear from Jen Kates, from the Kaiser Family Foundation. Jen is the Director of HIV Policy at the Foundation, and directs the HIV-related policy projects, conducts policy research and analysis, and provides HIV/AIDS expertise to the Foundation's public health information

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campaign and media partnerships. Jen is going to speak about prevention strategies for women. Jen?

JEN KATES: Janet, it's very great to be here today. I want to thank the CSIS Task Force and my fellow panelists in advance. I'm going to try to keep this short, and fortunately, a lot of the statistic issues were covered. The first thing that I want to make, and I'm going to come back to this at the end is, while World AIDS Day's campaign for the year and the theme for today is on girls, and too often we still think of focus of women and girls or gender as a special day, a panel, and I think from the specifics and those of us who work in the field we know that it's not. It's something that's integral to everything that we do in response to the epidemic, so it's not an added on component, it really has to be front and central.

So, I'm going to discuss prevention, and specifically the work of a new CSIS HIV Task Force working committee on prevention. We've handed out a one-pager on the committee's purpose and goals. I want to review some of them here. The reason I'm going to do that is, I think the work of this committee is addressing head-on some of the challenges that we all face in addressing prevention among women and girls. So, why was this committee formed? The main reason was to address the concern among many, not just on the CSIS Task

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Force, but many of the groups that are doing prevention work globally, that prevention itself is at risk, and that risk may be increasing. So, why is prevention today at risk? There are several reasons. One is that prevention services historically have been underfunded. There is a funding gap overall and also for prevention. Two, and this is probably one of the more challenging ones, there is an ideological gridlock, often, to discussing prevention in Washington and elsewhere that gets us stuck. It's hard to get past some of the ideological differences. There are still many misconceptions about prevention, what works, what's effective, how to deliver, prevention services, and there's worldwide attention now to treatment, which is obviously a relief to a lot of us who were worried that there wasn't enough attention or consensus a few years ago, but has that shift been at the expense of prevention? And are we losing sight of prevention in and of itself? I want to read a quote from a new commentary that was in the *Lancet* that just came out, and I encourage you all to read the *Lancet* this week. There are several important articles in there, but this is just a quote from a commentary about prevention. These were many experts from around the world. "Although prevention should encompass multiple integrated elements including links to expanded treatment access, changing or maintaining of

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behaviors aimed at risk avoidance and risk reduction must remain the cornerstone of HIV prevention." Of course, that makes it the most complex endeavor that we might want to undertake.

So one of the challenges to prevention is the challenge of measuring prevention. I'm just going to list some of those here: Measuring behavior change is not the same as measuring the number of pills. We all know this, but it's easy for me to say it: It's really, really challenging. We cannot always do a randomized control for clinical trials for prevention. There are ethical reasons we can't, and there are practical reasons we can't. To see population levels change is what we all hope to see, a reduction in prevalence and reduction in incidence takes a very long time, and there have been few really scaled up studies—or not just studies, scaled up interventions to allow us to look at that kind of effect. And sometimes prevention interventions may be held to a different, or even a higher standard. Are we applying the same percentage of effectiveness, for example, into antiretroviral treatment and viral suppression, what we hope a vaccine would deliver to behavior change? Actually, models looking at behavior change at the population level find that a very small percentage change in behavior has a dramatic impact over time on HIV incidence and prevalence. That's

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models, not what we've been able to see yet, but gives us hope. So the main goal of the Working Committee on Prevention was to facilitate the bipartisan discussion of prevention among US stake holders and ultimately strengthen the US response. To translate the large body of literature that is out there on prevention, some of which is very hard to weed through and try to pull out what is the most important salient points for policy makers. Some of the products to look forward to that we'll be working on on the Committee, one will be a prevention inventory of some of the key PEPFAR documents, what is being looked at around prevention and some of the key documents that are already out there, the legislation strategy and the country plans. We also are going to look at the measures that are being used to evaluate or assess prevention over time, not just in PEPFAR but through the Global Fund. There are standard measures out there and we think it might be helpful to highlight what those are. We may also be looking at what funding is for intervention, convening experts around some different topics. I'd be very open to hearing. I should have said this up front—Phil and I are cochairing this working committee, so we'd be very excited to hear your suggestions and input what it could be doing. So, key questions that we're grappling with on the committee, and I think is a central question today for women

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and girls, how to define prevention. There are approaches, such as ABC, and I want to make a distinction between an approach which ABC and prevention intervention. ABC in and of itself isn't prevention, it's an approach to prevention, and different organizations or different communities may put an emphasis on the A, on the B, on the C, but it's an approach, it's not prevention overall. So, that doesn't necessarily answer our questions. There are many lists of prevention interventions that have been developed by UNAIDS, by other international experts that we can look to. One of the challenges—and I'm going to propose a framework to think about—is that there are so many multiple factors that contribute to risk for women and girls, and we heard many of them today. They're complex, they're societal, they're deep. And to deal with them is very challenging and expensive, more expensive than potentially a short intervention, and just harder to identify as prevention. So, let's conceptualize prevention interventions in two linked ways. The first would be direct, or HIV-specific prevention intervention, the kind that you and I might recognize, like mother-to-child intervention of transmission or increasing HIV testing and counseling opportunities, or condoms. You understand those as directly linked to HIV-prevention. But there's also a whole host of indirect interventions that look at things like

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increasing economic opportunities, and educational opportunities for girls. We heard of a lot of others that are out there. So, what I want to do is borrow a couple of terms from the conflict and security setting, which I've been doing a lot lately. For direct prevention, I'd like to substitute the term "Operational Prevention", and for indirect prevention I'd like to substitute the term "Structural Prevention". In dealing with conflicts you need both. You need operational prevention that is going to deal with the prices at hand, and you need structural prevention to address the underlying forces and the root causes of the conflict, and ultimately both are designed to prevent conflict. I'd welcome your reactions to my appropriation of the terms.

The reason this is so important, however, is there are serious implications for funding, strategy and for programs. The discussion that's going on now for all of us is, where do you draw the line? PEPFAR has much more money than has ever been made available by the US federal government before, but it's a limited amount of money, so where do you draw the line on all these interventions, and how many PEPFAR dollars can go to the operational prevention intervention? How many can go to the structural prevention interventions? We know, as every one has knowledge, that both are needed. I think this is really central for women and

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girls, so I'm just going to give some examples of each of those. You've heard a lot so I'm not going to go into them in detail. We've heard a lot about women and girls at particular risk, everything from high-risk behavior partners, whether those are husbands or boyfriends or just casual sex partners. Lack of knowledge of HIV—there's a knowledge gap, or biologically are risk. There's a whole host of factors that have been identified. Some of the operational and direct prevention/interventions are HIV awareness campaigns, condoms—both female and male, providing transportation so women can get to HIV counseling and testing sites, pure education on HIV/AIDS, school-based education. All of these things that we would all recognize as HIV prevention intervention. Some of the structural interventions, again, much harder to get our hands around and much harder to identify a direct link to prevention outcome are things like stable livelihood, boosting economic opportunity, eliminating school fees, microfinance initiatives, many of the things you've heard. I want to add one other dimension. When you start to broaden your perspective and look not at just operational prevention but at structural prevention, it opens up a whole range of venues and providers and interveners that we can all work with. So it's not just the HIV clinics and the HIV-specific sites, it's prenatal clinics, reproductive

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health clinics, family planning, TB and STD clinics, and antiretroviral treatment rollout.

None of this is news to you, but I think it's helpful to look at the prevention interventions in this way. I'm going to sum up really quickly because I think we are running out of time, but I think in conclusion, and I derive this, what I stuck into this framework when I started actually putting down on a piece of paper was looking through all the reports that are out there, pulling out of those reports the different prevention interventions that were identified. They weren't called direct or indirect, but I put them into those boxes. One of the things that I think is ultimately, or something that underlies all of them is that women and girls have to be part of the population for all of these interventions, and also have to be involved in the design and thinking of all the interventions, throughout the course of developing of HIV prevention. That goes for gender analysis too, which is slightly different. I think the two ways of thinking about this operational structural intervention help us to understand the tensions that exist with limited dollars, limited program capacity, but both need to be addressed, and both are needed and are important. So, I will end there, and look forward to your reactions to that report. [Applause.]

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JANET FLEISCHMAN: Thanks Jen. I think that was very helpful and it will also lead to some interesting discussion, both now and in the future as we grapple with these issues. Again, we're going to switch the agenda because of people's time constraints, and we're going to move now to Michelle Gavin, who is Senator Feingold's Director of International Policy issues. I should not that Senator Feingold is the cochair of the CSIS HIV/AIDS Task Force, and served for nearly a decade as the chair or the ranking member of the Africa sub-committee in the Senate, and has been a strong advocate of human rights issues in Africa, justice, issues of women's rights, and HIV/AIDS. So, we're going to hear from Michelle on the Congressional perspective.

MICHELLE GAVIN: Thanks, Janet, and thank you so much for inviting me. It really is an honor to be here with such distinguished and expert copanelists, and I just want to especially note how energizing I find it to hear from the distinguished Ambassadors who are here today, because these issues are often difficult to discuss. They're often—they lead down sensitive roads, and I think there's a lot of courage involved in coming forward and talking about them so frankly and practically and sensitively. It's energizing for me, and I think for all of us who are tackling HIV/AIDS issues it can become overwhelming, so energizing

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interventions are just what is required.

This is my standard disclaimer as a Congressional Staffer: Of course, my words are mine and shouldn't be attributed to Senator Feingold. Basically, and I'll be very brief, I have seen the lay of the land, in terms of where I think we're at on Capitol Hill on these issues, and there are two points of good news, and one point of not good news. On the positive side, we have clear, bipartisan, across the board recognition that women and girls are especially vulnerable. We have the statistics, we have the facts, and they're in front of everyone, and you'll often see in Congress discussions of this issue, people reciting these statistics, and there's a lot of nodding. "Yes, yes, we know, women and girls are especially vulnerable for these problems." Discussions of limited choices that women and girls have, limited access to different services. Yes, a lot of nodding. Everyone accepts that. So that's the good news, that we have that shared basis of understanding.

The problem is, we don't have a lot of consensus about what to do beyond that. You saw that when Congress passed the AIDS bill in 2003 that authorized the PEPFAR, you saw again and again throughout the bill that there's an awareness of this issue, substantivity to it and interestingly, in light of Jen's presentation, an emphasis,

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not on operational issues, but on structural issues that the Congress asked in the strategy report that we requested. We asked for specific strategies to meet the needs of women, including empowerment of women in interpersonal situations, interfacing. A description of specific strategies to increase women's employment opportunities. Productive resources, microfinance programs. You had there in this bill—that had widespread bipartisan support—you had there Congress buying in not just to the operational interventions, but to the structural ones as well. Okay, that's positive, but the strategy report that was delivered to Congress didn't really delve into these issues. I admire the tremendous work that the people at PEPFAR have done and USAID have done. It's a mammoth job, and there's so much that is positive to be said, so I don't want to cast this in the light of beating up on people, but the fact is we haven't really developed specific strategies. We don't seem to have specific strategies to address those issues, and I think that there's some discomfort sometimes in fleshing them out. There are a couple of reasons for that. One, sometimes, if we get down a road that gets to some politically sensitive places, when you talk about collocating services at Family Planning clinics, whoa! Red flags are suddenly flying all across the room, and nobody wants to destroy this important consensus that we've achieved

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to date, so there's a little concern about ending up with our discussion getting hijacked by a different discussion that has proven to be very contentious time and again.

The other problem is that they're all supposed to sound very diffuse, right? The structural elements that have made this pandemic as horrifying as it is are—talk about overwhelming—you think AIDS statistics are overwhelming, start talking about why women and girls don't always have the power to make these choices. And other structural elements fall into this category, too. Public health infrastructure, generally. There's hesitancy to talk about these factors that in my mind sort of create the enabling environment for a pandemic to be this bad. So now it starts to sound like development bit large, right? It becomes an agenda so broad that people feel like, whoa, we've got to focus here. Otherwise we're going to wind up doing a little of this and a little of that and nothing's going to get done. That's sort of the dilemma that we have, recognition of how real this issue is, and then the sensitivity and concern about moving forward. It's also part of this diffuse sense of the problem plugged into the fact that Congress loves quantitative measures of progress. People want to go back and say to taxpayers, "Yes, your dollars are doing something, and I can show you here on this bar graph the progress that we've

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made." It's totally understandable. It's a good thing about representative democracy, but sometimes it makes it really hard to get invested in structural issues, because it's hard to say, these are going to be the targets and these are going to be the measures, and this is how we'll get it done. I think that makes the issue less appealing for people who are trying to deliver the results, and it makes it less appealing for the people that champion, perhaps on Capitol Hill.

After that sort of midsection of not so good news, the final point that I just want to wrap up with is that it's important to remember at the same time, there's a lot on our side, in trying to move forward and affecting this issue more effectively. One, you really do have widespread consensus. The people want to fight AIDS. If the people understand properly, they are invested and really want to help. So if you can't really get at this pandemic without getting at these issues, that brings people to the table. Eventually you're reeled in, whether you want to be or not.

The other goes back to that earlier point. On the bright side, the members of Congress want to go back and tell their constituents that we're making progress. We want the most possible bang for the buck. We're not going to waste our money. So again, if you can't effectively fight AIDS without expecting gender issues, then Congress has a problem with

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that, because it's a lot of taxpayer money, and it's a really big issue and we want to get it right. I think sometimes that talking about things in this way, talking about are these investments really getting at these problems, are we getting it right, can help draw people in, rather than jumping to a more politicized perspective of issues. We've got this kind of general lay of the land, and I hope—I'm somewhat optimistic. [Applause.]

JANET FLEISCHMAN: Thank you very much, Michelle.

It's very helpful to get a sense of what it looks like from that perspective on the Hill and therefore help us in our own efforts to strategize it. Next I have the great privilege of introducing Asunta Wagura who is the Executive Director of the Kenya Network of Women Living with AIDS. She founded the Network in 1993 along with four other women living with AIDS who were seeking to create a safe place for women to support each other and to protect their children from the fierce stigma surrounding HIV. Kenwah, [misspelled?] as it's known became a registered non-governmental organization in 1998 and brings hope and health to the community largely through private donations and extensive voluntary commitment of its members. Asunta is also a member of ICW and will speak to us a bit about the work of her organization and some of the issues she sees from the Kenyan perspective. Asunta?

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[Applause.]

ASUNTA WAGURA: Thank you very much for this opportunity. Distinguished guests. I would want to say I'm grateful [inaudible]. I want to give you a little bit of background of my personal experience and how I came to be HIV/ work. I tested positive back in 1988. I was 22 years old then, and my life was just brightening up. I had just joined a medical college and the person who disclosed by HIV status to me did not do counseling. She just told me not to go around, and she just told me, "Asunta, I'm sorry. You have AIDS." For that, from there it went to find out how can I go about my living. She told me, "There isn't much to plan for because you might not live beyond six months." From that time, my life started rotating and revolving around six months, and being first of all from my family—I am coming from a poor family—it was a complete let down. My family, my mother was very disappointed. Without going into the details of the trauma I went to do, when six months were over, I was not dead, I was not sick. My family told me—I just took root somewhere to die from, and of course nobody was there who could explain how I got to be infected. Of course, there was nobody to listen to me, to explain how I got infected. Of course, everybody put it down to, "She is a prostitute. That's why she is infected." It is within that rejection,

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isolation, agonizing that I founded The Kenyan AIDS Work of Women Living with HIV and AIDS, there women who are HIV-positive, and we said within this organization we will offer that which we were not offered, and so we offered very compassionate counseling to those who are infected, with particular focus with women with HIV.

Through this struggle, I have lost three of the founding members. We are actually two now, and luckily after 14 years of struggling with HIV, in the year 2002 I was fortunate enough to access antiretroviral drugs, and of course at this time, signs were very evident of full-blown AIDS, and one practicing doctor told me, "Asunta, you have no option but to start on ARV's." My doctor had told me I have done all that is possible, and now we cannot save this [inaudible]. Of course, I had skin conditions, all of the rash. Everything was evident that I was going to die. I am the mother of one child, and all along my child, whenever I went for conferences, whenever I went to go away, he was asking me, "Mom, what did they say?" He didn't ask me who they were. He sought if I was coming back with a good message, had they found a cure? Essentially what he had told me, US did something about it. He said, "Mom, are you aware of the US did?" I said I would try to see what was in the news. After the Barcelona conference he asked me, "Mom, di

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you see anybody who has lived 15 years with HIV?" Of course, that was the 14th year I was living with HIV. The reason why he asked me, he wanted to know, I'll be there the next year for him. I know even when I leave for this everybody will take care of him when I leave for Washington. He'll be asking me, "What did they say?" I know he's actually asking me, he doesn't want me to tell him about the long policy documents, about the PowerPoint presentations, what he wants to hear is that there is hope, that they will be able to access the long talks about treatment, and that they will be able to see their children, and when most of the women present their cases to me, they don't tell me, "Asunta, I'm so worried I'm going to die." They never talk about their death. It's, "I'm so worried what will happen to my children." I tell them just traveling, I tell them that—I am so happy that most of the policy makers are [inaudible]—the PEPFAR, the Global Fund, he gets to hear about these resources through the media, and that's the fact, who actually ends up with these resources? We need to be involved. We want to be part of the implementation. We want to be part of leadership. And I can tell you it's the woman at the grassroots who attends that patient in the bed, it's the one who changes the bedding, it is us who witness when these people die desperately and miserably, but we know that there are resources to address

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the projects that they go through.

I want to say something about why I campaign for access to treatment. It's because I'm on this ARV therapy; I've seen them dramatically change my life. I live a fulfilled life. I can discuss with my son about him going to graduation. I talk on an area I always [inaudible]. It's because now I can live a fulfilled and very hopeful life. I live for the Kenyah. We have 3,000 women. Through my own we have money to put everyone on ARV's and only one we lost in the year 2003. She died of [inaudible] complications. So of this 63, I survive, and therefore they are healthy, and I am able to coordinate their activities. So I don't have to contribute their treatment any longer. They go on living and contribute to their own welfare, their own treatment, and to see about their children. So, I ask today, those who are involved that we need these programs to be made for the people, both flexible and accessible to the people, but not like the other way, like as people made for the program. Because a program like PMCTC in my country is very popular, but the communities they work with who live on less than half a dollar per day, they cannot access the PMCTC program. They all deliver at home. There is nobody to access them in the home set up, and whenever I try to seek whether they can be admitted into the PMCTC program I'm told, "Asunta, they

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should have gone for antenatal. They should have gone back there, but that is not the scenario [inaudible] is quite high.

About access to treatment, it's still a nightmare in the communities I'm working with. Of course there's a lot of publicity, drugs have gone down; they are costing less than eight dollars, but when you walk into the hospitals you get the surprise of your life. You are told you have to pay consultancy fees, you have to pay, CB4 count, viral load, and all that amounts to not less than \$110. And I'm talking about a person whom I had to provide the meal, transport to the hospital only to be returned unto the doorstep. I'm sure many see this hopelessness they are not even able to pursue the [inaudible] of accessing the treatment.

Many children come after their mothers have died and they look at me, and i can see it the reasoning in their eyes, "You must save my mother. You sit in a position to save my mother. You did not save my mother." And I can assure you, we do not have safety [inaudible] for [inaudible] infants and vulnerable children, and most of them heat to the streets, if not into the system, the girls become prostitutes or commercial sex workers in order to sustain their siblings. They are on getting infected again, and the cycle is repeated. Whereas, for the boys, of course, they join to-

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they will not remain orphans forever. They do not remain young forever. They join in criminal activities and I'm sure you have heard that [inaudible] and violence have gone high. When I look at the [inaudible] and the shooting, I say, "We cannot address this problem from the top, we can only address it from the root because what we are seeing is outcome of a long time problem. So I may call the policy makers, the resources, let them be channeled at the grassroots communities, I boast to access this, just because they once were involved with the implementation.

Let us [inaudible] a balance that you don't always hold meetings and discussions and deliberations in five-star hotels. Just as we could also hold meetings at the community level because it's the people who are with the problem, and I appreciate the time you made for me. Thank you. [Applause.]

JANET FLEISCHMAN: Thank you so much Asunta. It's so important for us to have your voice here to hear your ideas and learn from you about what's happening on the ground and be able to integrate those sorts of thoughts and ideas into the programs that we're pursuing in an ongoing way. So we appreciate your presence here today.

Last, but never least, Dr. Phil Nieburg. I'm sorry Phil, that I know that you're going to be very brief in your presentations because you have such a small topic. Routine

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testing, special risks for women and girls. This is obviously a very complicated topic, very timely and there's no better than Phil to present it in all its complexity. Phil is a pediatrician, trained in infectious diseases who has worked in public health since 1977. He currently divides his time between Project Hope where he's the Senior Technical Advisor on HIV/AIDS and tuberculosis, and the Center for Strategic International Studies here, where he is a Senior Associate with their Task Force. He's also an adjunct faculty at the University of Virginia Center for Biomedical Ethics and the Institute for Practical Ethics in Public Life. Phil?

[Applause.]

PHILLIP NIEBURG: Thanks Janet, and good afternoon to everyone. I'd like to thank the other panelists for their contributions of their own. I hope today to not just revisit the ongoing debate about why the international community or individual countries or people say yes or no to what has been labeled as routine HIV testing. I'd rather suggest a new perspective, some perhaps provocative perspectives to be included in the discussion.

First of all I'll spend a little time on brief background, just in case there are people here who are not familiar with the current discussion or debate. The idea of the concept of voluntary counseling and testing for HIV has

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been around for many years, but with only a few exceptions, the numbers of people tested in various programs remains low. There are many overlapping reasons for this low uptake, including lack of resources, lack of leadership, stigma, peer violence, et cetera, and you've heard many of them earlier. In any case, it's now that counseling and testing programs have not always been as successful as hoped at providing information about HIV-status to large segments of population. Globally, the most recent estimates are that no more than ten or eleven percent of all HIV-infected people are aware that they are infected. In some places the rates are even lower than that. However, the recent increase in the number of scale of antiretroviral programs has put the idea of a need for greater HIV testing focus. In some countries, and Botswana is a good example, even the availability of antiretroviral programs was initially not enough to increase the number of people being tested, and because those numbers being tested and treated were initially well below expectations, the program, what's been labeled as routine HIV counseling and testing has begun in Botswana, in which people going to certain healthcare facilities are to be counseled and tested unless they opt not to be tested. One of the handouts is a recent article from CDC's Morbidity and Mortality Weekly Report describing the results of that

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expanded testing program specifically in antenatal clinics. Major international agencies like WHO and UNAIDS are now involved in the global dialogue on this set of issues. Earlier this year WHO issued a couple of documents on routine testing, one of which was cosponsored by UNAIDS, and I think that's one of the handouts. So, in contrast to the traditional counseling and testing approach of individuals actively seeking testing sites, this new expanded testing model is based on health systems bringing forward HIV testing and counseling options to individuals who come in contact with various components of their system, such as clinics for tuberculosis or sexually-transmitted infections, or antenatal care or family planning. It is intended that people will retain the right to opt out of this testing when the offer is presented.

I wanted to next mention some but not all of the concerns that have been expressed about this routine testing and the testing programs. First, it actually raises an ethical quandary, not the only one that's based on testing, but the quandary between the rights of access to treatment and the right of protection from abuse that may go along with knowledge of infection. The one question—I think they're basically rhetorical questions at the moment—is routine testing really mandatory HIV testing in disguise? There have

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been a couple of comments in the HIV literature making this claim. Hopefully the answer is no. There may be an undercurrent in some places, including this country and other countries of discussions still going on about mandatory testing. Second is, can an opt-out system be truly voluntary? The concern seems to be convinced to be tested because of an inadequate pretest counseling and inappropriate persuasion when they really would prefer not to be tested. The answer to that may vary locally. Hopefully that will not occur, but what needs to happen is these testing programs, the standards need to be operational research done about the [inaudible]. Will counseling and post-test support be accurate in terms of disclosure negotiation, protection from stigma and discrimination? And again, the answer to that is going to depend on how well the local programs are resources and how well the staff are trained as to what the laws and policies are. And, finally on this list, will HIV/AIDS mortality/morbidity rates improve or will suffering be reduced, and will transmission rates fall? Again, the answer to that is not known, but the point is, it definitely needs to be looked at.

So, to begin my comments about this, I wanted to talk for a minute about the semantics of the testing issue. Semantics are important in HIV/AIDS as in other areas of life

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because the way that people label and describe things provides clues on how they really think about it. The first comment is about the use of the term "routine testing". The term "routine" is defined in various dictionaries as established or habitual, or mechanical or regular, which relates to a rule, and there's an implied sense of requirement in these terms, and that may be partly responsible for the occasional misconception that a routine approach to testing is equivalent to or a proxy for mandatory testing. It's not clear to me where the term "routine testing" came from, but its use was apparently to refer to the offering of testing. In fact, in the handout from the WHO and UNAIDS is that they used the phrase "routine offer of testing" in their discussion. The term "routine testing" itself never appears. There's been one particularly unfortunate episode a few months ago in the New York Times discussing Botswana's program, used the term "mandatory testing" in the headline. And so this semantic aspect argues for a less provocative term such as "expanded HIV testing".

A second comment is about the title of the specific topic I'm talking about today. There are clearly special risks to women and girls from the HIV testing process. We'll talk about some of them in a minute, but in retrospect, I might have preferred in the title to include not only the

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concept of special risks, but also the concept of special benefits, associated with expanded testing such as reduced stigma—as more HIV-infected people are identified and treated, improved access to prevention of mother-to-child transmission of HIV or benefits of uninfected women coming from learning that their sexual partner is infected. Those are a couple of examples. The real question at hand is how to balance the benefits with the risks of increased testing, how to programmatically tilt that balance toward increased benefit and away from risk. I'm raising this issue, because I think we need to be very careful of the public discourse, make sure there is public discussion that remains balanced.

It's very clear that the issue of expanded access to testing is greatly complicated by the gender dimension of the pandemic, and I wanted to put a couple more of my biases on the table in terms of thinking about this issue. One is that success in reaching global goals for prevention, care and treatment will require that a larger proportion of the population are aware of their infection status. Secondly, gender-based violence or both physical and the non-physical kind, including intimate partner violence is a very serious issue in any, if not all countries. In many countries that gender-based violence is reinforced by laws that disempower or otherwise disadvantage women. Next is that an expanded

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approach to HIV testing is happening. It's the only way to achieve the rapid increase in numbers receiving treatment that has now become a consensus international community. As such, that reality of expansion needs to be addressed by moving a discussion from whether it should happen to how it should happen.

One other comment is that the sense in the discussion today around testing issues needs to be that not being tested and not finding out that one is HIV is infected is somehow equivalent to avoiding rather than postponing the need to address issues of disclosure and prevention. Although it may be true that gender-based protection mechanisms will improve over time, and the risks therefore will decrease, it's also true that having people find out about infections much later, people will become clinically ill with AIDS may mean that the critical issues have to be confronted at the time when people are sick.

Another comment is that it's a bit ironic that I'm talking about this issue today, in the sense that it's ironic that the focus on HIV testing has come about because of all the public attention given to antiretroviral treatment. I say that because the major topic of World AIDS Day is the increasing feminization of HIV pandemic. That increasing feminization is based on a failure to prevent HIV

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transmission, it's not directly a treatment issue. There obviously are treatment implications, but it's a prevention failure. And so, it's important to remember that most women and girls in the world who are at risk of HIV are still uninfected, so we need to make sure that we don't inadvertently focusing attention away from the prevention issue, and that was raised a little bit earlier.

Okay. The bottom line, in terms of thoughts or recommendations: One, women and girls definitely need extra protection from gender inequalities during expansion of testing; Two, the transition to new testing options has to occur very carefully, in a way that enhances the legitimacy of new models in the eye of the public. And the public, including its individual members as well as civil society has to be given a clear explanation of the goals and mechanisms of many of these [inaudible - off mic] The 4 C's of testing are Counseling, Consent, Confidentiality, and Care access will continue to be respected.

Next, local decisions are at least as important as global decisions. Testing has to be accompanied by extensive outreach to civil society to help ensure the availability of protection. Fourth, operational research and ongoing evaluation is needed to examine every facet of an expanded testing model, including documentation of risks, costs and

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benefits. And finally, steps to successfully implement structural change needed to provide comprehensive prevention, protection to women are likely to occur very slowly no matter what we might wish at the moment, so we need to reach a consensus on what position will be taken in the interim on testing to facilitate the broader access to testing while providing the maximum possible protection in local circumstances. Thank you. [Applause.]

JANET FLEISCHMAN: We are officially out of time. Do we have—can we take a couple minutes for questions? Thanks very much. First of all, I wanted to thank the panelists because I think they provided an excellent overview of the range of issues that underpin the need for attention on these issues and the importance of moving forward on all fronts. I'd like to take one second as my prerogative as chair here to recognize Violeta Roth, who is a member also of ICW, the International Community of Women Living with AIDS, their representative from the Andean region. She's here for events on World AIDS Day tomorrow and I think we'll give her the opportunity to ask the first question or make a short comment. Violeta. [Applause.]

VIOLETA ROTH: Is this working? Thanks a lot for this opportunity. I really appreciate every presentation. I really can learn about your experience, working on issues of women

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and AIDS. I would like to support the comments of Asunta, which is one of my close friends now, and I would like to remember what she said. We want to be part of the programs and not the people for the programs. As women living with HIV, we are already leaders working on the AIDS response and I want to call you to take us as leaders and include us into the decision-level process and policy design process, not only as beneficiaries of the programs. If you don't know how to do it, you just have to ask the women living with HIV or you can also look at the website of UNAIDS and think on the Global Coalition of Women and AIDS. They have very good recommendations to include women and AIDS, and Janet was working with them as well. I would also like to remember the comments of Peter Piot this morning in a meeting this morning earlier. He said the US is the only country that can move the world, so I really prompt you to keep on doing this support because your impact in the world as a country is not something that we cannot measure now, but we will see after. But, consider this, because not all countries are taking the issues of women and AIDS as a priority and we need to guide all habits to do this justice, the PEPFAR and other US initiatives are doing.

And I would also like to add, to take advantage of this opportunity to ask all the US funding programs to also

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look at South America. I know Africa has special difficulties to face HIV/AIDS but also South America, and also countries from the Andean region, like Peru, Bolivia, Ecuador. I am from Bolivia, and I can tell you all the issues that are happening in Africa are also happening in South America. We are often postponed in the HIV/AIDS programs because we are supposed to be a region with a lot of access to treatment. They say we have 75 percent access to treatment, and that is true, because Brazil is there. If we take out Brazil, then we have many problems in AIDS responses. So, I would like you to promise, as Americans who are looking for accountability on your dollars and your programs, please don't forget to look at South America and the Andean region. [Applause.]

JANET FLEISCHMAN: Thank you very much. We're very glad you could be here to join us and it gives us more time to extend the panel. We have a little bit of time for some questions, so let's open it up. And please identify yourself.

LELEA KILBORNE: My name is Lelea Kilborne. I'm working with the Christian Children's Fund. I just wanted to take you up on your invitation and ask the two representatives of ICW to comment on the idea of opt-out testing [inaudible].

JANET FLEISCHMAN: Asunta, do you want to start?

VIOLETA ROTH: I'm just going to answer the question

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quickly. That's a very complex issue. In Peru now, it is mandatory that all pregnant women and the petitions and the benefits are the consequences of testing or not testing are many. Some women with HIV agree with this law, meanwhile, some feminists don't agree. Feminists women face the violation of human rights of women, but women with HIV say that it is good for women to be tested as mandatory in the antenatal care because some of them lost their children because of AIDS and they wanted to be tested before. Other women were offered the test, and said they would rather ask their partner who says, "You don't have to test. Trust me, I have never been with anyone else." So they didn't test, and they were positive and they lost their children to AIDS. So, I cannot say ICW will say this position or the other position. Of course, we believe, and I think all people with HIV believe voluntary testing is the best option but not always so easy to do. We need to consider all the situations in each country. Many women just found out they were HIV-positive because they had to test in the antenatal care, so I am also a representative of ICW in this particular meeting, but I also know that ICW would fight for the human rights of all people, those living with HIV and those who are going to test.

ASUNTA WAGURA: [Mostly inaudible - off-mic.] It is

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important testing. You can test negative [inaudible] and in my country [inaudible]. There is the emphasis on the mother. passionately was in place to oppose when I was [inaudible] and I just violated that and I went ahead and gave him baths. My child is 14 years and I think what I appreciate so in my life. I can't imagine if I went ahead and aborted him. Unfortunately for me there was no information telling me don't breast-feed, don't do this. But now we have all that information. [Inaudible] in fact, I think I managed to gather courage only in this year in August to have my child was tested and luckily he tested negative, but that I gathered courage, because I knew if you test positive, I have means of accessing him to antiretrovirals, but I tell you, it was the most trying moment of my life. Thank you.

JIM FRAZIER: Hi. I'm Jim Frazier with United Nations. A question for you USAID in terms of the delivery of antiretroviral delivery to the PEPFAR countries. You didn't mention what the status is on that update on delivery of antiretrovirals to the 15 PEPFAR countries.

CONSTANCE CARRINO: We have a report that is out from the US Government, if I could remember the month for you, but I know it's on the state website. I think initially we have 25,000 people on treatment and plan, we're estimating based on the programs by next summer 2000 people on treatment as we

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start rationing the program. There's been a tremendous amount of support as you might imagine. The treatment regimens, of course, have to be whatever regimen is approved by the country we're working in. We're working with whatever the national plan is and in some countries, the case of South Africa, for example, the country is providing their own drugs and we're providing services around it. It depends on how this is being put together. I think folks on the inside of this have been pleasantly surprised, if not shocked at how quick the uptake has been.

JANET FLEISCHMAN: I think Phil has a response.

PHILLIP NIEBURG: Just a quick comment on the last, prior question. I think it's important that you're not making the automatic assumption that care means antiretroviral treatment and that when you're thinking about testing, the number of conditions that cause suffering for people with HIV-infections like tuberculosis, depression and lower respiratory disease and diarrhea, where the specific treatment— and [inaudible] care as well—specific treatment is available. Keep in mind that even under the most optimistic scenarios, most HIV-infected people in the world are not going to have access to antiretroviral care. It's important to think about those other people.

JANET FLEISCHMAN: Is there a—oh, sorry, Connie.

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CONSTANCE CARRINO: Sorry not to add this, but it's because it's just happening this month, back on the issue of treatment and antiretrovirals. The US Government is actually sitting down with WHO, UNAIDS and the Global Fund for AIDS, TB and Malaria so that by the end of January we should have a sense of how many people are on treatment for the whole world. This is a real issue in terms of measurement. I'm not sure if that's where your question was going, but we're pretty committed to doing this as donors together and not just going bilateral.

JANET FLEISCHMAN: I think since we've run a bit over time, if there are not more questions we'll wrap it up now. I want to thank you all very much for coming. I want to thank the panelists very much for their insightful contributions, and I hope we'll all be meeting at frequent intervals over the next months as we move forward with this important agenda. Thank you all. [Applause.]

[END RECORDING]