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**Thursday Plenary
Kaiser Family Foundation
July 22, 2010**

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MALE SPEAKER 1: Good morning everybody. The International AIDS Society and its partners are proud to sponsor a number of prestigious scientific prizes and awards at AIDS 2010. The prizes and awards are aimed at rewarding promising researchers doing outstanding research on HIV and AIDS. The IAS/CCABA Prize for Excellence in Research Related to the Needs of Children Affected by AIDS is being awarded today.

This prestigious \$2,000 prize is jointly offered by IAS and the Coalition on Children Affected by AIDS. One prize is awarded to an investigator who also demonstrates excellence in research that is likely to lead to improved services for children affected by HIV and AIDS.

LORRAINE SHERR: Good morning. My name is Lorraine Sherr and I'm part of the steering group for the CCABA and it is quite a privilege for me amongst a team of industrious people who work for children to award this prize for 2010 Excellence in Research Related to the Needs of Children Affected by AIDS is awarded to Priscilla Akwara from UNICEF.

Priscilla comes from Kenya [applause] and she submitted and presented yesterday an absolutely excellent abstract, Who is the Vulnerable Child: Using Survey Data to Identify Children at Risk in the Era of HIV and AIDS, which is a quality abstract that allows us to have solid, evidence-base for decision making and we're thrilled.

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We're also going to give her a wonderful certificate from the IAS today, but in addition to that, we've got some drawings because we felt as children, we should have something from the people for whom Priscilla serves; her real population. And these are two children affected by HIV and AIDS from South Africa. [Applause] Priscilla. [Applause]

MALE SPEAKER 1: Without further adieu, it gives me great pleasure to introduce the plenary session of this morning. And I would like to introduce for you the co-chairs of the session who will be in charge of introducing the speakers.

Ashkok Alexander is the Director of Avahan, the Bill and Melinda Gates Foundation on Global Health Program HIV Prevention Initiative in India. He leads strategy development for the initiative. He identifies effective programs, and oversees grant making. Alexander works closely with India's central and state governments, NGOs, and corporate partners in these very, very, extremely successful initiative that the Gates Foundation has [inaudible] in India.

Next, I'd like to introduce to you with great pleasure and in fact, it is my honor to introduce the first lady of Georgia, Ms. Sandra Elisabeth Roelofs, who is an advocate for the United Nations Millennium Development Goals with a special focus on the reduction of maternal and child mortality, extreme poverty, and infectious diseases.

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She truly knows that universal access is the way to the millennium develop goals. She currently works as a Nurse in Tbilisi. We are honored to have her here with us today.

Finally, I'd like to introduce to you Jeffrey Sturchio who is the President and CEO of the Global Health Council. He was a long-time leader of Merck Company, a long-term partner in the fight against HIV and AIDS, whose quiet diplomacy lead to programs treating more than 100,000 AIDS patients in Botswana, as well as protecting millions of Africans from legal blindness.

Sturchio worked for nearly two decades in America studying as the company's first corporate archivist and ending as Vice-President of Corporate Responsibility as well as President of the Merck Company Foundation.

Let us work on these three grand heirs on the global fight against HIV and AIDS today. [Applause]

ASHOK ALEXANDER: Good morning ladies and gentlemen. My name is Ashok Alexander and it's my great pleasure to introduce the first plenary speaker, Professor Carlos Caceres. Carlos Caceres is Professor of Public Health at Cayetano Heredia University and Director of the Institute of Studies in Health, Sexuality, and Human Development in Lima. He obtained his medical degree from Cayetano Heredia University in 1988, and his master's and doctorate degrees in public health

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epidemiology from the University of California, Berkeley in 1991 and 1996.

At present, he's co-editor of Sexuality, Health, and Society and a member of the UNIAIDS Prevention Reference Group. Professor Caceres is also a member of the IAS Governing Council. [Applause]

CARLOS CACERES: Thank you very much for the honor of this invitation. As you see, we have changed the tide of our talk to reflect how we feel about the role that this approach, combination prevention, could play in the longer-term response to HIV if well understood and applied.

The topic of combination prevention was highlighted in discussions in the last conference and it's increasingly taking into account as a sensible way to go in policy debates. For example, the UNAIDS Health framework identifies 10 priority areas for focused support by the UN System at country level, including reducing sexual transmission, preventing people who use drugs from getting HIV infection, removing punitive laws, policies, and HIV related stigma and discrimination, stopping violence against women and girls, and strengthening social protection systems, all these linked in a combination prevention framework.

However, SIPI [misspelled?] combination prevention has not yet become a guiding principle of HIV programming. In part, such limitations can reach results from labs, results

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from demonstrating actors about the novelty, the possibility, the efficiency, and the need of combination prevention.

A lot of that we feel is a result of confused use of this concept. So our goal today will be to try to find concepts about combination prevention, argue that such interventions including human rights strategies are center to HIV prevention and discuss how and why it can provide a standard for a next phase of the global HIV response.

Part of the general conviction around combination prevention stems from an agreement that there are serious problems with the way HIV prevention programs are planned and delivered, and concerns that too much debate when pitting one intervention approach against others, when it's clear that reducing HIV incidence at the national level requires multiple strategies when they are coordinated and mutually supporting.

While conceptually over the past 30 years, we have moved from understanding risk groups to risk practices to cultural contexts and social vulnerability. Most of our prevention work has remained focused on changing individual behaviors and lately to susceptibility to infection and infectiousness.

Moreover, our programs are not only disbursed, but a few good standards are applied only to a limited extent in part due to insufficient dissemination. Moreover, there is deep controversy as to what the right way to approach prevention

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should be, even amongst scientists. Also, as [inaudible] pointed out, our programs are fragmented and scattered.

Perhaps the most critical problem is that we focus on short-term change. This largely relies on limitations in our constant models, but also from the emergency response model prevailing in HIV, and from the need to demonstrate the impact of investments during the life of projects or studies.

Finally, most of prevention work in the world is never evaluated, so technically we learn very little about its impact, in part due to limited investment in prevention evaluation research. Still, over 54-percent of global prevention expenses are focusing on the general population, globally defined.

Classifying country's epidemics by academic level, this graph shows that prevention expenses on most at-risk populations in low-level and concentrated epidemics are still below seven-percent of total prevention spending, with men who have sex with men have the least attended to with less than one-percent in both cases.

In generalized epidemics, prevention spending is even worse with less than one-percent of prevention spending focused on groups most at risk in general. While our understanding of HIV epidemiology has been guided by others and mainly focusing on factors affecting the reproductive number and much HIV programming has use a proximal determinants model, basic public

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health recognizes that health outcomes are also a function of their environment.

Individual aspirations and conducts are shaped by interacting individual characteristics with their social and cultural findings, by relationships, by the services and conditions in their community centered organizations, by broader social, cultural, legal, political, and economic, and even physical or mental factors at societal or national level and beyond.

We all know that combination prevention emerged as a term only as a few years ago as a analogous to combination treatment, one of the most important achievements in the HIV response. This graph, cited by Coates [misspelled?] and colleagues in the The Lancet series brought the analogy even further by using the expression highly-active HIV prevention to cause the combination of behavioral and biomedical strategies, ARV treatment, social justice, and human rights in the context of leadership and community involvement.

It's true that the concept of combination prevention is used in more than one single form however. We will briefly describe three types. The first one is the tactic of combining two or more intervention strategies. For example, needle exchange programs plus opiate substitution programs.

In 2009, NIH issued a call for applications for pilot studies to identify and test the feasibility of combined

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strategies for prevention. However, the goal was restricted to biomedical and behavioral prevention and its structured interventions.

Type two is about combining diverse strategies to meet the needs of diverse sub-groups in the population. For example, to jointly launch information and services tailored for several sub-populations found to be at risk.

Finally, type three would be the strategic combinations of biomedical, behavioral, and structural approaches throughout those key courses of HIV risk and vulnerability for a particular population.

For example, Jones strategies to empower women or to involve men in context with high-incidence related to concurrent partnership or working with MSM and transpeople with behavioral change promotion, STI treatment and antiretrovirals, decriminalization of homosexuality, and community organization, or likewise, with injection drug users in needle exchange programs, opiate substitution, decriminalization of drug use and mobilization.

Type three combination prevention is in essence, the definition agreed upon by the UNAIDS Prevention Reference Group which emphasizes the use of biomedical, behavioral social structural strategies for creating multiple levels to efficiently respond to needs based on prioritization, partnership, and community engagement.

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So, more appropriately, we are talking about evidence informed comprehensive, strategic, human rights-based programming. In essence, this is not a new concept, but I think this is the most important lessons learned in HIV prevention over three decades already.

When saying evidence in form, we referred to as three kinds of evidence. First, epidemiological partners and trends. For example, data, where the new cases will come from. Second, main drivers of those epidemiological trends. For example, proximal [inaudible], social, and biological drivers.

And finally, no reach of available interventions for those epidemiological partners and their drivers designed within a human-rights framework as pointed out by Eve Soudrassonby [misspelled?] This graph by Case and colleagues presented at this conference illustrates implementation of combination prevention in the future.

For 22 of the hardest hit countries in the world to better accounting of the 75-percent of the global worldwide of HIV, the AIDS 2031 modeling were grouped, and made more projections for the possible course of epidemic. In the status course scenario, with coverage of the interventions remaining at today's level, there will be 45 million new cases between now and 2031.

In an alternative scenario called scaled interventions, where many of today's interventions were combined and scaled-up

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including circumcision, counseling and testing, treatment, and community organization in generalized epidemics, as well as condom use and harm reduction among those at greatest risk in concentrated epidemics.

By 2031, there will be 29 million cases overall. This means that over the next couple of decades, 45 million infections are expected in status quo conditions, 25 million or 57-percent are avertable.

One simple way to classify HIV prevention interventions considers three broad categories. First, behavior interventions, the most traditional in the prevention world focused on individual behavior change to reduce exposure of infectivity, for example, reduce the number of partners using condoms, using clean needles.

Second, by a biomedical prevention, which encompasses approaches where the use of biomedical tools or procedures is key for circumcision, several strategies using antiretrovirals such as PMTCP or PET, the inclusion of treatment as prevention, as has extensively been discussed in the conference, or at instrumental threat vaccines, and microbicides, of which we heard exciting news this week.

Of course, they are not purely behavioral or biomedical strategies and there is some overlap in the components.

Since 1995, several first started to work on structured interventions, including SWET [misspelled?], Parker, and some I

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told you, Blankenship, Pronique [misspelled?] and colleagues, and we also have the 2008 Lancet Review by [inaudible] and colleagues and papers from the AIDS 2031 Social Drivers Working Group.

Certain interventions are those focused on aspects of the social, political, economic, and even physical environment that determine people's vulnerability to HIV through restricting access to care and a general more forms of social exclusion.

For example, laws criminalizing HIV infections, sex work, drug use or homosexuality, state violations of right, poverty leading to migration and transsexual sex, cultural norms restricting people's sexual autonomy or producing discrimination.

Thinking concerning such factors is important supported by an extensive literature of social continuance of health as emphasized not long ago by another committee appointed by WHO. The new depths of structured interventions involves changes in laws and regulations as well as decriminalization of transmission, drug use, sex work, or homosexuality, changes in culture and social norms, environmental enablers, as well increasing access to services, community mobilization and empowerment and policy dialogue stakeholders.

For example, the poster social inclusion. This could be a snapshot of how behavioral and biomedical factors are

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influenced by various kinds of structural factors. I won't get into the details shown in this graph, with behavioral, biomedical, and structural interventions. But we'll mention that structural interventions will include those in the social and cultural domain. For example, stigma reduction goes in the political economic domain, for example, human rights programming or microfinance. And those in the physical environment are seen as example with the structure and transportation development.

Now let's turn to a point about the role of human rights in this formulation and how it is more than just rhetoric. The protection of human rights is not only an ethical principle, it is central to effective intervention. Discrimination or racism of HIV started gender, sexual orientation, drug use or sexual practices deters people from accessing prevention services and makes them more vulnerable to infection.

This is exacerbated where discrimination is institutionalized through law and policy. Good prevention planning starts with human rights analysis, understands people's needs, and constraints in program design. It's not sufficient to just plan to protect human rights and implementation. Moreover, environments will protect human rights and discriminatory an individual motivation of HIV.

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For example, operation shown by Eve as well, Straube [misspelled?] and colleagues worked on the potential of combination prevention in IV user epidemics. They model the potential impact of the human rights intervention in Ukraine.

They highlight that policy practices will directly influence at risk of HIV acquisition by effecting where, when, and with whom, and the context in which drugs are injected.

For example, rationing injections, injecting and shooting pre-loaded syringes to avoid arrest. Those having experienced police beatings are more likely to report with the persons which use or use pre-loaded syringes. Effects are highest in Odesa [misspelled?] where 24-percent of IV users report having ever being beaten by police. It is assuming that without police beating, those individuals who have been beaten might behave more like those who have never been beaten. In this model will predict to maintain a 19-percent reduction of new infections in Odesa between 2010 and 2015; clearly, a very meaningful reaction.

Another study also models the impact of stigma on PMTCP interventions. In essence, they predicted that stigma and discrimination reduce the impact of PMTCP programs. In height of participants, such reduction in impact could lead to 55-percent additional prenatal infections.

Stigma could reduce the effectiveness of PMTCP by reducing the proportion of women being HIV tested, mothers

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taking the nevirapine, the proportion of children getting prophylaxis, and adherence to feeding guidelines.

Critics of combination prevention tend to misinterpret the concept as doing everything for everyone, including the kitchen sink, which is quite different from what this approach calls for. It is also said to be unfeasible. Well, the data of effectiveness of combination already exists. Studies like Sonagachi, image stepping stones on other hand have many lessons to be learned.

For example, the image trail showed a 55 reduction to intimate partner violence, a key factor of HIV transmission among women in South Africa, who received the combination intervention of partner violence and gender and HIV education.

Political focus where needs are capacity to deliver are also crucial. The other harm project in India was also one impressive example of combination prevention initiative, which began with a standardized package of biomedical services adapted to local settings through microplanning and delivered to scale including community led outreach, STI services, and condom distribution.

And then other structured interventions such as support for community mobilization are now focusing to promote human rights and to reduce harassment. The impact of the [inaudible] intervention and HIV instances may be inferred through monitoring the observed changes in HIV prevalence and reported

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behaviors. This interim analysis by Picols [misspelled?] and colleagues compares a model based on observed data with another model based on no projection for what might have happened with no intervention.

Still, although seeming progress, this analysis suggests the moderate decline in incidence which will be reflected in lower HIV prevalence in the coming years. On the monitoring the potential effects of combination prevention, let's see an example from my own country, Peru, where HIV is 70-percent concentrated on MSM and transgender populations.

This model by Bieter [misspelled?] and colleagues shows the role of the combination package for MSM, including condom and lubricant promotion and distribution. Commenting on behavior intervention and antiretrovirals, the number of HIV infections per year, not just MSM.

The green line about growing levels of prevention and MSM shows new infections per year that continue to increase. The blue line with 100-percent coverage of MSM prevention and ARVS, the number of new infections clearly starts to decline.

So high-coverage of interventions for the most affected group, MSM, and trans, is necessary to reverse the trajectory of the epidemic in Peru.

With more means about HIV intervention, it's also said that it cannot be evaluated. While it's difficult to map and prove the course of change, some examples mentioned have been

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evaluated. It's easier however, because these combinations of interventions at similar levels of proximity.

We also need something like combination evaluation. Finally, right now, we cannot quickly tell if any prevention program has had any effect on new HIV infections or not. And this lack of information, we can see the case for further investments in prevention. We still need impact measures, particularly through moving from emergency approach to long-term response.

We really need an incidence test to rapidly measure changes in incidence following interventions. Nevertheless, prevalence trends and monitoring are good at telling us what happened retrospectively after many years. For example, this graph from Hallett [misspelled?] and colleagues shows the utility of more into retrospective, changes in the epidemic over time.

Mainly we are looking at national responses and hence assessing potential role of interventions rolled out by those changes. In Zimbabwe, around 1990, there was a natural decline in new infections because the epidemic had spread amongst those at highest risk of infection and was moving to lower-risk groups.

But then 10 years later and unfortunately in the year 2000, there seems to have been another decline in instance, a larger one, that was more likely driven by individuals changing

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their own behavior. It's more likely that the second change was associated with individual behavior change because it was too large to be explained by anything else.

Is it too expensive? Because violence is a focus of ongoing discussion, for example, to what should combination prevention be compared? Likewise, benefits to be counted should include synergy, comprehensiveness of the response, the human-rights side of value, and accessibility among others.

We just must remember that those affects are often not needed. Fortunately, costs are not the same across interventions. And for structured interventions, these unfortunate changes may bear much lower or one-time costs. The economic and cultural changes such as the promotion of gender equity and economical opportunities should be seen as broader developments to structured interventions with the key added value in HIV prevention.

And as such should help in integration of HIV programming within the bigger picture of development. Importantly, that will show ARASA and others have engaged in initial levels to costs, a range of human-rights interventions that are essential for expanded ART programs.

Based on data from Southern Africa, public sector interventions including human rights training or service providers, know your rights campaigns, monitoring of human rights abuses and access to just initiatives were costly and as

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it is evident from this graph, the cost of human rights interventions constitute only 1.4-percent of total expanded ART program costs.

Stigma has effects on a number of interventions, not only in prevention, but also in treatment, care, and support. If we effectively reduce stigma, we are not only likely to increase coverage and effectiveness of our programs, but such improved effects on incidence and mobility may in fact help reduce stigma further.

We have, however, to continue studying how stigma can effectively be reduced. We know it's not only a matter of information and training, but a feeling of people's deep fears and concerns beyond rational arguments. Some studies are being tested, conducted, but we need more research in this area.

For example, this collage of pictures from [inaudible] or festive uproar, a combination of structural actions to reduce stigma around sex work of women and transgendered people and funds were only available to conduct a qualitative evaluation, although the intervention rates were meeting in Congress and the proposal for law reform.

It included a series of demonstrations as well as a component with a video seen over 16,000 times a year too. You can see display of this at the art gallery in the global village here in Vienna.

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Again, since many good programs never get evaluated, perhaps we have to find ways to better produce post-hoc assessments of such experiences and to agree on how such evidence can be considered for planning.

This is again to show that the more detailed structuring with regard to HIV tend to have broader development effects concerning gender equity of poverty reduction or inclusion of sexual minorities and social justice. This is a very important graph.

We need to begin understanding our actions as not necessarily having all effects in one or two years as seen in traditional HIV education. Also having effects in three to five years as in community empowerment or even in more than five as we do promotion of gender equity. To think of them in combination and to take advantage of their synergy.

This quotation from Kevin Moody from the Global Network of people living with HIV showing positive health, dignity and prevention as a combination approach. Also highlights the personality of a person, the crucial links between prevention and treatment and importance of community leadership.

To finish some key challenges for combination prevention include the need for better tools to know our epidemics, particularly to ascertain more incidence and to better estimate the size of populations and the need to close the evidence gap including gathering better impact data. We saw

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contradictions in our models and amongst ourselves and even improve our conceptualization of combination prevention.

Here are your take-home messages. At this point, it is clear that the focus on individuals is not sufficient. Combination prevention is not about implementing a rigid panel of redundant interventions. Rather, it is the strategic, evidence informed combination of biomedical, structural and behavioral studies in the human rights framework.

Investing in structural interventions is not only an ethical obligation, it is worth the cost. It is particularly critical at the point when we are switching our thinking to ensuring a sustained long-term response to HIV. In that way it may be called to become a standing and long-term response to HIV.

Perhaps this view of combination prevention could become the flagship of a recent call for a prevention revolution that Dr. Sidibe has emphasized at this conference. Where a new diplomacy for prevention should seek to change mindsets in the concepts of the need to strategically and long-term conduct our work where we need to tackle the epidemic in the next decade or two.

Let me end with a brilliant quote from the Commission on AIDS in Asia, "The successful implementation of HIV intervention therefore demands, first of all, that local level barriers be addressed and that an 'enabling environment' be

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created. This is not difficult to achieve. Often, what appears to be intractable resistance to respecting the basic rights of most-at-risk groups yields to thoughtful advocacy and bridg building with local authorities and powerbrokers."

I am greatly in debt to my co-authors B. Zalduondo, Tim Hallett, Carlos Avila, and Michela Clayton, to the AIDS 2010 focal points, K. Daly and K. Thompson. To many authors who shared their data generously and to numerous colleges who support what is extremely important. Thank you very much.
[Applause]

SANDRA ELISABETH ROELOFS: Hello to all of you. We are very much looking forward to the presentation of Elaine Abrams. Professor Abrams is coming to us from New York where she started out as a biochemist and became a medical doctor specializing in pediatrics and family care and focusing on mother to child transmission. She not only works on prevention and care, but on research, clinical trials, and policy making through preparing guidelines for PMTCT.

She is a real asset to our PMTCT agenda. I am happy to ask Professor Abrams to come forward. She is also a WHO Advisor and for the U.S. Public Health Service and professor at the Mailman School of Public Health and Columbia University. Professor Abrams. Thank you. [Applause]

ELAINE J. ABRAMS: Good morning and thank you to the organizers for inviting me to be part of this extremely

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important meeting and to be part of this very distinguished panel of speakers.

I am quite honored to be able to bring the issues of women and children to the audience this morning. I will be speaking with you about eliminating vertical transmission, otherwise known as mother to child transmission. I will talk some about the background and how to do it and what we face moving forward.

In 2008 there were 430,000 new pediatric infections reaching over 2 million infections in children globally. There were 390,000 deaths attributed to pediatric HIV alone in 2008. Of the 1,200 new infections occurring daily, more than 90-percent are estimated to be attributed to vertical transmission.

During the opening plenary, Julio Montaner noted and put forward the agenda for treatment for prevention and noted that this has been a well-established methodology in the area of vertical transmission. Antiretroviral treatment can prevent transmission of infections to babies. This is indeed true and in settings like where I come from in the U.S. where we have had widespread access to antiretroviral therapy, we have seen remarkable successes in the area of vertical transmission with transmission rates of less than one to two percent.

In New York State where I work, we had six new infections in 2008. This compares dramatically with efforts in

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high prevalence, high burden settings. In 2008, it is estimated that only 70,000 pediatric infections were averted and 200,000 inverted infections since we first started prevention programs over a decade ago.

Let's step back and just take a moment to review some of the basic concepts around vertical transmission of HIV. As depicted on this timeline transmission can occur during pregnancy, labor, and delivery and postpartum during breastfeeding. Not all infants born to women living with HIV will acquire infection. It is estimated that 25 to 45-percent will acquire HIV without any intervention. The proportion of children who acquire infection vary by the timing of exposure as you can see a greater percentage of infections occur during labor and delivery compared with pregnancy. Infection during breastfeeding depends on whether the baby breastfeeds exclusively or mixed and duration of feeding.

Over the last decade, we have identified multiple factors that relate to or are associated with the risk of transmission, maternal, infant, host, viral, and obstetric factors. Two factors really trump the rest. Women with advanced HIV disease are at highest risk for transmission and at the highest risk for their own disease progression and death. Antiretroviral medications given at any point along that timeline, during pregnancy, labor and delivery or during breastfeeding can significantly decrease the risk of vertical

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transmission. If given to mothers for their own health can also result in the expected gains in maternal morbidity and mortality.

In 1999, Garcia and colleagues elegantly identified the relationship between maternal health status or viral load and the risk of transmission. As you can see in this slide, women who had high viral loads greater than 100,000 at delivery had very high risk of transmission with 40-percent of those non-breastfeeding babies acquiring HIV. This compares dramatically with no transmissions occurring among the 57 women who had viral loads at delivery less than 1,000.

More recently, Kuhn and colleagues looked at women enrolled in the Zambia exclusive breastfeeding study. This was a study of breastfeeding and weaning practices in Zambia prior to the widespread availability of ART. Women were staged during pregnancy and received a CD4 count. Kuhn colleagues applied the new WHO guidelines for ART eligibility to these women and found that 54-percent had a CD4 count less than 350, and overall 68-percent of the 1,000 women they studied were eligible for ART.

When they looked at transmission amongst the babies in this cohort, they found that 88-percent of the babies who acquired HIV during pregnancy and delivery were born to women who were eligible for ART and 88-percent of the postnatal transmissions occurred within the same group.

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Furthermore, looking at maternal deaths, there were 75 maternal deaths within 24 months of delivery. Almost all of those deaths occurred as one might expect among the women who were eligible for treatment.

Maternal health influences child health outcomes in a number of other ways. Children born to women with advanced HIV disease are also at higher risk of developing AIDS or dying if they indeed become HIV infected and at higher risk of death of unexposed babies born to women with advanced HIV disease.

Some very eloquent work in Uganda Murman and colleagues identified the use of ART and cotrimoxazole in adults requiring treatment in household. When they treated these adults, they found a reduction in death among children within the household as well as a startling reduction in orphanhood.

Let's now turn to the traditional four pillars of prevention of vertical transmission of HIV in which the Global Response is based.

We will first start by looking at prevention of HIV infection in women, a topic that has been covered widely in this conference. In Sub-Saharan Africa 60-percent of adults and 75-percent of youth living with HIV are women. Female youth are at disproportionately high risk of acquiring HIV. Recent studies suggest that pregnant and postpartum women may be at even higher risk for new HIV infections during his vulnerable period.

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For women living in countries with generalized epidemics, it has now been well demonstrated that the greatest risk of requiring HIV. Infection is through marriage or cohabitation, the very time when one thinks about starting a family. Gender, power, and equity put women at increased risk for HIV acquisition. This is particularly poignant in marginalized populations like sex workers and IDUs.

To date, few prevention methods have been made available to women. They rely primarily on male and female condoms. I am sure there is not a single person in this room today who isn't excited about the promising news from CAPRISA 004 about the tenofovir microbicide gel.

Also, there is recent evidence of other progress in the area of prevention. A new UNAIDS report sites declines in HIV prevalence among youth in 15 countries and shows evidence of positive changes in behavior that are associated with its decline and prevalence.

I would like to point out in particular a new study in Malawi where girls and their families were randomized to cash incentives as a way to keep them in school and lower HIV prevalence. They have found in this randomized study that these cash incentives actually were associated with approved school attendance and lower HIV prevalence.

If we move on to prong two, prevention and unwanted pregnancies given an estimated 80 million unintended

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pregnancies annually among women it is not surprising that there is a high unmet need for family planning among women living with HIV, and high rates of unintended pregnancies being reported at 50 to 90 percent.

Increasing family planning and contraceptive use can be an effective strategy to prevent new pediatric infections. Unfortunately, policy and funding restrictions over the last decade have led to somewhat strained relationships between HIV and reproductive health programs. Relaxation of those policies and new funding for family planning will allow us to move forward in the field providing family planning women who want to prevent or delay pregnancy.

Yesterday I was stopped by an esteemed colleague, Dr. Ruth Nduati who suggested that we just change the name of this prong to ensuring safe motherhood. Many adults with HIV, particularly in the context of increased ART availability are expressing a high desire for wanting children. Women on ART in Nairobi slum describe motherhood as proof of recovery and a way to regain self-status. Many ART programs are now reporting women starting treatment and becoming pregnant shortly thereafter.

I don't have the expertise or the time today to go through the multiple factors that influence reproductive decision making in adults living with HIV. This table is meant to display the complexity of this kind of decision and the

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appropriate interventions. I do want to point out in particular two areas that have been very vulnerable to human rights, the attitudes of health providers, and policies and guidelines and legal considerations.

If I move on now to pillar three, prevention of transmission of HIV from an infected woman to her infant. In 1999, Laura Guay and Phillippa Musoke reported the results of Hivnet 012, which demonstrated that a single dose of nevirapine to the mother and a single dose of the nevirapine to the newborn to the mother in labor could result in a 40-percent reduction in vertical transmission of HIV. This was transformational and led to the first vertical transmission programs in high prevalence resource constrained settings. Coupled with rapid tests, women attending antenatal clinics could be counseled, tested, and given a pill that could save the life of their child.

An open access program by Boehringer Pharmaceutical and the heroic and relentless of the Elizabeth Blazer Pediatric Foundation and their local partners facilitated the rapid expansion of PMTCT programs using single dose nevirapine throughout Africa and many other parts of the world.

Progress has been stalled and despite a dramatic change in the landscape of HIV treatment, women and children appear to be falling behind. In 2008, only 21-percent of women worldwide received an HIV test, pregnant women. 45-percent of women

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estimated to be living with HIV received prophylaxis and only 32-percent of the newborns received any ARV prophylaxis.

If we look more specifically at Sub-Saharan Africa, we see some better results with 58-percent of pregnant women having received any form of ARV prophylaxis. If we look at this more complex figure of the 20 high burden countries in Sub-Saharan Africa accounting for 80 to 85-percent of new pediatric infections, we see in purple the total number of HIV positive pregnant women and in orange HIV positive pregnant women who received prophylaxis.

There are a number of countries that have done very well. Botswana with 95-percent coverage and South Africa with 73-percent, but Nigeria in particular and several others are way behind. Nigeria is 210,000 positive pregnant women of which an estimated 10-percent received any prophylaxis.

We have to remember that most prevention programs have been layered onto the maternal child health setting. That gives us an opportunity to look at key determinates that are influencing uptake and success. Three major determinates are utilization of mother child health services, particularly ANC and maternity services. The level of national scale-up of transmission prevention programs, and particularly decentralization to the primary health level. The depth of vertical transmission prevention services, particularly implementation of a more comprehensive package of programming.

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Let's look at two scenarios that lead to low uptake of prevention programs in Ethiopia. Low ANC utilization accounts for the poor overall uptake of ARV prophylaxis in positive women. In Nigeria, by comparison limited ANC utilization and poor services account for this large unmet need.

In 2006 WHO revised their guidelines to include short course AZT during pregnancy and short course to the baby and emphasized the need to actually initiate treatment to HIV positive pregnant women with CD4 counts less than 200. There has been a limited depth of services for prevention of vertical transmission and a very slow transition from single dose nevirapine to multidrug regimens. Few women are having CD4 testing. There has been a low rate of ART utilization during pregnancy and weak linkages for long-term follow up.

If we look at ART, ARV use across low and middle-income countries in 2007 and 2008 we see that only about 10-percent of women with known regimens are getting ART therapy. In our programs at the International Center for AIDS Care and Treatment Program where we support through PEPFAR PMTCT in 11 countries and in Africa, we have seen a change from single dose nevirapine over the last three years to more multidrug ARV regimens, but little increase in the use of therapeutic ART during pregnancy.

In Botswana a program with a highly successful ART program, we see the complexities of trying to provide women who

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are eligible with the ART. Among 668 women identified during pregnancy who were treatment naive only 60-percent received CD4 counts, and only 23 of 62 women who had CD4 counts, less than 200 actually initiated ART. A stock out of CD4 reagent contributed to the CD4 issue.

If we look at the other side of the equation, there has been limited depth of services for the HIV exposed infants with low rates of prophylaxis and difficulty with the uptake of infant feeding guidelines for exclusive breastfeeding. There have been very weak systems for infant follow up with only eight percent of exposed babies receiving life saving cotrimoxazole and 15-percent of children getting early infant diagnosis.

Finally, I would be remiss if I didn't turn to the last prong and focus particularly on those children who acquire HIV infection, children lag behind adults in the ART scale up. There have been 275,000 children who have initiated ART worldwide, only 38-percent of the estimated need.

WHO has recommended for almost two years that almost all infants start ART upon diagnosis but relatively few have actually been initiated worldwide, primarily due to a high loss to followup at each step at the cascade from delivery to infant testing to engagement in HIV care.

Let's turn back and think about this overall problem. The MCH is the home for women and children, their medical home.

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They get a course set of services within the MCH. We have successfully integrated vertical transmission prevention services within the MCH and have moved forward with some prevention activities.

Simultaneously with the rapid scale up in successful initiation of treatment for more than 5 million individuals, we have established a series of services or core package that need to be provided in order to appropriately treat individuals for HIV. These are noted here, often given in the ART clinic or HIV care and treatment program.

I'd like to propose that until we successfully bring all of these services together, we are not going to be able to adequately eliminate vertical transmission and this kind of integration or linkage is going to take huge effort in creativity. Without it and without addressing the health needs, particularly of the pregnant women we will not be able to go further.

First and foremost, this will require unyielding pressure to have equal access and open access to ART for every individual in the world that requires treatment, particularly for pregnant women and children.

We've already begun to see the impact of ART services on child health. In the study by Ndirangu from the Africa Center that was published earlier in the year in *AIDS*, they began to see a decline in early life mortality. First with the

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introduction of PMTCT services in 2001 and then later when they implemented ART programs. In KwaZulu-Natal, South Africa they began to see even greater gains in under two mortality and post-neonatal mortality. At this meeting, they presented further data showing a relationship between maternal ARV and under five mortality in the same area.

There have also been some accomplishments in programs in vertical transmission that require mention. Despite the CD4 problems I noted, vertical transmission rates have been less than five percent in Botswana with a widespread scale-up and equal access to ART as well as vertical transmission programs.

In a recent assessment of early transmission among children in immunization clinics in KwaZulu-Natal, South Africa showed early transmission rates of seven percent, which compared with a very similar study in 2004 to 2005, which had a 21-percent transmission rate. A fabulous drop in the number of children acquiring HIV. Multiple country and program reports are now documenting lower transmission rates among women and infants receiving PMTCT interventions.

I would say there is no better time than right here and right now to move this agenda forwards. We have sound scientific evidence. We have new guidelines that are being distributed and announced at this meeting for the use of ART for treatment of pregnant women and prevention of vertical transmission as well as new infant feeding guidelines. These

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guidelines suggest that women start treatment with CD4 less than 350 like all adults and emphasize the importance of CD4 testing.

They also extend the duration of prophylaxis throughout pregnancy and for one year postpartum, so women can safely breastfeed their babies. We have successful experience implementing complex ART programs that need to be applied to women and children and we have highly visible interest and commitment from UN family, international agencies and donors with a new campaign for virtual elimination of mother to child transmission.

The time is right here and right now and I urge everyone to join this movement. It is possible, it is feasible, and we can prevent babies from becoming infected and we can keep women and families healthy. [Applause]

I'd like to end [Applause] thanking you. And I'd like to in particular [Applause] bring to note three people. Dr. Allan Rosenfield, who was the Dean of the School of Public Health [Applause] who is a lifelong advocate for the rights of women; Dr. Alan Berkman, who was instrumental in the Treatment Access Campaign [Applause] and who made access and equity the hallmark of his career and Dr. Wafaa El Sadr, a mentor and colleague [Applause] who many of you must know or are probably working with on projects today whose inspiration, unending

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enthusiasm has been a dominant force in our response worldwide to this epidemic.

And I thank all my colleagues who are very patient, who have helped with this presentation. And to all of the scientists and implementers who are contributing to the good health of women, children and families. Thank you. [Applause]

JEFF STURCHIO: Hello. It's an honor to introduce the Jonathan Mann Memorial Lecture this year. The lecture was inaugurated at the 13th International AIDS Conference in Durban, South Africa. I'm reminded actually from what Elaine said that I first met Allan Rosenfield at the Durban Conference. And, it just brings back a lot of memories for all of us.

This lecture is sponsored and supported by the Global Health Council. The Council also sponsors the Jonathan Mann Award for Global Health and Human Rights together with JSI and IAPAC. The Jonathan Mann Memorial Lecture honors the memory and legacy of one of the key figures of the 20th Century in the fight against global poverty and illness. Tragically Jonathan Mann and his wife, Mary Lou Clemmons Mann, herself a world renowned immunologist, were killed in the deadly crash of Swiss Air Flight 111 in September 1998.

Jonathan Mann is best remembered for his extraordinary contributions as the visionary physician and public health official who clearly articulated the connection between poverty

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and ill health. He was the Founder and First Head of the World Health Organization's Global Program against AIDS. And he believed that improved health couldn't be achieved without attention to basic human rights.

I think it's fair to say that he would have applauded and certainly welcomed the theme of this year's conference, Right Here Right Now. And on that theme, it's a privilege for me to introduce this year's Jonathan Mann Memorial Lecturer, Meena Saraswati Seshu. [Applause] So -

Meena is the General Secretary of Sampada Grameen Mahila Sanstha or SANGRAM. It's a little easier to say that, at least for me. It's an organization based in Sangli, India which has worked for the empowerment of people in sex work. Ms. Seshu has worked with marginalized populations, particularly rural women, adolescences and people in sex work on HIV and AIDS, sexual and reproductive health, violence against women and gender and sexual minority rights through grassroots rights based organizations in Karnataka and Maharashtra. Her title is No Excuses: The Living Experience of the Struggle for Rights. So please join me in welcoming Meena Seshu. [Applause]

MEENA SESHU: Thank you. [Speaking in foreign language] Good morning. I'm here to tell you a story. A story of struggle and success. We struggled and we fought. It wasn't always clear that we would succeed. And sometimes, we

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did not. I was trained as a social worker. As professional social workers, we are trained to guide communities. But our struggles revealed to us that this approach was not only faulty in achieving results, it was not ethical. For instance, what did we, a band of middle class women, know about the sex worker community? But we were all ready to guide them.

The sex worker community resisted all our attempts and taught us that effective interventions are only possible if we respect their knowledge, experience and participation. They brought on to us the simple truth that dropdown programs that are not guided by community knowledge, community experience and community participation do not work. [Applause]

As we struggled, we learned that pragmatically only right centered approaches actually worked. It was this approach that helped us reach 5,000 sex workers within six months. Our monthly requirement of condoms, fully a breadth, reached 350,000 condoms a month within a year of starting the invention. It was also this approach that showed us that when we decided to work with rural women, adolescences, young people, men who have sex with men and trans people.

I would like to begin by introducing you to my friend and colleague, Durga Pujari, who was one of our first outreach workers. Durga is now President of [Inaudible], RAM the collection of women in sex work who have struggled against

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injustice and triumphed. And I hope this works. [Video Played]

[Applause] Thank you Durga. [Applause] This community of sex workers taught us that they're the most effective educators of both their trials and other women in sex work. They helped us develop what we now call the SANGRAM Bill of Rights that comes from our experience in Sangli.

I remember in 1993 the Information, Education and Communication Committee in charge of AIDS, [Inaudible] this is the pre-national AIDS controlled organization base, once sent out a long list of client negotiation strategies for sex workers. This included graphic photographs of STI symptoms, how to talk to men; convince them about condom use, etc. I was young, naïve and 29 years old. The HIV educator and me took the list, called a meeting and sat down to discuss this new tool.

A [inaudible] and a brothel owner listened to me patiently but couldn't stop laughing throughout the meeting. She made me understand how ridiculous I was being. She asked me directly if I had any knowledge or dealings with men. The sex workers finally told me, we know how to deal with clients. We know how to deal with men. You just get us good quality condoms. And we'll do the rest. [Applause]

The first SANGRAM Bill of Rights was thus born. People have the right to be approached with humility and respect. Sex

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workers were not treated respectfully in the health services. And thus, avoided going to the Civil Hospital. The Civil Hospital approach [inaudible] for the good of the sex worker community, SANGRAM should do a collaborative program with the Civil Hospital that would bring high quality medical services right to the door step of the community.

So we called a meeting, told community leaders and we set up a clinic just outside the brothels for treatment services. We spent a lot of money and set up a temporary structure just outside the brothel area which had a medical unit, a counseling room, a mini lab. There were about 10 doctors.

Imagine my horror when I went to the brothels the next day. The community was deserted except for old women and very young children. They actually run away from Sangli City and abandoned their houses to avoid getting treatment or being corroded into getting treatment. We were flabbergasted. We couldn't understand why they weren't flocking to these accessible services. The Civil Hospital doctors were furious.

But we learned our lesson. You learn that you can't tell people that they must get a test or they must be treated. You can explain and offer but it must be in a way that allows them agency. It has to be a consulted process. That's the second bill. People have the right to yes or no to things that concern them.

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In 1997, after the collective of women and sex worker [inaudible] was registered; we felt we had done our duty and we wanted to close SANGRAM down. But the women of VAMP understood the epidemic better than most of us. Durga, who you just saw in the film, said that HIV was like a big river. And by working with sex workers, we had built only one dam. Building a dam at only one site will not stop a massive flood she said. If we really want to stem the tide, we have to build dams at different bends of the river.

She explained to us that men listen to sex workers about condoms but they did not seem to even discuss sexual issues, forget condoms, with their wives. I remember she said maybe we needed to teach wives negotiation strategies.

[Laughter]

VAMP pushed SANGRAM to reach [inaudible] women and young people. The sex workers observed that young men were especially hard to convince about using condoms. They did not want to sacrifice sexual pleasure. And they did not want to hear the consequences of not using condoms. And thus, a rural non-sex worker program started.

At that time, women living with HIV who were pregnant were told that they should have an abortion. There was no Nevirapine, no nothing. But even with the knowledge that many of these children would be born HIV negative, women were told to abort. The struggle was to create a safe space to discuss

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rights as well as legal and medical issues affecting people living with HIV and AIDS.

I would now like to introduce you to a member of SANGRAM PLUS, the collective of women living with HIV/AIDS from Sangli District. [Video Played]

SANGRAM PLUS was born to help address the intersection of violence against women and HIV and AIDS. Women's' rights are particularly difficult to talk about because they challenge traditional patriarch structures. SANGRAM's solution to this is to try a collective consciousness in order to strengthen people's ability to assert their rights and negotiate safety.

People have the right to reject harmful social norms. The challenges of reaching out to rural women and young girls were numerous and deep. Being accused of breaking up marriages, challenging sexual norms, helping young people get together to talk rationally about sex and HIV, reaching sheltered young girls, giving them the language of rights and urging them to take control of their lives is not only a difficult task, it's near impossible in a conservative set up.

Our interaction sexuality education classes are a right. Our strong feminist perspective is difficult to digest for most young men. As is similar in most parts of world, young men crammer for information on sexual pleasure and the women, of course, are tailored to show more interest in reproductive health issues. We deal with controversial issues

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around sexual diversity in an open and honest manner. MSM, trans people, sex workers are part of the comprehensive sexually education administered by the SANGRAM activists. Pleasure me safety is our slogan.

People have the right to stand up and change the balance of power. Challenging social norms, challenging the most powerful in the district - police, [inaudible] leaders, political leaders, [inaudible] leaders. [Inaudible] And eventually getting them, if not to be supporters at least not obstacles, is the struggle.

At the state and national level, some success has been achieved in the engagement with government and non-government actors. Working with sex workers, women's groups, HIV/AIDS activists, career activists within the country and outside has resulted in concrete gains.

Mobilizing the voices of sex workers as citizens and community leaders to influence Government of India to abandon its plan to amend the immoral Traffic Prevention Act was without doubt one of our major successes. The amendment would have further stigmatized sex workers by criminalizing the purchase of sexual services. For women who did not think that they could go to the local police station to help believe that they can talk to the group of ministers in Delhi is indeed an achievement.

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And with information from our International Networks of Sex Workers, the Global Network of Sex Work projects; NSWP and the Asia Pacific Network of Sex Workers; the National Network of Sex Workers India was able to argue that there's no evidence from any country that criminalizing demand is an effective strategy for preventing violence against sex workers, trafficking in persons into sex work and certainly not HIV. [Applause]

In 2007, the National Network of Sex Workers India hosted to the meeting of the Global Network of Sex Workers Projects to rewrite the UNAIDS' guidance note on HIV and sex work which was then presented to UNFPA and UNAIDS in Delhi by the Indian sex workers.

But the most exciting journey has been the recent success in influencing the request for proposals to the Global Fund Round 10 from India. The National Network of Sex Workers set up a sex worker led consortium which was able to advocate for our inclusion as partners in the Round 10 proposal from the Government of India.

We are challenged by having to compete with large, international NGOs for PR status. We are still calling for the sex worker led consortium to be the primary recipient and are hoping that for the first time in the world, sex worker collectives will be given this right to choose their own

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homegrown representation to the Global Fund. [Applause] We need the Global Fund to work for us. [Applause]

In our region, HIV became a problem at a time when the political power of religious fundamentalists was growing. It wasn't bad enough that sex workers were already harassed and abused by the police. Although it was clear that sex workers were a central part of the solution of HIV, to HIV, we have had to deal with centuries of entrenched stigma and social distain.

Religiously motivated vigilantes from India and eventually from conservative Christian groups in the United States, who wanted to rescue sex workers from lives of immorality, have targeted SANGRAM and VAMP for advocating for the rights of sex workers. The raids have been violent and conducted with missionary zeal and thug like brutality. Raids only drive marginalized communities underground. And long-term community work gets disrupted.

It was only the collective strength of VAMP that did not allow the HIV outreach program, condom distribution and access to treatment services to be disrupted. The raids on VAMP established the fifth bill of rights. People have the right not to be rescued - repeat, not to be rescued by outsiders who neither understand nor respect them. [Applause]

In 2000, a small group of men from Sangli approached SANGRAM asking for a program focused on men who have sex with men, coatees [misspelled?] and jagapas [misspelled?]. Coatee is

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a [inaudible] labor for males who may feminize their behaviors. Jagapas are male [inaudible] a form of [inaudible] prostitution linked to the Hindu religion.

I would like to tell you a story that has helped me understand the true meaning of rights. Pandu from Muskan, the collective of coatees and jagapas. [Video Played] [Applause]

Pandu taught us the most important right of all. People have the right to exist how they want to exist. Our workers taught us that people like Durga, Mongila [misspelled?] and Pandu don't marginalize with the hypocrisies of the system. Like all survivors, they do have the courage and strength to create a world that has much to offer. A world that's not only by their pain but also their dreams for a society and a people who will affirm their right to self worth, dignity and livelihood that no one agency can either confirm or deny.

Before I end, I have two issues that I'd like to bring to your notice. I take this opportunity to show solidarity to the Alaei brothers, AIDS physicians wrongly imprisoned [Applause] since June 2008. I appeal to all of you [Applause] to sign the petition at IranFreetheDoctors.org.

That's Cheryl. On 15th June, 2010, Cheryl Over was denied entry to the United States of America on her way to attend a meeting of the Technical Advisory Group of the Global Commission on HIV and AIDS at the invitation of UNDP. Cheryl, as we all know, is a designated researcher of sex work, health

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and human rights activist and long-term sex worker's rights advocate.

The denial of entry was based on the U.S. Government's belief that Cheryl represented a high risk of involvement in prostitution or trafficking of persons and that she's believed to have a prostitution related conviction from the 1970s which nobody can trace. Current U.S. legislation rests its ground on crimes involving moral turpitude. Moral turpitude? [Laughter] Entry was also denied for any person believed to have been a sex worker in the previous 10 years regardless of criminal record and applies to people from countries in which sex work is recognized as an occupation. Nobody from the Netherlands can go to the States. Sex workers that is. [Laughter]

This denial of entry raises serious concerns for sex workers who wish to attend the International AIDS Conference to be held in Washington, D.C. in 2012. [Applause] Can you imagine a world AIDS conference without the red umbrellas? It's not happening. [Applause]

I would like to end this presentation by acknowledging my mentors and co-authors, Joanne Csete and Jonathan Cohen. [Inaudible] Wilder and [Inaudible] for the film clips, Francois Ziti – I hope I've said it correct. Francois Ziti of OSI who held my hand through this process. Kelly Long of [Inaudible] for the magical PowerPoint. You must thank her. My gurus, the incredible collect of [inaudible] the also beautiful coatees

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and jagapas from Muskan and the quietly strong resisters from SANGRAM PLUS. Thank you very much. [Applause]

FEMALE SPEAKER: Just two short announcements. At the end of this session, today there is an opportunity for you to meet the plenary speakers. Join them between 1:00 p.m. and 2:00 p.m. in Global Village Session Room 1.

And second, on each of your chairs is a postcard. This is a chance for you to sign onto the Vienna Declaration. Please complete the card and return it in the bins by the doors as you exit the Plenary Session. Thank you. Thank you to the chairs and to the speakers. Thank you. [Applause]

[END RECORDING]

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