

**TIME Global Health Summit
Breakout Session:
What Will Improve The Future For Women?
November 2, 2005**

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At the TIME Global Health Summit, held in New York Nov. 1-3, TIME magazine convened leaders in medicine, government, business, public policy and the arts to develop actions and solutions to the world's health crises.

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Terry McCarthy: Ladies and gentlemen, welcome.

Thank you for coming. I know we're running behind time, and there are people still coming up. The last session ran late. I know this always happens in conferences. And I should say that I'm very well aware that the next session is the two Bills [laughter], as in Clinton and Gates, and you all want to be there and be there in time for that. So we are just going to have to abbreviate what we're saying here so you can leave here with about five to six minutes to get down there because I know there's going to be a lot of people going to that.

Anyway, I'm Terry McCarthy. I'm the L.A. Bureau Chief of TIME Magazine, and thank you for joining us. This is a panel on the future for women: education, family planning, healthcare and so on and so forth. We have four wonderful panelists.



I would first like to introduce Dr. or Mr. Fazle Hasan Abed, who came the furthest, all the way from Bangladesh. He is the chairperson of the Bangladesh Rural Advancement Committee, now known as BRAC, has won many awards for that. And I think services over 100 million people out of Bangladesh's—or touches 100 million people out of Bangladesh's population of 140 million. Quite an extraordinary organization, which we'll hear more about.

To his right we have Professor David Bloom, who's a professor of economics and demography and chairman of the Department of Population and International Health at the Harvard School of Public Health. And in the middle we have Dr. Zeda Rosenberg, who is the CEO of International Partnership for Microbicides. And sitting right to my right is Carol Larson, who's president and CEO for David and Lucile Packard Foundation.

And we're here to talk about women. And I just wanted to start with a little cautionary anecdote of my own, if you will bear with me. I was in Afghanistan around the time of the [inaudible] War in 2001. And one of the things that became of

great interest to us was, as soon as the Taliban left, there were a number of women who staged this protest in Kabul where they literally took off their burkhas. And this, for us, was quite extraordinary, because we'd spent several months in Afghanistan with literally an entire population of women covered, completely covered so you can't see their face. So we thought this was a great story, and we decided we were going to actually do a cover story on women in Afghanistan lifting the burkha.

But as we went around to interview these women, and it turned out that the majority of them were not that interested in taking off the burkha. We learned first that a small group had staged the protest, but after that, most women were not that interested. They said, "You know, yes, the Taliban forced us to wear the burkha, but that's not what our real problem is. Our real problem is we weren't allowed to go to school," because the Taliban literally wouldn't allow them to go to school. "Give us education and give us decent access to healthcare," because also they were not allowed to be seen by doctors who weren't women. And if they

weren't educating women to become doctors, you can see the problem. And so it was a very good introduction to me to the importance of seeing what women really needed in their own context, and not going for the cheap journalistic—you know, burkha comes off; pictures of women who haven't been seen for so many years.

And so with that cautionary note, I'd like to first turn to Dr. Abed because you've been working with—you set up BRAC in 1972, and from the very beginning, you went to women. Women have been your focus. And I'd just like to ask you what was the initial inspiration there. Why did you focus on women for poverty alleviation?

Dr. Fazle Hasan Abed: Well, we looked at the situation of women in Bangladesh. I thought that women had double disadvantage, one being poor and the other being a female. And we also noted that women took a major burden of poverty in Bangladesh. In other words, if the husband would work only enough, women are the ones who would be looking after the children, trying to find food from

neighbors and so on. So we looked at the role of girls in our society. And we felt that, even from early childhood, a girl child is looking after her younger siblings; she's the one who's helping her mother, and she is looking out for the domestic animals. And then when she is married, she's also being poor, in a poor family. She takes the majority of the burden of poverty. In fact, the management of poverty in our society is mostly done by women. And we thought that if that were the manager, managing the poverty in our society, why not focus our attention on the women and organize them for power, give them knowledge, particularly legal, paralegal training? We also provide consentization [ph], and we organize women for power and then federate them as an association at a high level. So basically what we are trying to do is the women as the change agent of our society.

So we go for not only for organizing women but also provide them with service and credit, et cetera, resources, training and entrepreneurship, and those kinds of skills they need in order to do business. So we have got almost 5.2 million women

in Bangladesh organized in 115,000 groups. And they are changing not only their own communities, but being linked to the market, and sort of connected to the global economy.

Terry McCarthy: Now, the one thing that nobody can do is work or organize anything if they're sick. And one of the biggest threats that is facing women is HIV/AIDS. And I'd like to ask Zeda about, firstly, the susceptibility—women are more susceptible to AIDS—and what we can do for poor women. We've heard a lot about the antiretroviral drugs which advancement was just waxing very eloquently in the other meeting. And tell us about women and AIDS and what you think can be done to try to prevent it in a cheap way.

Dr. Zeda Rosenberg: Right. And I think there's been growing recognition of the feminization of the HIV epidemic. Women are at much higher risk of acquiring HIV infection where they themselves are sick but also taking care of other people who are sick, the children or the husband. The young

children in the family are then being asked to take care of their dying mothers and fathers and then the cycle of not going to school continues.

So HIV is affecting the whole fabric of the community, but particularly women. All things being equal, in any sexual encounter, a woman has a greater risk of getting infected with HIV because she sees more virus. She has a higher viral inoculum. And right now, the conventional methods for women include the male and female condom, abstinence and behavior change. And for most women throughout the world, those factors do not affect their risk. Many of these women are married; they can't abstain. Their behavior is not an issue. They are getting infected from sometimes their sole lifetime sexual partner, which is their husband, and condoms are just not used in the relationship, especially many women throughout the world want to have children. And you cannot use condoms and conceive a child. So, the so-called ABC, which is very important for controlling HIV in parts of the world, doesn't work for some of the highest risk

women in the world, which are many of the married women.

So they need another technology for their prevention. And that's where the notion of the microbicide has come in, being brought to the attention, by women activists saying, "Women need something else." And the public health community has to step up to the plate and design a strategy—

Terry McCarthy: Tell us briefly about microbicides. I know they're still experimental.

Dr. Zeda Rosenberg: Well, they're still experimental, but these are designed as topical gels or creams or intravaginal rings that slowly secrete certain kinds of drugs that will kill or inactivate HIV. So it's used locally, vaginally. And women can administer it themselves. Some of these products can be used once a day; they can be used once a month if they're intravaginal rings. All of these are still in experimental design, but clearly there are lots of options for these kinds of barriers, chemical barriers, for HIV prevention for

woman. And especially with the advent of highly active antiretroviral therapy, a lot of these drugs that are used to treat HIV infection can be used topically to prevent HIV infection. So our goal has been to get those drugs and design them topically and start doing the clinical testing, and hopefully get them marketed.

Terry McCarthy: Now Carol, the Packard Foundation dispenses about \$200 million a year in grants, which is quite a lot of money. I know a lot of that goes into family planning programs, particularly in developing countries. Could you tell us a bit about one particular program I believe that's been particularly successful in Ethiopia?

Carol S. Larson: Yes. Just for people in the audience who may not know, the Packard Foundation is a family foundation that was started over 40 years ago by a husband and wife, co-founder of Hewlett-Packard, Dave Packard. And right from the beginning, they really believed that reproductive health was a central issue, not just for women but

for women's education, for economic development, for the environment, many different arenas.

We started 40 years ago, working with great partner organizations such as Black [ph] or other non-profits working internationally. And over that 40 years, we've learned a lot of lessons, and I think one of the things that's really exciting about this conference is that it's focused both on long-term solutions, with looking for new and better solutions like microbicides, but also letting people know that there are things they can do right now that are working.

For the last six years, we've been working in Ethiopia with on the ground organizations like BRAC-BRAC, I don't think you're in Ethiopia, but it's organizations like that that are effectively delivering comprehensive health services to women and their families in remote, rural areas. Our focus as a foundation has for 40 years been on the importance of reproductive health, but the services are delivered in the context of the needs of women and children generally, and the families. So one of our best partners is the Amhara Development

Association there, that is not only involved in healthcare but also in economic development. We've given them some money for microfinancing. Other foundations and other government agencies are funding them for building schools and clinics. The good news is that in that six-year time period, in the areas in which the Amhara Development Association was working and we're funding. When we started, contraceptive prevalence use among reproductive-age women, childbearing-age women, was only five percent. Their desire was much more, and with some information and some education and some family-friendly delivery services, it's now gone up to as high as 50 percent contraceptive prevalence rate of use within that region.

So these kinds of stories, and I'm sure there will be similar good progress indicators on issues of primary education, et cetera, but there are things that work now, as we've heard throughout this whole conference, by bringing services at the community level, giving women leadership positions. And we have some great experience with that in Ethiopia.

Terry McCarthy: Now David, reproductive health, of course, is a large issue, but there are other health issues affecting women, particularly in developing countries. You have one particular one that I was curious to talk about.

Professor David E. Bloom: Yeah, I think it might be interesting to address some attention to the problem of indoor air pollution. It's a problem that severely affects people throughout the world. There are between 2 and 3 billion people in the world who are heavily reliant on biomass for mainly cooking and heating. I'm talking here about fuel lid [ph]. I'm talking about straw and other crop residues. I'm talking about dung.

And it turns out it's a very inefficient form of fuel, especially the way it's actually burned, typically openly, creating a great deal of smoke. And actually just before we began, Terry, you were talking about an experience you had not long ago in Tibet, in a hut, where I think you said

yak dung was burned basically until you—you didn't [inaudible], you said you passed out.

Terry McCarthy: Pretty much.

Professor David E. Bloom: It's really an awful experience for anyone who has ever had it. And it creates a severe burden of respiratory illness that is disproportionately suffered by women, because they tend to spend most of the time doing the cooking. Also children, for several reasons: one is they're often with their mothers near the stove; second is because children's respiratory passageways tend to be more narrow and particulate matter of a given size that they breathe in basically is more likely to cause an irritation and an infection.

What we actually know at this point is that the use of biomass in traditional ways is associated with elevated rates of infant mortality, elevated rates of child mortality, depressed rates of life expectancy, especially for women—depressed survival rates, in other words, for women. Because infant and child mortality is higher, we also see big

effects on reproductive health: fertility rates are higher. And in general, it appears from a number of quite careful studies that have been done that the use of fuel oil and dung, et cetera, and the indoor air pollution it creates not only causes health problems, but it really impedes the whole demographic transition from high rates of fertility and mortality to low rates of fertility and mortality. And by keeping fertility and mortality rates high, that impedes the process of economic growth, poverty reduction, et cetera.

Terry McCarthy: Thank you. Dr. Abed, I wanted to ask you more about healthcare in Bangladesh because you've had some extraordinary successes. I've noted some figures: that overall, while the economy has grown by five percent per annum in the last 10 years, poverty is down 20 percent, but infant mortality is also down by half. And life expectancy has gone up 13 years. That's just in 10 years, a 10-year time span. What has contributed to that? And how much of a role is BRAC playing in that?

Dr. Fazle Hasan Abed: Well, in the Year of the Child—it was also the Year of the Child in 1979—we just decided to try and cut down infant and child mortality in Bangladesh by focusing our attention on teaching mothers how to make oral rehydration fluid at home against diarrheal dehydration. So we did it for 10 years, going to every household in rural Bangladesh, teaching one to one. Every household. Every household. Fifteen million households we visited over a 10-year period, and teaching mothers how to make oral rehydration fluid at home, how to measure water, sugar and so on.

So that helped. And of course, in the later part of the 1980s, we also took up immunization programs against triple antigen: diphtheria, tetanus and pertussis, and also BCG and polio. And that had a tremendous impact in reducing infant and child mortality. And also, low and behold, what happens is that when the children are surviving, the fertility also goes down. And so we had a family planning program which was, in 1979 we had less than ten percent contraceptive prevalence rate. It came up to about 56 percent in the 90s.

So it had the virtuous cycle of low mortality and low fertility. And that was [inaudible].

We also trained—in each or our villages, we trained one woman in each village to become a health provider.

Terry McCarthy: Always a woman.

Dr. Fazle Hasan Abed: One woman in every village. So we have trained about 70,000 women who are operating in 70,000 villages, providing services for reproductive health, water and sanitation, family planning services and so on. So women themselves are in fact involved in changing their condition, and involved in development of their own communities. So it's integrated to the extent that it's education, it's healthcare, it's economic development through microfinance and income and employment-generation program. So it's all integrated, with the women as the focus of our attention.

Terry McCarthy: And you're right down there at the grass roots.

Dr. Fazle Hasan Abed: Yes we are in the grass roots in the village.

Terry McCarthy: But Carol, tell me, contraception doesn't always work.

Carol S. Larson: Right.

Terry McCarthy: We can put in all these programs and it really doesn't work. What then? This is a very controversial issue with our current administration, as we know.

Carol S. Larson: Right. And the experience of the Packard Foundation, like so many other donors, our first priority absolutely is access to information, education and services for reproductive health, done in a way that's coordinated with meeting other needs of women, and bringing services to rural and remote areas.

It's also the experience of anyone who's traveled internationally or worked in other countries that the reality is that in many instances, women don't have either access to contraceptives—contraceptive supply is still huge—or the power to use them within their family setting. And there needs to be a back-up plan. And in every country in which we work, if abortion services are legal, there's a big problem in terms of access to safe and easily accessible services. Where it isn't legal, it's still happening. A half million women, as we've heard at many points in this conference, die in pregnancy-related causes every year. It's estimated that a fifth of that, or 100,000 women, die in connection with seeking an abortion in unsafe circumstances.

So the Packard Foundation tries to work with other funders to make legal, safe abortion services available. But even more so we are also excited and working with a number of people about making emergency contraception available. That is going to be a technological—and it's been around for a while, but a dedicated product and information and

education about it—that will make a huge difference to women. And so we're committed and have worked with advocates in India, in the rural state of Bihar [ph], to make available over-the-counter distribution of emergency contraception. And we hope that something like that will be available to women in this country at some point as well.

[Laughter] [Applause]

Terry McCarthy: Zeda, I was fortunate enough to have lunch with Mechai Viravaidya from Thailand, and he was talking about experiments they're doing in Thailand with lemons, both as a douche, as a contraceptive, but also with a very low pH, lemon juice apparently kills off a lot of STDs, including the HIV virus, at least in the lab. Now he's careful to say this hasn't been tested clinically. It's very hard to test that clinically. But if they're using it in Thailand as a contraceptive measure, and it seemed to have some success, was this something that could work parallel with microbicides?

Dr. Zeda Rosenberg: There are mechanisms of action that are in plain low pH. For those of you who don't know, the vagina is normally at a very low pH. It's usually very acidic. And during sex, when semen is there, the pH of the vagina rises to about neutral, and that body and nature's way of keeping the sperm very mobile so that they can swim and fertilize the egg. So it's nature's way of allowing for conception to take place. However, it's also a very hospitable environment with a high pH, for viruses and bacteria. So it's during the sex act, when semen is present, that you have all of this transmission of other sexually transmitted infections.

So it's been a theory for a long time: what if you kept the pH of the vagina at its normally low pH even during sex, and that you buffer the pH down even more when semen is there. It would be contraceptive because it would immobilize the sperm, and it would also inactivate many of the other pathogens. And so there are clinical trials right now, something called Buffer Gel, which is a gel that is based on substances that can buffer the pH

of the semen down. So that concept is being tested as a pH modifier. I think that most people think that that will be, if at all, partially effective. It's not going to be a home run, blockbuster target against HIV, because there will always be HIV that can get around the pH issue.

I think that the notion of any drug or any approach for a microbicide needs to go through vigorous safety testing. We learned the hard way; nonoxynal-9, which was tested as a microbicide/spermicide that, when used frequently as would be the case for prevention of HIV infection, it actually, as a detergent, caused extensive irritation to the vaginal mucosa. It's like washing your hands with soap 20 times a day. You really don't want to keep doing that in the presence of HIV.

So whatever we do, the first point of order is you do no harm, and you make sure that the safety of these products is not compromised whatsoever. So again, any of these approaches, whatever they may be, have to go through vigorous safety. And I think that that's where it's much more difficult to test

safety of lemon and lime juice. It's much easier to test the safety of some of these more specific antiretrovirals.

Terry McCarthy: I would like to open up for questions, but just before I do that, David, can you tell me briefly more about the family planning program in Colombia, which I hadn't realized has got a phenomenal success rate. What happened there?

Professor David E. Bloom: I think that sort of technological innovation in the area of reproductive health and contraception I think is wonderful. But I think we also shouldn't lose sight of the fact that there are many examples in the world where family planning programs have been implemented on a large scale and have had enormous impact.

The one in Colombia I think is maybe one of the best examples in the world. It's a very fine program. It's called Pro Familia. It's basically a private, not-for-profit NGO that was set up in 1965. In the two decades following the establishment of Pro Familia, which really operated at a country

level, fertility rates declined in Colombia faster than in any other country in South America. Not only did fertility rates decline—and it's about maybe half a child per woman over the reproductive years—but there was also, and this seems to be quite important, postponement of first birth. And that actually seems to be a critical factor according to a blockbuster study that was just done by a doctoral student at Harvard named Grant Miller, who's now at the faculty of Stanford University. He shows that that is associated, and he deals with the difficult issues of causality there, but shows that it's associated with more educational attainment, with higher rates of workforce participation in earnings, also benefits to children. And actually his conclusion is that investing in quality family planning is perhaps the most cost-effective approach to poverty-alleviation that we have. It's a very, very careful study. I'd recommend it to anyone who's interested in this area.

We see the same kinds of results actually in Bangladesh. Kind of the gold standard for evidence in this area is the randomization of

villages and to treatment villages and control villages that took place in the 1960s and then in 1977. Very high quality family planning was introduced into the treatment villages, and the standard government program was what we had in the comparison villages. Within three years of the introduction of this very high quality family planning, there was a gap that got created between the fertility rates in the two groups of villages of 1.6 children that has been maintained to this day. It's really, I think, a stunning, very persuasive piece of evidence on the effect of family-planning programs, quality family-planning programs on fertility rates.

And then just as a last example, and it's not nearly as rigorous, but I think quite interesting, is to take light of the fact that contraception was illegal in Ireland until 1979. In 1979, contraception became legal, and there was some further liberalization that took place in the mid-1980s. What you see in Ireland is that the birth rate in Ireland dropped by a third in the 1980s following the legalization of contraception. And,

interestingly enough, the Irish economy doubled its growth rate, the growth of income per capita in the 1990s, so following from the improvement in fertility, the decline in fertility rates that followed from the legalization of contraception.

And so the message here, I think, is there are things we can do. Just straightforward, simple instruments that we know work from other contexts can be applied and can make a gigantic difference to well being, especially for women.

Terry McCarthy: Thank you for bringing up Ireland. It's the country I was brought up in. [Laughter] When I went to college, condoms were illegal. Some questions, please. Thank you. The lady there and then the gentleman in front.

Female Speaker: [Off Microphone] What is the timeline of bringing microbicides to the market? Is it as fast as you would hope? And if not, what can we do about the barriers that impede bringing microbicides to the women who so desperately need them?

Dr. Zeda Rosenberg: It is never as fast as we hope. That's a given. There are currently five different products that are in expanded efficacy studies right now. They're the first generation of products that were developed by NGOs prior to knowledge of the highly antiretroviral therapy approaches. Should those work, we are looking at a five-year timeline. Should they not be as effective as we hope, then the next generation of products is currently in safety studies. We'll be entering efficacy studies next year, we hope, and then we're look at probably 2010, 2011. And no, it is clearly not as fast. What has happened recently, which has made all of us much more optimistic is that the pipeline of drugs that we can now use as single agent or as combination agents has widely expanded. There are pharmaceutical companies now stepping up to the plate and providing royalty-free licenses for the developing world for some of their highly active antiretroviral drugs.

Terry McCarthy: Thanks, Zeda. Just one moment. I should say that I am keeping an eye on the time. I know you all want to see Bill and Bill. And we'll take two or three more questions and then we'll break, because you'll all want to get downstairs for that. So this gentleman first, and then that lady over there. Thank you.

Male Speaker: I'll keep my question very brief. Issues of culture seem to be very important in dealing with women's health in different settings. Dr. Viravaidya talked about the role of the Buddhist monks and the religious establishment in Thailand helping with the family planning. And I know that it's been an impediment in certain other countries. Dr. Abed, I know you are all for challenging customs and traditions, but I wanted to know how best to work with or at least not antagonize religious groups or cultural groups in the setting that you're working in to best promote women's health.

Terry McCarthy: Dr. Abed?

Dr. Fazle Hasan Abed: Well, one needs to work with the culture that one operates in. We are working in Afghanistan, and we have to work with Afghan women in the same tradition that they are used to. But I also feel that the question of culture that sort of subjugates women has to be challenged, in the sense that in the name of culture there is a lot of subjugation that goes on. There is a lot of gender roles which affects women and their health. In Bangladesh, for example, a woman would never eat before her husband and children eats first, and she would be the last to eat. So we have been challenging these cultures in the sense that we are organizing women and men to try to change this culture and practices.

So I think just because this is the culture of a country, we shouldn't just leave it alone. So I always felt that it is worthwhile sometimes to challenge culture, the traditional practices, and try and see if one can change those.

Terry McCarthy: Thank you. Yes.

Female Speaker: Thank you. My name is Takania [ph], and I work for the United Nations Information Fund. And I was just—actually, Dr. Abed, you have already answered what I was going to ask. That we are talking about empowering women, but we are not bringing the men into the picture. And I think that as you mentioned—your example of actually working with the women in the villages and giving them power. And the other thing I wanted to bring up is education—that I think it is the powerful tool that, when you educate a woman or a child in a society, it actually makes a very big difference. So I was just wanting to talk more about getting men into the composition [ph]. Thank you.

Terry McCarthy: Carol, do you want to address that?

Carol S. Larson: Sure. I think that we've seen in countries like northern Nigeria and Ethiopia and Pakistan is that a good first step is to really listen. I think people have mentioned that a lot. At a community level, listen, talk to people, hear what they're thinking. Second is, work with the

women. The women are incredibly courageous, and a lot of our grant making is done working with women who are working very creatively within their religions and their systems. And the third message about involving men is, I think begin with youth. In a lot of the countries, in sub-Saharan Africa but I know personally mostly from Ethiopia where we've done a lot of funding of this, the youth clubs that are bringing young people together, and talking not just about reproductive health issues but a lot of other issues, have a great affect, I think, over the long run. But the women leadership and advocates have been so key in so many difficult settings.

Terry McCarthy: Thank you very much. I think we should probably break, because I think we've got a time shortage here. I'm sorry to cut you off. But more awaits you. Thank you so much. [Applause]
[END RECORDING]