WEBVTT

366:23:37.000 --> 366:24:03.000
Лгбт-файф Джинс Я Вибачте Злова Піймеум Витал адаміцією Йосиф Саїд тіняничової рати мій Форум Стар павло має Бутиймайонер ставник Корінь Це Таксаархія Вейд.

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Якщо це відбувається я проживаю львівської ентузіазм і пробують живуть свої.

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У Івано-франківську, алов'яносто.

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Нбас з Каменяр а не про момент а має певну компанію, обрання тенденцій з метою Чорнобиль це з кам'янець-квика і онлайн Ем мафія Ендодедеманс вийшов кисень анни Юнаред стейц Гендерної зброї.

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Гепен або.

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Це реєстр Ну, я б хотіла співати так блакит це величина марвелери кол-центр я інформацію інвайц ваммія Ціла.

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Команда Легендарний Валерій Валерійович.

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Тенький саме, щемтенький самеч подивіться, емігрант бій де близда як теж пропала аксесуари а коли ми печ-аркозу і ога фекалли 5 а основне у мене є ситуація.

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And that prep is not a tool that is being accessed by communities that need the most. And when it comes to cisgender women, in particular, there's a huge need.

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That and we know that part of the need when it comes to cisgender women is choice and options and that potentially daily pills for prep is not the best option for cisgender women, and that we know the more options that we have, the better utilization is.

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And so I'm super excited to be able to moderate such an important conversation. talking about transgender women.

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I'm also really excited about the amazing panelists that we have and so I'm going to introduce Dr.

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Jean Morazzo. She is a scientific leader in the field of STI and HIV prevention.

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Microbiology and the microbiome of the female genital tract. We are so honored to have her now as the director of the National Institutes of Health National Institute of Allergy and Infectious Disease.

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Diseases, NIAD. Nowa conducts and supports basic and applied research to better understanding 3 and ultimately that and allergic diseases.

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As the newest NIA director, Dr. Braso, oversees Nyad's budget of 6.3 billion dollars, which supports research to advance the understanding diagnosis and treatment of infectious immunologic and allergic diseases.

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She supports research at universities and research organizations around the US and across NAAD's laboratories.

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And really, what she's doing is supporting research to advance the understanding, diagnosis and treatment.

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Of infectious, immunologic and allergic diseases. Her research in Discovery and Information's implementation science has focused on that on the human by microbiome, as it relates to female reproductive tract infections and hormonal contraception, which we know is so important, which we know is so important when we're talking about cisgender women.

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She focuses on prevention of HIV infection using biomedical interventions, including prep and microbicides and the pathogenesis and management of bacterial biogenosis, sexually transmitted diseases, and HIV infected people and management of antibiotic resistance in gonorrhoea.

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She has been a principal investigator on NIH grants continuously since, 1,997.

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Anna served frequently as a peer reviewer and advisory committee member. She served as a mentor to trainees at all stages of professional development, including on NIH venture training grants and was the recipient of the American sexually transmitted diseases association's Distinguished Career Award, the highest recognition of contribution.

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Черговий сезон менше ніж ми Альфа діагностика патріархату а потім а прем'єратів на інвесторів власних цін у бойовому стані це були видивідуальні.

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Як?

366:30:12.000 --> 366:30:42.000
Адже день з Кінобрігом м'якей клей конфлікту а інформаційний амбіангом А Мамі Ай правової Мірі відбирають Айфиш і Сама Елв'я 5 перерахував це Бій там не факт-фест А взагалі не дуже багато інструментів

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інструменту та ольга агіна і ви що ви вважаєте, А слайд самурайз ам.

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Біцій паблищ Чарльза самоврядування ви невозили латвії так Мандат Собірофлайн Тендіт захворювань.

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Ембріус милий Водмор Інфменшин Я інженер, А її пропрацювали Бо це 1 з Осбб там майже 100 років працював в спілкуванні А Я маю на увазі Я дуже люблю Кладтера у мене є і мій тип бойлер, Деспет А я люблю Ембарго

366:32:21.000 --> 366:32:51.000
Акцент Чого Час, бензину це піклування не дає пенсій початковий інформаційний фонд оон це чай з бендери?

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Це Звичайно, милий. Пенграфи з'явився. Зазвичай сміливо.

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Все Будь ласка, Цей директора бензину. Гость. Кандидат в історію варіанти де пенсію у фонді-джменті там, праведливо реагує на телефон Девор Алла сергій чинник цілий опрацював і Дисерлін за нове місто характер це варіант Там

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економіка Франкфурт де системи Ющенка проджає Азем-агресор Енд в Виматорі і не пропровадження Він співає і Па 5 Слайд емоційно не дуже сильно сприйняття для цього не було у Фрукті Японія не Проть Нульга

Дейра Анек

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Хюанс по економічну авіаспресію в початкових Флобович А в де старий фокус по а Ми зі свого садочку орієнтуємося це будь-який період іноземних у мене аеропорт немає будь-якій формі бо з Айфур ви

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неугезував Арчаунд-аут Урол Ефексі тут фотографують аптек інформаційний формат це іншу емфорії ковбасою чи їздити на 15.

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Мільярдів про її санкції фарм магія Ось це за 2 роки тому.

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Передати сприйняття Двигун Скеос Брайм Спадкоєм реакція Фрн і це як їм Направду самоорганізації у вигляді пролий прапор ставить як комп'ютера астми Луїк організовують або синтетичний вит Харик-райс Албіс Та обмежуюся з

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Екс-сол Географія Бо Я з дитинства промисловий Атмосферні Михайлович Де Телевізор чують свій чабладзовоїк Інвестори втягують Кнел Будапештський Онлайн-курс і це і тхаєм Дач великої ферико під час

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ініціативи савченко а продовжив його статистику Чистила Пробачте, амбасадор підтримувати ефект солодкий кол-центр Номер очей за конфлікт це ви янголи ви янголи фейсбук а ми з ним ахметов пергафумів.

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Slightly underhead, half had had a child, about 12% reported having had or had a sexually transmitted infection at baseline and 21%.

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Self identified as commercial sex workers. That was the terminology used and most of those were in the India group given where the demonstration projects were actually held.

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This is what the HIV incidents looked like when you categorize it by some of those critical. Characteristics that I mentioned.

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So what was our overall HIV incidents incidents in this project? And remember the way that we look at incidents is simply a number.

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Over the person years, so you account for how many women were followed over time. Remarkably, we saw 32 infections, so no infection is good,

but this was a lower number than we expected.

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And that puts the incidents at point 7 to give you a sense of how that compares to what's being seen.

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For example, right now in women in many parts of sub-Saharan Africa, it's still around 3.5 to 4%.

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And if you look at really young women, it's even higher. So this, represented a much more diverse group, even though we had good representation from from sub-Saharan Africa.

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You can see, that the incidence was higher in younger women. So it was 1.3 in women who were younger than 25 relative to point too far other things that were associated with somewhat higher incidents, although not significantly were married status as well as never having had a child.

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Again, these aren't really separated, but it these are characteristics that we have seen before in previous studies, of.

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Okay, in the in cisgender women. So this is, really important, slide that I wanna take just a second to talk you through.

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I mentioned that we had dried blood spots, for objective measure of use of some women that was about 147 and then the remainder of those women that we had adherence information on.

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The subjective ones where they said what they were doing was again in about 2,800 women. Let's take a look at the objective measures.

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So what you are looking at here, is the likelihood of detection of Tinaphaber in the blood over time and it's broken down by those categories that I mentioned before.

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So again, we were able to relate. The level in the blood and assume what that reflected in terms of the pills that women had been taking, how often they had been taking it.

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So let's look at, for example, the extreme of women who, who had evidence in the blood of taking it daily.

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And that was started out very low, about 10% and went down to almost 0 by the time of end of follow-up, okay, which was about 96 weeks.

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So by objective measures, very few women were taking the pill every single day. Let's go up to a more liberal sort of measurement.

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So what about detecting pretty any Tanofavir that would be consistent with at least one pill a week That was actually quite a lot higher.

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And interestingly enough, that was about 60% that stayed somewhat consistent over time. But, so, those are probably the 2 parameters.

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You can see that about 25 to 30% of women were using the product. By direct measures here, over time, between 4 to 6 times a week.

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So that's actually, I think, very interesting and we're going to come back to that.

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Now, what I wanna also say and make sure people are aware of is that just like we saw in the early prep studies of Tinapha Vierra products or Ultanavir or Tuvata in cisgender women.

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There was not a lot of agreement between what women said they were doing and what the measurement in blood said was really happening.

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So if you look at the percentage of women who reported taking this product daily, it started out. At, 60%.

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And it actually stayed above about 50% throughout almost the whole study and then did decline towards end. But you can see that over this time, even subjective reporting declined overall.

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So when you look at what women were saying they were doing, it was in some ways the only thing that correlated with the objective measures were the less frequent use.

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So a lot of women were saying they were using it when they weren't using it. But the women who were using it less frequently actually were, reflected that was reflected in in the measurements in their blood.

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So pretty interesting and and gave us a chance to look at this. Now, What we did here and again, I won't belabor this, but we were able to take that data.

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Again, as I mentioned, and apply it to the whole group with this modeling approach and we ended up describing 4 key groups of women and you can pretty much intuit that that's what those data looked like even when you look at those graphs that I showed you whether it was by self-report or by direct blood measurement.

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So there were women who probably were using it every single day. Not a lot, about 500 out of those 6,000 plus, almost 7,000 women, 6,300 women, but they were definitely there and they were a discreet group.

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There were women who were using it 4 to 6 times a week. That was a little bit more about 700.

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There were women who started out using it. Perhaps with great intentions, and then declined over time.

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I think that is a critical group. And if you're thinking about engaging with women about the importance of Prop.

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I think this group deserves a lot more study because clearly these women engaged They maybe even wanted to continue, but why didn't they?

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We don't know. That's important. So that was about 1,100 almost 1,200 women.

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And then there was a substantial group that was consistently low or perhaps none. So those 4 groups are what we really used in our final analysis.

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Because the really big question is, what was the HIV incidence in each

of these groups. And this is the slide where, the, the key result is, and I think what is, what really was most amazing to us that even though this was a demonstration project, even though, you know, the the the data were limited.

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I'm going to talk a little bit more about some more limitations. We observed 0 HIV infections in the women's who were using it consistently daily 7 days a week, but even in the women who were probably using it 4 to 6 times a week, there was only one out of 658 women infected.

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The vast majority the rest of the infections I already mentioned how low the incidence was overall Are the remainder of the 11 infections which were 11 of the 12 occurred in women who started out high but then declined women who started out high but then declined or women who started out high but then declined or were consistent low users.

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Line is that even with this very, very low incidence of HIV overall, higher patterns of adherence were directly associated with a lower risk of HIV infection.

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Now, I've already mentioned some really critical limitations. Whenever you pull data from a large heterogeneous, bunch of projects, you know, you're introducing chaos, right?

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But you know, life is chaotic. So I like, I like this because it's a real world.

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So I like I like this because it's a real-world, analysis that reflects the fact that life is chaotic, but we still had a really biologically plausible result.

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Helpful. We did have some different follow-up. So and the follow-up was associated with adherence and that's a critical, a little bit of a statistical nerdy thing, but and we did try to control for this and the analysis, but it makes sense that if women more more likely to take the product, they probably were going to stay in the study more for because the same things

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that favor retention and a study favor the ability to take the study product, right? So the women who might have needed the product most and who might have been even more likely to get HIV may not have been

the ones that we managed to keep in the study the whole time.

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So that's a really critical point. I already mentioned the fact that the blood levels were available for only a small number of women.

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I should point out I didn't say this, but when you looked at the characteristics of those women, they were very reflective of the group overall.

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So that gives you some confidence that you are using that group appropriately. And then you know you always were scientists.

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We always want more data. We always want more people. We always want more measurements. So if we had more, maybe we would have been able to have even more impressive or reassuring results.

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So just in conclusion, and then I wanna make sure it looks like we've got at least 10 min for questions, which is great.

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It's the largest assessment of effectiveness and adherence of oral, in diverse global real world settings.

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And cisgender women, gotta be very careful pointing that out. Already discussed the relationship between.

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High adherence or consistent use, probably better to put it that way, versus not with HIV and incidents.

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And I think that the broader context of what this really means needs to be very much evaluated. I mentioned mentioned that we don't know when women.

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Or if women timed this product to perceived risk to me that makes perfect sense. We're very capable of figuring these things out.

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We don't always know, right, when we're going to be at risk, but many times we do.

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And I think that that could be a bridging to what we know with MSM and transgender women that there is adherence forgiveness if you use the product around the times that you are at risk.

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And I think that makes sense, but we have not been able to really nail that down for cisgender women.

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And then the last, I think, sobering piece of information that I would emphasize is remember. Over half of the women since gender women in this these projects did not use this product consistently so Truvata is World Trivata Works.

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I think it's great, but it is not going to meet the needs. Of all cisgender women and that's why we need to keep working very hard.

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On additional prevention options such as long acting modalities. I really want to thank, everybody who made that analysis possible.

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Particularly the participants for their really heroic participation and staff at these settings. And I want to thank all of you for being here and I'm going to turn it back to Rancho.

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Thank you so much, Dr. Morocco. That was fantastic. And I'm excited to open it up to see if anybody has any questions, any clarifying questions.

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That she can answer. Awesome. I think it's, I honest has a question.

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I see your hand raised.

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Yes, so this is, I think so much. I'm really delighted to have you present to the group and really thank you to Jim as well for being able to bring more Ukrainian participation here.

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Congratulations on your work. I'm conscious that of the 21% of the data for this analysis came from India.

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And I'm also, I think we're all cognizant of the differences in background prevalence from this diverse group of studies.

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So, how is that sort of added into your interpretation in terms of the findings? Especially around related to forgiveness, whereby cisgender women do not have to take a pill every single day, but that is the message in our global guidelines, in our national guidelines, and what we encourage, you know, sort of at service delivery.

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And I say this because, I had the wonderful opportunity of visiting the Calcutta, a demonstration project as well.

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And, and there is also that variability in terms of the, social support and support that was offered to demonstration project participants like there was like just something that like I observed in in Calcutta as was also with my store was really the, the wonderful community engagement.

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And so just conscious of of that element if you maybe can provide some interpretation. And how that could skew the findings.

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Thank you, Dr. Morrison. Thank you again for all your wonderful work.

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Thanks, Janos. It's so wonderful to hear your voice. And to see you.

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Thanks, thanks for being here. So let me start with our first thing about the demo projects providing support.

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I'm probably overstating it when I say that this is a real world analysis, right? Cause even demo projects aren't real world.

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I think demo projects are real world relative to the kind of extremely rigorous conduct of quote unquote randomized placebo-controlled blinded trials.

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But even in demo projects people have have support. Personally, I think everything should be like a demo project.

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I wish that we could provide support for people to, to be adherent to these interventions.

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To me that would be perfect. But I acknowledge that, that you're right. Again, I talked about chaos.

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There's chaos, there's demo projects, and then there's randomized controlled trials.

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So, so I agree with you that's, that's something important to note. Regarding your question about entry India.

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I would be cautious to, make country specific or even demo project specific. Recommendations and inferences from these analyses in these data and the reasons are first of all so much of the assumptions made depended on sort of putting everybody together and making sure that all those characteristics that I showed in the analysis were really carefully weighted.

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We did not include country in that because, you know, there were some characteristics that are so tied with country like the commercial sex work.

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Self-designation and India that you really can't do that. So I think that this is more of an aggregate signal that should be kind of thought as applying across these populations when you get to individual groups you're really gonna have to look carefully at the setting their patterns of perceived risk and exposure and the capacity they have to continue to use the product.

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So excellent question. I think there's probably better studies and opportunities to look at that. Specifically in that situation.

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Awesome. We have a question, in the chat. Are there plans for doing some things.

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Yeah, that's a question, a good question. I am not aware, that that is underway.

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I think that we are moving really rapidly towards longer acting products so you probably know that there's a very broad portfolio for multiple.

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Groups looking specifically atlandic cap per v. Which is is i think gonna offer again talk about adherence forgiveness one way to address that is to give people something that just last a long time.

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So I think my sense is that. Nothing against Truvada it's been an incredible tool and if it works for people they should they should continue to use it but I think it's just really important to recognize relatively that this does not work for all women and it didn't even work for the women in many of the women in this demonstration project with the support that Yanos mentioned.

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So my sense is that Probably time to recognize this works in some contexts, make it available in the suite of interventions but continue to pursue other options that we hope will really address people's lived experience and needs.

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You bet in the chat said earlier, choice for women is the key to the future. And, I think that is absolutely right that without choice, without additional options, what we see in some context is growing disparities around for those who works well for and for those that it doesn't.

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Okay.

366:59:32.000 --> 366:59:35.000
And for those that it doesn't work well for, what we know is it tends to be all of these other some of the chaos that you talked about right that are things it's hard for people to control and so giving people options that are more controllable.

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Yeah. Oh, yeah. Okay. Thank you so much.

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The best options for this women.

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I really want to pick up on that because we design access programs about what we've shown work, right?

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And what works works for the women who were able to do it. We kind of don't talk about the participants.

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Let's just say participants, not even, says gender women in general, we don't often think or talk about the people, you know, in whom it didn't work and why.

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I mean, I think, I think we're getting there, but it's really again getting to access programs need to recognize that they're fantastic and we're gonna grow them and we need them, but they focused again on what we've shown work and not everything works for everybody.

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Thank you, Janis, for the clarification in the chat to our Ukrainian colleagues around Truvata and some clarity around that.

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Jim, your hand is up.

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Thank you, Ronnie. And thank you, Dr. Morozzo, Jeannie, for making time for us today.

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I know your time is really precious and just before I get to my question. How much more time do we have with you?

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Our webinar goes until the half hour after. And I don't know that you could stay the whole time.

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So I'm just trying to manage. All.

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I wish I could, I probably have about 8 more minutes. So yeah, cause I need to get to at 10 o'clock.

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But.

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Okay. That's right. Thank you. Thank you again so much.

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And so excited about this data as you know like I was in the session that you presented. I'm a couple of years ago at Croy.

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And and chasing this down was so delighted to see the article come out in JAMA. Before I get to my question, I want to uplift what Julie Patterson says in the chat, cause it's gonna tie into that, but she

talks about adherence forgiveness and how a really powerful concept and a game changer to show that this should be extended to cisgender women's youth.

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Vata for prep and we've had this sort of dogma that women have to be super adherers they have to take 7 pills a day 7 pills a week I'm sorry and that they have to take 21 pills in this in the US we the CDC tells Women, they need to take 21 pills before they get protection and then they need to be super adherence.

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And this is incredibly frustrating now with science that shows that that's not exactly the case. And And we know that the WHO for a long time has has said cisgender women need 7 days before protection.

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So what do you think about, you know, the the ability or how this paper might help change guidance.

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So it's more in line with science and more quote, real world. So we're not telling women they have to take pills for almost a month.

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Before they have protection and that we're not telling women that only super adherers will have strong results here you showed us that that's not the case so What does this mean for guidance, especially from the CDC and and other places that are still not kind of.

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Totally caught up with where the science is.

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Yeah, that's an excellent question, Jim. And let me start backward. So when you look at CDC WTO guidance.

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They are, as you know, fixated on and probably appropriately so evidence right so evidence-based guidance, they use that term a lot now.

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What happens when the evidence you have doesn't support what you think needs to happen? Which you know which may be that I mean I think I think this analysis And I think also many people's experience in the field, is that event driven prep or a prop with this product.

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Or it's counterpart, right? Discoby and we didn't even talk about

that.

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Somebody mentioned kidney and bone, effects in the, in the chat. What what would need to happen to validate what we think we're seeing in this study or what I hypothesize we're seeing in this study, which is that the women who are using the product 4 to 6 times a week We're probably covered.

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During the time of the highest risk of exposure, right? I think what this says It doesn't go so far as to say that event driven oral, enough of your base prep is gonna work in women.

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I think it does go so far as to work in women. I think it does go so far as to suggest that a minimum of 4 pills.

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A week is probably enough to cover most of the events that are going to confer risk. Now, do we need an additional level of evidence to sort of say, not only that, but you can actually time maybe the of 2 or 3 pills around an act exactly as we have recommended in the context of MSM and transgender women.

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I think we probably need more evidence to specifically say that because that may mean going down from 4 pills to 2 pills, right?

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If you're doing a pre and post, which is, is what we ideally would like to get to.

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So I think from these data, I personally would be comfortable. With that 4 pill a week threshold.

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Recognizing all the limitations of this study. But I think for formal event-driven prep, We probably need some more robust data.

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Now, one big message from this though, I can't remember if it was, Raja or somebody else.

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This concept that you, you are a terrible person or you're We're going to get infected if you don't take it every day, that's what needs to go away.

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To me, that is sort of again setting an expectation. It's incredibly patronizing. It really sort of shames, has the potential to shame people who, you know, either can't do that or just don't, you know, can't make it happen.

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So to me, the message is, you know, people who need prep need to figure out how to make it work for them.

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And this offers them one option where you can say, look, if you can at least take it, you know, 4 days a week, you can feel probably pretty safe, right?

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You know, if you can take it every day, that's gonna be like, whatever metaphor you wanna use, it's gonna be an extra layer of protection.

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But the 4 days a week make a lot of sense. It's gonna be an extra layer of protection. But, the 4 days a week make a lot of sense.

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And then, but the 4 days a week make a lot of sense. And then intuitively, of course, if you're gonna have sex on a Tuesday, you would like to make those 4 days Sunday, Monday, Tuesday, Wednesday, right?

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But that means again, getting back to this chaos concept. Planning is not always in the mix here.

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So I think those are a few of the thoughts that I have, and I hope that helps.

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I do think the guidance, does need to consider this carefully. I can't speak for whether they should do it or not, but I certainly think this is a very strong signal.

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Thank you for that. And just really quick, thank you, Ron. You just, what do you think the appetite is to do a study around event-driven prep?

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For cisgender women to actually nail this down. Like you've given some signals here, but it's not enough to say we can do that driven.

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Right.

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So is there appetite to do this?

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Well, I would turn that back to you, and ask, certainly the community, I think scientifically for me, I absolutely have the question, do I get to decide everything despite, you know, my job?

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No. It really requires a lot of scientific input and a lot of community input, but I think if if people things think it's important we really want to hear that.

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So.

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I think that's a great segue into the next kind of question I want to go into. We have Whitney in the chat talking about, MPTs, multi-purpose technologies.

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And I think when we're talking about cisgender women, this is such an important piece.

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And she says that some of her very small modest study findings show that folks who can become pregnant would be very interested in biomedical products to prevent pregnancy and HIV and or STIs.

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AVAC is in a great job tracking the progress of these products however it feels quite distant and I can add a caveat I think especially for folks in the United States.

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It feels very far away. what can the social science research community do to support the pathway to implementation.

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Are there questions that need to be answered to support the importance, priority of NPTs?

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So I think there are a lot of questions. First of all, I will say I don't think there are many more enthusiastic, advocates for multi

purpose prevention technology than I am given my background and my focus on women's health and, and the fact that we know, I mean, going, I always go back to the early prep studies and cisgender women voice and fempp in addition to

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others. And the reason women stayed in the study despite the fact they weren't taking the products was because they got birth control, SDI screening and treatment and care.

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Right? So, so women were concerned about pregnancy and they were really concerned about STIs. So we really need to that to me was just a gigantic message that we we ignore at our peril.

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I think that the path forward for MPTs has been challenging largely around the regulatory landscape and the availability of actual products that we know are safe and can be combined and can be administered and can be shown to be effective.

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So it's an incredibly complicated situation as all of you know. I do have a lot of and enthusiasm for the Matrix program that is being led by Sharon Hillier and others, which is actually looking at the dual prevention pill, that specifically will be a combination of antiretroviral prep as well as hormonal contraception.

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I think there are potential I think for vaginal rings in particular that could be contraceptive and also deliver.

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That makes the exquisite sense to me. And now that we have long acting injectable prep, we should be thinking about combining that with long acting injectable, injectable hormonal consumption.

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And I know people are, I don't mean to, to say that they aren't. So I feel like after a lot of years of of perhaps not a lot of coordinated movement we're finally getting to the point I think in the next 5 years where we may have some real data on really products that actually have legs, you know, and may have sustainable opportunity for manufacturing deliveries and and they may be safe and

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effective. So I'm pretty optimistic. I recognize all the challenges, but I think this should be an incredibly high priority for women's health.

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Awesome, awesome. There's a lot of comments in the chat about dosing.

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And, I think you answered a lot of that very well. Kind of like your thoughts around how folks should proceed.

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And the needs that we have for more information around that. So that is a fantastic.

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Let me see. We have another kind of comment from Julie who's going off in the chat with some great stuff.

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I just want to make sure we get there. And she said, we may need more robust data to have clear evidence that event-driven oral prep will work for this woman, but we are very unlikely.

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To get those that data because the research system is also patronizing and will not offer the funds to support this kind of research in any longer and to women because they are focusing only on long acting prep.

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And so we'll love your thoughts on that. Especially in the role that you get to sit in.

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Well, you know, I What I can say in my role is, Not always everything, but I will just I will just say I will just say that.

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I continue to emphasize that choice is important and I continue to emphasize and believe that long acting prep is great.

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But again, that requires planning and access. And self recognition that you need that product, right? What it doesn't cover are the times that are unplanned where you may not be in a position to get those products.

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So I still think on demand, quick acting products should be prioritized and considered as part of the suite of interventions.

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So again, there's no one size fits all here. We don't ever We have

very few, if any, magic bullets, magic shots, magic pills.

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They, we just don't have those. That doesn't, that's not the way we need to be thinking about this.

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It's not person centered. It's not real world centered. And it's just not I think where we need to go.

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So I hope that Partly answers your question. Great, come.

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It's, it does. I think so. And you know, Dr. Moss, so thank you so much for being here.

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I know that you have to run, to, your next, thing, but we are so grateful, for the time you spent with us here today.

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Like I said, I think I can probably speak for so many of us here who do HIV advocacy, work in DETA for a long time that, you in this role.

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Feel so exciting. And to have a assisted woman who is in this role who I think, you know, can really kind of advance us to I think I hope that we get to see you know the end of HIV together.

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Yeah.

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With you in this role is really extraordinary. So please, a virtual, round of applause for you, and you showing up here for us today.

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Thank you very much.

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Oh my gosh, thank you so much. First of all, I meant to thank James for the playlist.

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Any any talk that starts with Beyonce? I am there. Second, I love the idea of having us experience and the HIV together.

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Nothing gives me more energy, more hope, more commitment. So let's do

it. Hey, thanks you guys.

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Have a great weekend. Yeah.

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Thank you so much. I'm so excited to introduce our next person. So we're not done yet.

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We still have one more amazing speaker. I's gonna come up. Joyce does program development and advocacy program at ISF.

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Joyce does program development and advocacy program at ISFA Africa, the initiative for solutions Africa, the initiative for Solutions Africa.

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She has over 10 years of experience in development work, implementing projects on maternal child health. Sustainable livelihoods, girl child education, economic empowerment, and sexual reproductive health targeting adolescents, girls, and young women.

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She has a huge amount of experience in advocacy, capacity development for startup organizations and community projects and experience working with national and county government implementing international, national, and grassroots projects.

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So very, very excited to bring a Joyce up to a talk about cisgender women and prep.

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Joyce, how are you?

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Very well. Thank you so much for that. Introduction and thank you to Dr. Jean.

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She has already left. For a wonderful presentation which has set a background on what I will be speaking about.

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So thank you, Jean, as well and thank you for the opportunity. For this space.

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Yeah, so I'm going to pick up from what, where Dr. Jane has, has stopped and kind of just bring the voice from the seas gender women.

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And the work that we have been we have been doing. So it's going to be, we are going to start broad and then we can I will give us some reflections on the paper as we come to the end of the presentation.

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So let me start with a beautiful faces on your screen that you see. This was taken during the HIV, HIV and women conference in Nairobi in February.

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I think we have some some of the participants of the workshop in this in this webinar today. Yeah, but I wanted to talk about it to say that, I think Jim always does the Kroe, Magarita breakfast.

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And this was our session for a Magareta lunch with the young women because in the conference there was a lot of science and we needed to come together with the young women.

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To just talk about the science, talk about what the understanding clarify some of the questions that they had. And it was clear that sometimes in research.

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In research presentations, conferences, workshops, really sometimes we could be speaking to ourselves, the communities.

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Don't understand some of the terms don't have a lot of questions. And yet the science is about the same community who don't understand.

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So we created a space. Where we could speak. With the young women. And see their understanding of the conference and the science.

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And that was great. So I would talk about. The African Women Prevention Community Accountability Board.

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Because we are really focused on programming on advocacy around choice. For these gender women of African women and girls.

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And really I would not do justice with this presentation without fast

focusing on the work that the African women prevention community accountability board are doing.

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So we are comprised of 11 women from 7 countries. And those are the countries that are listed there, some of the participants here are part of the board, so a shout out to you, Evette and other members who are on the call.

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On the call now So we are how we organized. We are from eastern and southern Africa and we are talking about choice and introduction of options.

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So as we speak about prep, about choice, about what is in the pipeline, that's a conversation that we are having and actually a movement that we are having right now as women and girls.

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We are an intergenerational kind of board. We have older generation, sometimes they make fun of us and say we have mileage and we have the younger generation.

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So it's a kind of a mentorship space as well where young women also get mentored. See?

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And advocacy really for choice and HIV prevention and reduce the focus on reducing new HIV infections.

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So we focus on policy change access and rollout financing for choice. We are engaging at national, regional, global levels and sometimes at the country levels.

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We are also doing subnational engagement, with some of the people that we are engaging on.

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So last year we developed a HIV prevention choice manifesto for women and girls in Africa. And I will speak a little bit on the call to action for the manifesto for women and girls.

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Because it will answer the question as If prep is not working for C gender women, then what? What choice can we bring or what do women have in the pipeline if the prep options is having challenge as we

have seen, clearly.

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So this choice manifesto tries to to point out areas where program policy should implement so that we can see a reduction in the new prevention.

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So the goal of this choice manifesto is a future free of HIV for African daughters than women in Africa.

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So the call to action is center people and communities. A key and marginalized populations.

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We need to focus here and ensure that we we scale interventions that target key and marginalized populations.

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During research and development of serving good participatory practice, the guidelines ensuring that communities are at the center. That they are informing ongoing and future pipeline.

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From pure future pipeline of research products from onset design, formulation, and that they are really at the center and they are the ones.

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Talking about the kind of products for prevention that they would like to have. And then choice is key. We have to scale up massive scale and increase access.

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To save and effective HIV prevention options, methods. I that we have at country level while also thinking about the pipeline what is to come and how we can ensure that our health systems are geared or strengthened in such a way that they can uptake the new options.

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So to ensure that women have control over their health and their bodies and access to a full range of effective and safe options.

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That works best for them and we know that women have a lot going on in their lives. So sometimes one option at one time may not work, but may work at another time.

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And we are going to talk about that later on in the presentation. So programs that deliver that's all about integration of HIV prevention.

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Largely at the moment the HIV prevention is done as a vertical program but I think more integration as the board we call for more integration into the existing whole sexually productive health services, including, those posted on the screen, family planning, of local cancer, STIs, prevention and all that.

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And then finance choice. So strategy and financing choice would look like this that they actually staff who are paid in clinics in in in places in in facilities.

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Is fully staffed, there is a budget and there is a procurement for choice based HIV prevention.

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So not just mentioning that you support choice but actually have it reflected in your budgets. In the kind of stuff that you have in all that.

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The future we have said and Dr. Jean was very clear on this that we have options at the moment.

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But they are not sufficient. They are not, there is no magic bullet to one option and that one size does not fit all.

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Therefore we need to prioritize getting more. Products from research, both systemic, non systemic options because what we have seen even in the paper for Dr.

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Jim is that people are in different circumstances of their life. Some want a prep driven, driven option. Some want long term, some watches for a short while, some like women would want something safe if they are breastfeeding or or pregnant populations may want to consider options that are non-systemic.

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So considering all that and then lastly adopt a human rights-based approach to choice. Addressing stigma discrimination, criminalization, criminalization, cannot over emphasize this as we are seeing, criminalization, cannot over emphasize this as we are seeing this currently in the world as a movement.

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Of criminalization we are seeing bills we are seeing countries people who cannot even access the prep that we are talking about because they are criminalized because the bills have been passed and they have become you know they cannot no longer access some of the services that we are talking about.

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So the choice manifesto was launched in September last year. We had a champion that's, who is the executive director of UNH.

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Who continues to champion choice and champion the choice manifesto with us. So I'm going to move on to reflections on the, on the paper that we have just seen.

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And I will start by by reflecting that Prevention versus treatment that we are talking about prevention here.

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And it's different to talk about treatment for people who need. Treatment for to save their lives. And prevention.

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Sometimes treatment will get more emphasis than prevention. And therefore it's good to remember that we are preventing here and the kind of motivation that you find in treatment is not always there in prevention, especially when it is rollout, on a broad rollout, like a national rollout.

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You find in treatment that, their support groups and you have to keep, you know, the support group, these regular checkups and all that.

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And there is more offered in treatment actually than in prevention. And therefore for somebody to get the self-motivation to keep going for prevention.

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It's something that we need to talk about. So we know that, women, the rates for HIV infections are high.

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The other thing that we know is that we are off track actually for meeting the global goals. The other thing that we know for sure and we have seen in the in the data in statistics is that HIV rates, new infections rate are higher in younger women.

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And we also know that younger women don't plan for sex. That sex just sometimes happen. They go to a party and they had not planned to to engage and things just happen.

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It's for younger women is harder. To plan for for for events and it just happens to them.

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So the question of you know event driven prep is a good one to think even when we are thinking about younger women.

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But also in older women events sometimes women are not really able to plan for for when to have sex and all that.

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And so if they have to take prep that way for 7 days to be effective, then perhaps these are some of the gaps in research where we are not able to manage high HIV infections.

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Most most since gender women they perceive themselves at low risk especially for those in monogamous relationships.

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Those were not doing engaged in sex work or drug or don't inject drag and all that and don't have multiple partners.

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So that is also another reason. But we also call for purposeful inclusion of cisgender women in studies.

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And also how we communicate about studies. If we are studying and we say this is meant for MSM, when we are coming to roll that out and offer it to cisgender women, then it becomes a challenge and also stigmatizes some product.

367:27:02.000 --> 367:27:16.000
So we must be able to to communicate. To communicate properly about products. We need to support adherence and then expand the options for cisgender women.

367:27:16.000 --> 367:27:25.000
We have talked about the low perception of risk, the stigma, poor social support. We have talked about that.

367:27:25.000 --> 367:27:31.000
And here we are really saying that we should be considering other products that can cover up for adherence.

367:27:31.000 --> 367:27:37.000
For example long acting prep options such as the injectable Cabalet and the Pivering vagina ring.

367:27:37.000 --> 367:27:53.000
That may at least alleviate their parents challenges that we are experiencing with the prep. We need to have tailored canceling, especially for cisgender women, supportive services that the stigmatize prep.

367:27:53.000 --> 367:28:03.000
There's a lot of stigma around prep and prep use. And that affect adherence and people wanting to access it and demand for it.

367:28:03.000 --> 367:28:16.000
Their privacy concerns and also their financial difficulties and and more support. Given to communities including cisgender women could really help.

367:28:16.000 --> 367:28:28.000
Then they are their concerns, genuine concerns, especially pregnancy and reproductive concerns, side effects. Concerns about long term effects and also partner consent.

367:28:28.000 --> 367:28:46.000
For service delivery, friendly settings for women. The attitude of the providers who are who are giving this options matters a lot in terms of adherence in terms of access and all that.

367:28:46.000 --> 367:28:58.000
We have talked about the communication that should be made clear about some of these products because once we stigmatize products and saying they belong to a certain group.

367:28:58.000 --> 367:29:11.000
Population then it becomes difficult for another to access this. Then we have really talked about this, acknowledge that high, but less than perfect.

367:29:11.000 --> 367:29:21.000
What we are calling the adherence holidays or and all that. That that needs to be communicated because it's not being communicated now.

367:29:21.000 --> 367:29:32.000
And that would alleviate anxiety around missed doses and in focused conversation on individual motivations. Yes, this is not well

communicated at the moment.

367:29:32.000 --> 367:29:44.000
Hardly do communities know this and therefore if you have failed to adhere to this Then you might stop taking prep and not show up in the clinic.

367:29:44.000 --> 367:29:51.000
We, and I will finish by saying, for program consideration, policy, considerations.

367:29:51.000 --> 367:30:07.000
That is really the high time that we implement the call to action in the choice manifesto because it does point out to areas where program manifesto because it does point out to areas where program because it does point out to areas where program policy and all that should be paying out to areas where program policy and all that should be paying attention.

367:30:07.000 --> 367:30:19.000
To ensure that choice becomes a reality. So the choice for us as accountability board, the African women prevention community accountability board.

367:30:19.000 --> 367:30:35.000
We do not talk for any particular product, but what we do is to say ensure that there is a basket filled with and effective options and so that when the communities come they can find something for their use.

367:30:35.000 --> 367:30:45.000
And we are also saying that different. Hence, there should be something for everyone, regardless of the circumstance that there are.

367:30:45.000 --> 367:30:59.000
So let me stop there and hand it back. And happy to answer any questions, but also note that I also want to join all of you in saying that we hope to experience the end of HIV together.

367:30:59.000 --> 367:31:04.000
Thank you very much. And Happy to take any question.

367:31:04.000 --> 367:31:17.000
Thank you so much, Joyce. That was such an amazing presentation. And, thank you for the work that you do, the choice manifesto is brilliant.

367:31:17.000 --> 367:31:23.000
I will start, take moderators, a privilege and I would love to kind of ask you, you know, if there's 1 recommendation we got to have Dr.

367:31:23.000 --> 367:31:34.000

Marshall here earlier, and so what would be the one recommendation we got to have Dr. Marcel here earlier.

367:31:34.000 --> 367:31:48.000
And so what would be the one ask that you have, of research? When it comes to, women HIV and PREP.

367:31:48.000 --> 367:31:58.000
Yeah, I think the one ask. If I can go is to say that The options we have are good, but they are not sufficient.

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And especially for C women. So the research should ensure that we get safe and effective products options for women.

367:32:08.000 --> 367:32:17.000
Because realistically speaking right now the only product that we can say is exclusively for women that they can use it's discrete.

367:32:17.000 --> 367:32:22.000
For women, it's only the vaginal the peering ring.

367:32:22.000 --> 367:32:29.000
So we need more options and also we need like the DAPEVE ring rolled out outside of implementation.

367:32:29.000 --> 367:32:45.000
Studies and we need to see how it behaves in a real world setting. From where we stand, we believe that the efficacy for the APV in ring will be higher in a real community setting.

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And also other options like the prep we had an experience in Zambia last week. We visited a clinic, a clinic run by the government that is already rolling out.

367:32:57.000 --> 367:33:14.000
And our experience there was that men, women, young and old are coming to demands for And so that is demystifies some of the misconceptions that perhaps one population is the one going to.

367:33:14.000 --> 367:33:32.000
Except but we were surprised that there was a 15 year old who came to get Kabale but there was also a 70 year old man who came to also get So, the way the products behave in a real world setting.

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Is very different in implementation studies and therefore our other ask is that Let the products that are already there be rolled out, let them go into their communities because communities are demanding for

them.

367:33:46.000 --> 367:33:48.000
Do you, so it sounds like, Young's actually made a comment in the chat, that in Europe, there's still a lot of work to be done around awareness.

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When it comes for a prep when it comes to prep and cisgender women, I would say here in the US it's a similar case.

367:34:01.000 --> 367:34:16.000
We have increasing awareness, but it's not very high. But would you say in the work that you'd done that you see significant awareness and demand for prep when it comes to cisgender women.

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Yes, I think, there's demand, for prep. With cisgender women, we have had community education programs.

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Where we are talking about all the options actually. And asking women what they would prefer, what they would like.

367:34:37.000 --> 367:34:49.000
But I think the significant peel burden has been such a challenge in all the creation. Forums that we have been, it always comes like, I don't like to take bills every day.

367:34:49.000 --> 367:34:59.000
And also it, women have been saying, I don't want to feel like I am sick because I am, it is prevention, but it's so much like I'm taking treatment for life.

367:34:59.000 --> 367:35:14.000
So, so that has been a significant challenge where communities say I want to stay back because of the peel button and the fact that this is prevention but I feel like I have to take treatment.

367:35:14.000 --> 367:35:25.000
For life but not to say that the communities are not demanding yes sometimes is the issue of access getting access to the clinics is a challenge as well.

367:35:25.000 --> 367:35:43.000
So as much as We have created the awareness the products are sometimes not available in the clinics or the communities are not getting access to the community and part of it also is because of stigma to go to a clinic and your HIV negative.

367:35:43.000 --> 367:35:55.000
But the prep is being offered in clinic where also treatment is being offered and that kind of creative. So we are still in the stigma and that causes people not to go for credential services.

367:35:55.000 --> 367:36:00.000
Because they offer together where the treatment is offered.

367:36:00.000 --> 367:36:17.000
And there's so much to learn from implementation, in the continent, thus far that I think is super applicable to places that are looking to really increase and scale up prep utilization.

367:36:17.000 --> 367:36:27.000
And so thank you for that. We have a question from Nita. She said, thank you Joyce for your valuable presentation.

367:36:27.000 --> 367:36:40.000
How are we engaging the users of prep to share their experiences in Africa? And maybe be part of advocacy within ethical requirements.

367:36:40.000 --> 367:36:56.000
Yes, that's powerful. So, What we are doing in our education awareness programs is that We always bring the users of the product because they have testimonies.

367:36:56.000 --> 367:37:06.000
Of the product working for them. The this, they demystify the side effects. All the fears that people come with.

367:37:06.000 --> 367:37:21.000
So we have always consistently, ensured that We are working together for advocacy with those who are using the products because they are the ones then who can give the testimonies of the product.

367:37:21.000 --> 367:37:26.000
And they give confidence that they have been using the product and they're okay. They still fear of side effects.

367:37:26.000 --> 367:37:37.000
They still fear of what will happen to me. When I start taking this drugs, but having people already on this on prep and talking about it openly.

367:37:37.000 --> 367:37:45.000
Yes and the testimonials go along way and these are great advocates. For us as well.

367:37:45.000 --> 367:38:01.000
I love that. I feel like figuring out ways to turn that advocacy into

employment for folks who are users is an important part of our advocacy journey and really making it sustainable and making it ethical.

367:38:01.000 --> 367:38:05.000
So that's great to hear. Evette, you have your hand raised. Come on down, come in.

367:38:05.000 --> 367:38:07.000
Tell us your question.

367:38:07.000 --> 367:38:13.000
No, thank you so much and thank you. Thanks everyone for staying on Joyce. Great presentation.

367:38:13.000 --> 367:38:43.000
I just wanted, you to talk a little bit about the information that we received with the country presentations if you if you want to around how choice the introduction of choice in the clinics where it is becoming, you know, part of the governments, you know, the government's plan, how that has then taken, is grown people taking up prevention methods instead of just taking a method that they are offered.

367:38:44.000 --> 367:38:53.000
They are now in, you know, for instance in South Africa, people who are offered choice counseling.

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Choose a method. They don't go out of the clinic without a method instead of just being given an option.

367:38:58.000 --> 367:39:10.000
We have the quantum available. We have, you know, we have PREP available. Instead, where there is twice counseling, people actually make a choice.

367:39:10.000 --> 367:39:21.000
If you, if you mind to talk a little bit. About the meeting last week and some of the key outputs from countries that you got.

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Awesome, great. Yeah, so, we had, a meeting with the board and we had some country presentations.

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One of the requirements as a board member is that you're a champion in your country to ensure that choice becomes a reality in the country where you are.

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And so in comparing what we are all doing in all the 7 countries. Yes, as the vet is saying choice canceling, it's something that we are pushing.

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As advocates. Such that it's the communities who end up choosing but not the clinics that end up just giving the methods that they think.

367:39:58.000 --> 367:40:28.000
People need and so choice canceling across the 7 countries is something that we want to uphold we want to continue doing and we already have 2 countries that are almost getting there and and especially Zambia and we're really happy with a case study in Zambia where they almost have all the products available and the clinic is offering the choice canceling and people are able especially to get along injectable

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Kabale there in outside of implementation studies. So we are really looking to Zambia so that we can use that as a case study for the rest of Africa.

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I know South Africa is also ahead with a choice and they are offering choice. But we also ask ourselves whose choice anyway because funders and governments are the ones and providers also.

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Determine what choice it is for individuals and that is something that we are in our advocacy we are calling out to say it's not about the funding, although we know that funding really.

367:41:14.000 --> 367:41:37.000
Determines choice for what's available in the basket but it's a call that really if we are to meet our global goals to end AIDS by 2030 We must really be honest with ourselves because We wanted to introduce prep but we have found in the statistics that prep doesn't work for everyone.

367:41:37.000 --> 367:41:40.000
We haven't met the goals for implementing oral prep. Therefore, we need to bring other products that can work for people.

367:41:40.000 --> 367:41:57.000
And that one size does not fit all. That's a reality on the ground and that people are in circumstances that make them choose one option.

367:41:57.000 --> 367:41:58.000
Sorry.

367:41:58.000 --> 367:42:02.000
As over the another and those reasons are genuine. We must program for person centered. Kind of approach.

367:42:02.000 --> 367:42:03.000
Thank you.

367:42:03.000 --> 367:42:06.000
Yeah, yeah, the

367:42:06.000 --> 367:42:09.000
Thank you so much, Joyce. I think that's such a good point. Our goals to.

367:42:09.000 --> 367:42:20.000
No.

367:42:20.000 --> 367:42:21.000
Okay.

367:42:21.000 --> 367:42:23.000
Are very much. Part of it was driven by the the admin of prep and the biomedical tool to help prevent HIV.

367:42:23.000 --> 367:42:34.000
But if it's not working for everybody, then we really have to readjust and reconsider what our approach is and reconsider investments that we have to make sure that the tools we have work for everybody.

367:42:34.000 --> 367:42:36.000
Okay.

367:42:36.000 --> 367:42:45.000
Darren brought up a great point in the chat. He said, thank you for the presentation. I think what we take away is that awareness isn't 1 and done.

367:42:45.000 --> 367:43:00.000
It is a continuous education process. Regeneration is a new generation and what we learn today may not be heard by the next generation and our learnings must adapt and be shared as language and knowledge evolves.

367:43:00.000 --> 367:43:08.000
I think that's such a great point. Enjoys, I'm interested in what does that education look like from an intergenerational lens.

367:43:08.000 --> 367:43:26.000
So how does it, how is it different for younger girls and for young

women and older women? What are some of the trends that you when it comes to talking about prep and awareness and education, persist women across our lifespan.

367:43:26.000 --> 367:43:35.000
Yeah, that's a great one. Yes, so it has not been standard. Education awareness programs are not standard across different populations.

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For young people, you have to be on TikTok on social media, on every other platform that you can be.

367:43:43.000 --> 367:43:53.000
And that's how the message. Is driven if you don't drive it. On social media, on TikTok, on X-.

367:43:53.000 --> 367:44:01.000
Then you're not communicating and reaching the, you're not reaching the young generation, the young women.

367:44:01.000 --> 367:44:13.000
But for the older generation we have found that you know having publications something written and also education programs face-to-face meetings.

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Hmm.

367:44:14.000 --> 367:44:20.000
You know, round table meetings, women have always organized in groups where they come and to do table banking.

367:44:20.000 --> 367:44:26.000
Those are good forums where young older women can receive the information across social media is not also the same.

367:44:26.000 --> 367:44:44.000
You can use Facebook for the older generation. I think Facebook is more friendly. Good for the young people you have got to be on TikTok and we have amazing amazing young people who are advocates and are using TikTok to actually take their medication.

367:44:44.000 --> 367:44:45.000
Hmm.

367:44:45.000 --> 367:44:52.000
For prevention so they come on live on TikTok and they take their their prevention and that really helps.

367:44:52.000 --> 367:45:00.000

To just keep pushing that you know we need to prevent we need to prevent among the younger population. I think that's what we are seeing.

367:45:00.000 --> 367:45:13.000
There's also artificial intelligence. Kind of messaging that you know young people now and everything is artificial intelligence.

367:45:13.000 --> 367:45:20.000
So for those who are able to use it, that communication, the prompt, the what I think it works.

367:45:20.000 --> 367:45:35.000
But we we for the younger generation we really have to to be very technology driven in passing the messages that you want to otherwise on traditional media.

367:45:35.000 --> 367:45:46.000
No, that wouldn't work, but also for the traditional media as well can pass the messages, you know, going live on programs that promote on television, radio shows and all that.

367:45:46.000 --> 367:45:57.000
Those work as well, but really for the older generation. Yeah, yes, product also that are more cool to young people than others.

367:45:57.000 --> 367:46:08.000
So we have found that we have to be, really creative in the way that we message for our products.

367:46:08.000 --> 367:46:09.000
Okay.

367:46:09.000 --> 367:46:16.000
If you message it and it looks for older people, the young people are not going to be. It's not appealing to them.

367:46:16.000 --> 367:46:17.000
Yeah.

367:46:17.000 --> 367:46:25.000
So packaging the content also very important. So lastly, maybe before maybe Jim comes on, I see, he hasn't muted.

367:46:25.000 --> 367:46:33.000
I wanted to say we have in the pipeline 3 products options. We have Kabalet injectable.

367:46:33.000 --> 367:46:40.000
We have, but I know the PV ring and we have in the pipeline maybe

longer, they do a prevention pill.

367:46:40.000 --> 367:46:47.000
So as advocates, our focus is to ensure that this gets into the ministry's policies, gets into the guidelines so that they can be rolled out.

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Some countries do better than others. But we are hoping as a movement as the board we can help to unlock regulatory processes.

367:47:00.000 --> 367:47:13.000
Such that drugs from research are brought to the country for much faster. Than what we have seen it has been such a struggle to get products in the countries but this is an area that we aim to focus on.

367:47:13.000 --> 367:47:15.000
So thank you very much.

367:47:15.000 --> 367:47:25.000
Thank you. Thank you so much, Joyce. Thank you all for being here. This has been an amazing conversation and I think that we can all agree that we Yeah.

367:47:25.000 --> 367:47:32.000
We get among cisgender women. And so I'm very honest to be able to moderate such brilliance today.

367:47:32.000 --> 367:47:38.000
Joyce, thank you. Thank you for everything you brought and I will hand it over to Jim to close this out.

367:47:38.000 --> 367:47:49.000
Thank you, Branya. And yes, let's do some thank you. So first of all, this panel was straight up rock stars, our moderator, a rock star, both speakers, Jeannie and Joyce.

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So let's give them some major Zoom love, virtual love, give the emojis. Put it in the chat. What an amazing lineup.

367:47:57.000 --> 367:48:04.000
I can't imagine. Having a better way to go into the weekend than with this. Amazing discussion.

367:48:04.000 --> 367:48:12.000
So thank you. And you know, behind the scenes I want to give special shout out and love to our 2 translators.

367:48:12.000 --> 367:48:24.000

Are you Ukrainian translators, Stas and Dmitri. Who not only are translating from English into Ukrainian, but doing so in a scientific manner.

367:48:24.000 --> 367:48:52.000
With lots of scientific words that are crazy in our own language, let alone in other languages. So. Please give them some love and thank you, Ganis, for always advocating on behalf of your colleagues and comrades and Ukraine were always really delighted to partner and offer you Ukrainian and some of our webinars and and much love and solidarity to all the Ukrainians who joined today or who will be listening to

367:48:52.000 --> 367:49:03.000
this. Webinar over a hundred Ukrainians out of the 500 plus who registered for this. Webinar so lots of interest Always happy to partner.

367:49:03.000 --> 367:49:12.000
Thank you, Janis, for making that happen. So thank you, Janis, Stas, Dmitri, Ronnie, Jeannie, and Joyce, and to every last one of you.

367:49:12.000 --> 367:49:14.000
For being here. The final thing I'll say is everyone who registers will get an email within the next day or so, maybe by Monday.

367:49:14.000 --> 367:49:30.000
With a link to the recording with the link to the slides, we'll have a resource document with all the great, .

367:49:30.000 --> 367:49:44.000
And information that was shared in the chat. So we'll have that all collated for you there will be, and for our Ukrainian friends who are on this call, there will be a link to the Ukrainian recording.

367:49:44.000 --> 367:49:51.000
In with Stas and Dimitri's dulcet tones doing all the wonderful interpretation.

367:49:51.000 --> 367:50:05.000
So with that said, we are going to close out this call. Thank you all so much for participating and hope to see you on our next Choice Agenda webinar coming up on Tuesday.

367:50:05.000 --> 367:50:10.000
Only watch the watcher all about systems and surveillance and criminalization. So another really hot topic. Hope to see you there.

367:50:10.000 --> 367:50:22.000
In the meantime, have a wonderful weekend. Take good care of

yourselves. Be safe. And we'll see you on the other side.

367:50:22.000 --> 367:50:26.000
Bye bye.

367:50:26.000 --> 367:50:27.000
Thank you. Jim and everybody. Take care. Stay well.