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ENDING NIGERIA'S HIV/AIDS PANDEMIC

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PANEL ONE: HIV/AIDS IN NIGERIA -- REACH DATA AND FINDINGS:

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P R O C E E D I N G S

MR. JOSEPH: Good morning. My name is Richard Joseph. I am a non-resident senior fellow of the Brookings Institution, associated with the African Growth Initiative and also with the Global Economy and Development Program. I'm also a professor at Northwestern University and a principal investigator of the REACH program that is the subject of today's meeting.

I wish to thank the Brookings Institution for hosting this symposium today, which is the final dissemination event of this REACH program that began in Nigeria's capital, Abuja, on May 4th. Greetings also to our Nigerian colleagues who have traveled a long distance to be with us.

This meeting marks one end stage of a journey that began over a decade ago when I discussed in Atlanta with public health experts that we needed to get social scientists more involved in AIDS research because a generalized epidemic in Africa could not be stopped without understanding the social, cultural, economic, institutional, and governance factors that render Africans so vulnerable to this disease.

A report just published this month based on a study by 50 social and political scientists commissioned by the International AIDS Society has confirmed all these points. Fortunately, the recommendations that they make, which emphasize that biomedical studies which have been so much the focus of work on HIV and AIDS must be supplemented by studies conducted by social scientists which until now have been fairly marginalized. Fortunately, we did not wait for such a study to be made and a report to come out. That is basically the understanding with which we started a number of years ago. And

also fortunately, the Bill and Melinda Gates Foundation and its offices, such as Helene Gayle and Lisa Carty were of like mind, and, therefore, generous funding was provided to launch this project which began officially in January of 2006 and has enabled us to carry out two pioneering studies in Nigeria on the social dimensions of prevention, risk behaviors, and attitudinal barriers to testing and counseling.

In the next three hours, you will receive -- be provided summaries of our data findings and policy recommendations. Copies of an interim report distilling the abundant data are also provided. Now, all of the research instruments and data will eventually be available online.

Now I will now hand over to my friend and colleague, Professor Ernest Aryeetey. He is a Brookings senior fellow and director of the Africa Growth Initiative, who will be chairing the first panel. Now, quite appropriately, I first met Professor Aryeetey when he was a long-time director of an institute at the University of Ghana Legon, at the time when we were exploring the creation of two collaborative projects. One of them the Consortium for Development Partnerships supported by the Gates -- no, by the Dutch Foreign Ministry, and the second, this Research Alliance to Combat HIV/AIDS, which, as I mentioned, is funded by the Gates Foundation.

So over to you Ernest and, you know, I'll let you take over for now.

MR. ARYEETEY: Thank you very much, Richard. Good morning, ladies and gentlemen. I'm very happy that Brookings can be a part of this outreach program. We've always been very interested in these issues and are increasingly becoming interested in issues relating to Africa. That is what brings me to Brookings. And I'm very happy that we are talking about events in Nigeria. Nigeria, which happens to be one of the countries that we are very strongly interested in here, in the Africa Growth Initiative. And so one of our partners is based in Ibadan, Nigeria.

We are talking about HIV/AIDS, and I come from a country where, or a part of Africa where whenever we think of HIV/AIDS we associate it with Eastern and Southern Africa. You know, many West Africans think it is either something that is much more relevant to East and Southern Africa. But increasingly we've seen how important it has become to the people and to the economies of Western Africa. And so I'm glad that we have a chance to discuss the significance in a very important country in the region and that today we have a very rich panel to do that for us.

We have on the first panel a team that includes Professor Erinosho, who happens to be the president of the African Sociological Association. He is very well known for his work and we are very happy that he is going to join us today to discuss these issues.

We also have Professor Isiugo-Abanihe, who is the former dean of the faculty of social sciences at the University of Ibadan and chair of the REACH core data committee in Ibadan. We are very happy to welcome you to Brookings.

We have also Oka Obono, who is a senior lecturer in the Department of Sociology at the University of Ibadan.

And then we have Gbenga Sunmola, who is a professor of psychology at the University of Ibadan and senior consultant at Nigeria's National Agency for the Control of AIDS.

So gentlemen, I'd like to welcome you to the podium and then we can begin with the first presentation to be done by Professor Isiugo-Abanihe.

MR. ISIUGO-ABANIHE: Good morning. The project is called Social Dimensions of HIV and AIDS Prevention. In this project we are concerned with two aspects of prevention: one is risk perception and behavior and the other is HIV counseling and (inaudible). What I have is a map of Nigeria giving us the sites for the research. It took place in Lagos. Lagos is at the bottom right-hand side and Oyo state on top. And then in

the East -- the eastern part of Nigeria, it took place in Cross River state, the extreme left-hand side. And the most interested Benue state. We chose this site deliberately because some are high prevalence areas and some are low prevalence areas.

REACH, which stands for Research Alliance to Combat HIV and AIDS, was started in 2006 as a collaboration between the University of Ibadan and Northwestern University. There are other universities who were also involved in this work -- (inaudible) University, Cross River University of Technology, and other places.

I want to give you a little background to the HIV situation in Nigeria. This is a trend data for Nigeria for 1991 to 2008. This is HIV prevalence among (inaudible) -- women who go for (inaudible) clinics in Nigeria. Of course, the prevalence rate was increasing for 1991 all the way to 2001. There seems to be some decline in 2005 and it looks like it started going up again. So the prevalence rate for now is 4.6. So we thought that when we started this work the prevalence rate was about 5 percent. And the HIV situation in Nigeria, as you can see, about 3 million Nigerians are living with HIV and AIDS. That's a lot of Nigerians. And that makes Nigeria the second largest prevalence -- HIV prevalence after South Africa. It's only 4.6, but the 3 million, because of Nigeria's size, the population of Nigeria is very large indeed, 150 million people.

I also want to mention that the figure shows there that only 14 percent of Nigerians have received HIV/AIDS testing and counseling, which is one of the major issues that we're interested in. How come people are not going to (inaudible)? So that's one of the two attacks we used in this study to find out why is the behavior not changing and why are people not going for HIV testing and counseling which is available in different places.

The objective of the study is to describe HIV (inaudible) perception and behavior, like I just said, in low and high prevalence areas in the country. The high prevalence areas would be Benue state in the North, North Central. The low prevalence

areas would be Oyo state, which is less than 1 percent or 1 percent thereabouts. Benue state is about is about 10.5 percent. And also to describe the factors that act as barriers so they use uptake of voluntary counseling and testing. This study took place, like I said, in different places in Nigeria.

We had a semi-longitudinal study, one that's investigated risk perception and behavior. It's a semi-longitudinal study that took place in Oyo state and Cross River state. We chose this area deliberately and we had workers -- that's why we call it semi-longitudinal -- we were supposed to be there for some time collecting data, observing what happens in society behaviors over a long period of time.

So it's different from the one we call cross sectional study. The second study that investigated HIV counseling and testing was a cross sectional study that took place in Lagos, Oyo, and Benue states. In each of these locations we had rural-urban strata for the data collection. In all, we had about -- we had 41 (inaudible) for discussions, (inaudible) interviews, and 10 informant interviews in different locations. Participants included (inaudible) in school, out of school, policymakers, teachers, household heads, sex workers, farmers, and traders.

Now, the qualitative study interviewed about 2,453 households across Lagos and Benue, and the semi-longitudinal interviewed 1,033 households in Baduku, Oyo state, and Uget. The data collection took place in these communities. And I want to say that this program enabled -– one of the objectives we had for this project is to train, to build a capacity of Nigerians to be able to carry out this kind of research, social scientists in Nigeria. And this study involved a lot of people, about 20 grad assistants, about 83 staff, and 10 principal -- co-principal researchers who were involved. Everybody was trained in different aspects of data collection. Training took place in Nigeria and also Northwestern, so it's important to note that the capacity of our staff were developed in this project.

Finally, I just want to say a little about the progress we have made. We had a submission workshop in Abuja. We had a couple at Northwestern University, Evanston, and Chicago. And this is the final lap of examination. We also intend to continue from the results of this study to follow -- imagine ideas for the research. And, of course, scholarly articles are being written from this.

Thank you very much. (Applause)

SPEAKER: Good morning. In the next few minutes I wish to describe and initiate a discussion of the gender dimensions of this same study, particular reference to the semi-longitudinal component of it. The most significant, I guess, result we've come up with is the importance of the community context for an understanding of the drivers of this epidemic. It has profound implications for policy because in a regime of collapse of civic infrastructures, which sometimes have been described as state failure, we find that this has dramatic implications for behavior, risk perception of disease. This can only be understood and responded to within a community context. So our results also point to the significance of governance for actually dealing with the pandemic.

In Ogap, which was the urban site, Alula, Oyo, (inaudible), and Baduku, we find that the sex distribution of our respondents were confirmatory of the kinds of expectations you would have for those kinds of communities. So in (inaudible), for example, we had 57.2 percent of the respondents male; and in Alula, 39.1 male; and Baduku, 37.7 percent male. This actually shows like in Nigeria, for most parts of the country, in an urban center where perhaps you have the seat of local government administration. There will be tremendous migratory inflows which are sex sensitive. Most men move in so you'll find a preponderance of men in that particular kind of community.

The age distribution of respondents shows a concentration of those respondents between the ages of 15 and 54 with a peak behind 25 and 29. The significance

of this also is that we are actually speaking with the most active -- sexually active segment of the population. And when it came to the in-depth interviews and the focus group discussions, they were actually in the position to describe real behavior as it pertained to them personally. That's why the age distribution is so fortuitous for our research.

Risk perception as we investigated showed high levels of anxiety in Baduku, 76.7 percent, relative to the urban center, 51 percent. And this is quite surprising and unexpected because as there is more NGO and civil society activity in the urban area and it has led to the tentative conclusion that a certain desensitization could occur when a community becomes inundated by information of this kind. Sexual debut across the three kinds of communities that we investigated in the semi-longitudinal component is declining more dramatically among women and more pronounced in the rural areas because the urban area -- there's a special kind of milieu that it represents -- has always had lower age at first intercourse relative to rural areas, but across board it's declining. And we link this to the collapse of civic infrastructure which also has implications for normative changes.

We've already said how "state failure," if you could put this in inverted commas, aggravates this pandemic, makes a response both difficult and ineffectual. With regards to a response, these results show that it is important to converge gender, economic and cultural factors as an approach to the pandemic at the community level.

In terms of partnerships on sexual networking, we found across board multiple concurrent partnerships, sexual partnerships more for men. And at each site men are at least four times more likely to have multiple sexual partners in addition to either a marriage or regular sexual partnership. Transactional sex is high and it's not necessarily confined to the traditional categories of commercial sex work, but it's actually distributed very generalized across the community.

In conclusion, the results begin to show, like we've said, although we've

said men are 4 times more likely, in one of the communities they are actually 10 times more likely as likely as women to have multiple concurrent partners outside of marriage in a regular sexual relationship and also apart from the gender dimension age. Persons age 25 to 39 are also more likely to have multiple sexual partners. Sexual networking is higher among this particular population, and this could either be because of the nature of entertainment, of information, the crises in modern living and how this manifests in normative terms, and this is the same segment -- this is the Internet generation, also. So perhaps this is among the reasons why sexual networking is high among them.

We find our sexual networking subsistent on the basis of transactional sex which makes it necessary to intersect HIV intervention with a gender sensitive approach. Gender reveals the need also -- the gender dimensions of the result reveals the need also to reassess current approaches while the semi-longitudinal component of the study draws attention to the need for contextual factors driving the epidemic. Just to explain that, we find that the current strategy of abstinence, fidelity, and condomization is not something which women are able to exercise (inaudible) in because of norms of female submissiveness, patriarchy, male supremacy complex, in the kinds of communities that we studied. So, for a comprehensive approach to the pandemic in the three kinds of communities that the semi-longitudinal study engaged in, there is need for a gender sensitive and pro quo approach.

Thank you very much. (Applause)

SPEAKER: Good morning. My beat is to speak to the results that we obtained in our survey of HCT HIV counseling and testing in three states in Nigeria: Benue, Lagos, and Oyo. I won't need to go into the details of the matter that (inaudible) explained except to say that it's multi-state random sampling in all of those states, covering nine large communities combining rural and urban areas.

Just a minute, please.

So I would like to say that the results we found, as we are going to see now and in subsequent discussions, they have the potential to advance the frontiers of knowledge and to also contribute to meaningful potential policy in the future and also in terms of evidence-based programming for the country. More important, they have the potential to increase the uptake of HCT in Nigeria. One thing came clearly from all the findings, the data that we analyzed: there are high-risk behavior and attitudinal processes in all of those populations in the sense that -- I will just give a few examples because of time. Almost all the members of the respondents that we studied, they have heard about HIV, but the majority of them did not know how to prevent HIV. They don't understand. They don't have adequate knowledge. Twenty-two percent just believe that screened blood is important for HIV. A large majority of people don't know that condoms can protect against HIV, more than 50 percent. And there are multiple sexual partnerships three months before -- they reported multiple partnership, concurrent partnership, STI diagnoses, three months before our study. And the majority of those reported they did not use condoms consistently. You know, so that is important.

But in terms of this slide that we see, it's also a significant finding that we see. There is a gap between knowledge and behavior. Most people -- fairly most people, 70 percent about -- they know about we are to take HCT. They know the place in their communities. But just only about 20 percent have ever taken in the last 1 year. So that is the sense in which we say knowledge in this case did not actually predict the behavior of people. Knowledge in this case also has not reached the ceiling. There is still a possibility to increase (inaudible) or thereabout.

Another finding we found in terms of distribution between urban and rural is that in both urban and rural populations the uptake is low, but it's lower in the rural areas. And we could talk about this later. Rural epidemics is not important in Nigeria. Seventeen

percent of the people in the rural area reported that they have taken HIV testing in the last 1 year compared to about 3 percent in the urban area.

You know, also education plays a great role in terms of what we found. There is a positive correlation between education and likelihood of testing. Most people who have spent more time in school, they were more likely to test than those who had little or no education. Thirty-five percent of those who had postsecondary education actually reported already tested compared to about 10 percent who had no education or primary education, you know. We investigated the reasons for HCT, the motivation and challenges, and that was very important.

Three reasons came out why people went to test, those that tested. And one major reason actually was what we call the provider initiative. In other words, AIDS care workers advised them to go and test. But the point here to be made, it is not the kind of health care worker which (inaudible). In other words, it's not in the context of (inaudible). It's not in the context of going to the clinic and then they discover that they have TB or they discover that they have STI in an accidental test. The majority of these health care workers advised outside the clinic, you know. So that is very important and it came out uniquely clear in our study.

You know, the other part is that just 10 percent said that they tested involuntarily because they are to wed, because they are to go for a visa interview, because they are to go for employment, you know. But VCT, the voluntary counseling and testing is low. It's actually low. It's about 23 percent of the people that had gone for VCT.

We could talk about this later, task implementation. PITC is more. (inaudible) take VCT, that's what we are saying. Most testing logically took place in the hospital setting compared to other settings. This is important. What are the barriers that impede people from not (inaudible) them from not taking tests? We identified six major

barriers. One good thing about the barriers is that they actually discriminated between those that did not test. Those that tested were different from those that did not test on those six dimensions. Those that did not test reported that they were not sure the partner would not oppose them. Partner opposition was one. That was why they did not test.

Disclosure difficulty. If they test positive they are not sure how to disclose. That is another reason why they did not go.

Cost concern. Some people, many of them, thought that cost was a problem. So that was why they did not go. You know. So.

Some people thought it was a death sentence. That if they had HIV they would not be able to cope. You know, so unconfidentiality. They did not trust the AIDS workers that their results would be confidential.

But then the other big one is stigma and discrimination. They thought that they would be treated as outcasts. They thought that they'd be isolated in the communities, you know, so.

But to just in one minute to tell you the opportunities for HCT uptake that also came out of the study apart from the barrier factors that we could use to uptake HIV. The points came out clearly that the community in a way wanted accepted home testing. They said if you bring testing to our homes we are going to test. More than 80 percent. That is significant. Communities want HIV testing to be routinized. That regardless of what you come for in the community, let them be tested for HIV. You know. And communities wanted assurance for treatment. They said if we did know that treatment is available for them they will come and test. And they wanted couples counseling as well.

Ladies and gentlemen, my time is up. Thank you very much. (Applause)

SPEAKER: Okay. Good morning, ladies and gentlemen. My beat is to discuss the high-risk behavior.

We went out into the field to find out what people are doing which they should not be doing, which are driving the epidemic. And we needed to do the study in a slightly different way. Usually people go into the field and they slam their questionnaire in order to study behavior. Well, we decided at the onset it was important to do ethnographic work in order to be able to identify the behavior patterns that are actually driving the epidemic.

In the course of doing this work over the past three years, we identified nine behavior patterns, nine behavior patterns that are actually driving the epidemic in Nigeria. The first among them is transactional sex. Now, you look at the literature. Interventions were always targeted at certain specific groups of people such as commercial sex workers and long distance drivers and so on and so forth. But from this study, transactional sex transcends very many groups: university students, housewives, unemployed people. All of them are into transactional sex.

My second point is about age of sexual debut and lack of parental oversight. I have there a newspaper cutting on the case of 11-year-olds who are being recruited in the Lagos area for transactional sex. In addition to that we have the problem of parental -- we have the case of -– I'm sure you must have read in the paper of one of our senators who imported a 13-year-old Egyptian girl and got married to her after paying about $100,000 to the parents. This is one of the issues that is driving the force.

Parental oversight is also very important in this context. Take a look at a picture there. You know, housing situation. People live in high density accommodations. Parents live with their children in one room and in the process of having sexual intercourse the children are able to see what is happening and this is contributing to the driver of (inaudible).

The third point is about misconceptions about HIV which is still very

widespread, perceptions about how to prevent, perceptions about the (inaudible), perceptions about what to do when they have sexual intercourse. This is still widespread in the community.

The fourth point is sexual partnerships going beyond spouses. In a polygamous environment, women are not that powerless, especially when they cannot find sexual satisfaction in relationships and they go out of the regular relationships with their partners to take risks and have sexual intercourse sometimes or many times unprotected.

The fifth is about mismatch sexual desires among partners. There is evidence to this effect that a lot of sexual partners indulge in extramarital affairs, but when you ask people questions, whether this is common in the community, they will say no. They will say yes, sorry. But when you ask them if whether they are themselves involved in extramarital affairs they will say no. But we know this is a big problem.

There's an issue of fatalism that comes out very clearly in the study. Fatalism is what will be will be. Why do we need to bother ourselves about taking any measures to prevent the disease? A feeling of despondency. We can't be bothered. Okay. We will just do what we like with our life. And then there is also what has been mentioned by my colleague, low condom use. A very important factor across the board. And alcohol also plays an important role in taking risks. Too much alcohol gives confidence that they can do what they like and take risks without preventing.

Finally, there is also the syndrome of denial of HIV. This is (inaudible).

Thank you very much. (Applause)

MR. ARYEETEY: Thank you very much. This is the time where I should turn to the audience and get your comments and questions. I must say this is the most disciplined group of presenters I've ever come across. (Laughter) They all took only the time allotted to them and in one case even less. Well, that should stimulate you to ask them

questions to make up for the time. Any comments? Questions?

SPEAKER: Hi. I was just wondering if you could comment on things that you've noticed about the drivers of HIV that are different in Nigeria from other countries in sub-Saharan Africa. I think it was Dr. Joseph who made the comment before that so much of what we know about HIV comes from Eastern and Southern Africa, and you now have this rich data to complement that. I was wondering if you could comment.

MR. ARYEETEY: Good. I think it will be great when you make your comment to say who you are and what institution you come from so we know who everybody is.

Yes, ma'am.

SPEAKER: Good morning. I'm (inaudible) Embassy here in Washington, D.C.

Congratulations on the work one. I think we're beginning now to define and get to understand the actual and real drivers of this problem in the continent. But what I wanted to know as we move towards formulating policy -- I used to work with an HIV and AIDS program in South Africa before I came here. And I have a fair understanding and I can relate to some of the issues and the findings of this study. But what I want to know is as we now move, translate this work to policy formulation, what can we tell policymakers regarding -- and I think this includes the Global Health Initiative of the Obama Administration, in fact, regarding how best then to get to the bottom of the problem. Yes, we can talk about health systems; yes we can talk about dealing with all sorts of issues, but what then? What recommendations are we making to policymakers regarding this?

Thank you.

MR. ARYEETEY: I understand that is going to be the focus of the second panel. But that's a fair point.

From behind. Yes, gentleman.

MR. UDAL: My name is Udal , Ambassador Udal.

Now, each time we discuss HIV there is always a problem of increasing incidence which means that the methods we've used in counseling people, treating people, are failing. What are we doing to change the methods so we can get better results?

Thank you.

MR. ARYEETEY: Last one before we come back to the panel.

MR. PATTERSON: Hi. Rob Patterson. I'm a consultant who did a lot of work on your federal strategy last year actually for the next five years for the health care system in tuberculosis and leprosy. So I had a great time eating your fish in Abuja. It's a great place.

Simple question. Two, actually. One, is this report available on PDF or an electronic form so for people when you travel back and forth you can share it with your colleagues?

And the second question is in flipping through the report your panel presented more comprehensive data or findings than are actually reflected within the report, such as alcohol's role in sexual risk behavior, et cetera, et cetera. So I'm wondering whether or not this interim report will be subsequently built out to include all the findings actually represented today by your panel.

MR. ARYEETEY: Okay, so let me come back to the panel.

SPEAKER: Yeah, let me answer the question. Are they hearing me?

MR. ARYEETEY: Yes.

SPEAKER: Okay. Okay. Why the study was not conducted in the far north? It actually took place in the north. Benue is north. It's north central. We're talking about far north, north of Nigeria, where we have Kano, Sokoto, Maiduguri. We didn't go

there. Initially, we actually went to the six geopolitical zones when we were doing the background research. In other words, we went there. Later on we decided to scale down. We didn't have the facilities to cover Nigeria and with that chose areas that have high prevalence in the north, which is Benue. The highest prevalence in Nigeria is in Benue, it's in the north. We didn't go far north, but we intend to do so if we're going to scale up to go there. They have very low prevalence there in the north. But part of it could be because of the method used to get this data. These are women who go (inaudible). A lot of women in the north don't go to (inaudible). So you have a select group of women who do go and these are the ones who are tested. About 60 percent of the women (inaudible) in the north don't go for (inaudible) services. They're scared this is a formal testing avenue.

Now, about increasing incidence. Well, I wouldn't say it's increasing. We don't have evidence of that, but, nevertheless, the rate is high and worrisome for a country like Nigeria with such a large size population. South Africa has (inaudible) prevalence rate. You know, Nigeria has only 4.6 as of now. I say only, but only is worrisome. I don't think we can say it's increasing; we don't have evidence for that. We can only have evidence if we do household screening. This is just based on evidence from (inaudible), women who go to (inaudible) services. I cannot generalize on the basis of that. That gives us a little insight into what is happening for the general population.

Thank you.

MR. ARYEETEY. Thank you very much. I would like to take a question from (inaudible). (inaudible), please.

SPEAKER: HIV. Why -- what are the differences in the drivers in Nigeria compared to South Africa and other African countries? I would like to quickly say that the epidemic in the country, in Nigeria, it is misleading to think that it's a homogenous epidemic. It isn't. The epidemic in Nigeria is heterogeneous. As vast as Nigeria is, so vast is the

diversity of the epidemic. You know, in terms of national figures, we are 4.5. It is some localities, like (inaudible) in Abuja is as high as 20 percent. In some local governments, in Cross River, it's as high as 14 percent. So there is diversity. Some states are as low as 1 percent or as high as 10 percent. So what that shows to us and what I found with my colleagues outside this study and partly within this study is that each area has peculiar drivers. There is no uniform driver of the epidemics in many of the states. In many of the states some drivers are generic. And in some states there are specific drivers. And I could give several examples.

There are militants that are causing -- that are influencing the drivers spread in South-South, in the Niger Delta area: kidnapping, causing social dislocations and economic problems; rape and prostitution. There are military men that come as belligerents or as peacekeepers. They are aware also of contributing also to the illness. When you go to another part of the country it's a different ballgame. It's the issue of long distance truck drivers. You know. And you go to the other side of the country, it's the oil boys that's come. The oil boys, the rich boys that come and sexual workers that surround them.

So you know HIV is a disease that travels. So migration plays a lot of role. In South Africa or in East Africa, we don't have huge (inaudible). I think everyone gets the idea of (inaudible). (inaudible), people that after finishing their school, university education, they are mandated to travel from their state to another state and serve another one year. That's a kind of migration. And we now find that among those group of people the incidence is as high as 10 percent in my own personal study and some studies done by NGOs in the country. So there are diverse rates that show differences in the drivers from other countries of the world.

Circumcision is there. It's one factor that is predominately common in

Nigeria. It's a protective factor we are told, but it is not there in many South African countries.

I would like to stop there, please.

SPEAKER: Yes. Thank you. I wish to address the subject of methods. It's clear that the rich initiative is leading us in the right direction for a pandemic whose origins lie in a number of different sectors. It's an epidemic like none that we've ever known before. It follows that routine methodologies might not be able to capture the complexity of what we're dealing with. And this was the thinking underlying pioneering efforts in setting up the semi-longitudinal study in the first place.

And what that entailed was to, in those three sites when the semi-longitudinal study took place, set up teams that were resident continuously in those communities and continuously (inaudible) over a long time, some upwards of two years continuously in the community, engaging with the community, utilizing observation on a day-to-day basis. And what this, in effect, amounted to was like mounting social laboratories in three communities to have the in-depth understanding to which we've already made reference in the quality and character of the kinds of results that -- no doubt that's a monumental effort. It's an enormous outlay of resources of time and money and competence and capabilities.

But it has helped us understand that, like my colleague is saying, in spite and in addition to the diversity of the Nigerian states, some constants have emerged. We're able to confirm that the pandemic spreads faster where you have, for instance, low female exercise of (inaudible) for decision-making; where you have high levels of poverty, whether relative or absolute; and where the fabric of society is slightly disorganized. This is the kind of thing you could draw correspondence with in the South African case.

So in talking about special drivers, it's also key to keep an eye out for the

confirmations that have come out of the (inaudible). There's gender there, there's poverty there, and there's also social disorganization there.

Thanks.

SPEAKER: Yeah. I think the key to HIV is to be prevention. Okay. And the key to prevention is to change behavior. And to change behavior we need to study people very closely, rather than use the usual methodology of collecting data using questionnaires. So once we are able to do an in-depth study of communities, we will be in a position to develop appropriate interventions to target those behaviors that are driving the epidemic. The problem is that we have over the years articulated prevention or interventions which to some extent are not closely aligned to behavior patterns at the community level, and I think that is the key point that we need to take into consideration in any programs that we are formulating (inaudible) prevention.

MR. ARYEETEY: Thank you very much. I'll take one more round of questions.

Ezra?

MR. SURUMA: Thank you. Suruma from Uganda and from the African Growth Initiative.

In Uganda we have a very heated controversy over the ABC -- abstinence, be faithful, and use condom approach. And although it has worked for us, it has been extremely controversial and contentious. I would like to hear comments whether you have this approach in Nigeria and what the outcome is.

MR. ARYEETEY: The lady -- the lady with the red top. Okay. All right.

SPEAKER: Sorry. My name is (inaudible). My question is about the employment pattern. Generally speaking, people stay with the family or more people have to go out to work somewhere and family life is more split. Is it more common or not?

MR. EGBULEN: My name is Chris Egbulen. I'm president of Action Africa here in Washington, D.C.

We have programs going on in parts of Nigeria and Sierra Leon at the current time, and my question at this point has to do with the nature of the intervention and strategies used to either educate or to stem the spread of HIV/AIDS among little children who might be in the primary school level, since that might be a way to in a sense stop the outgrowth of the pandemic in the long term.

MR. ARYEETEY: Yes.

MS. RODRIGUEZ-GARCIA: Thank you. First of all, thank you very much for a very informative presentation. I'm Rosalie Rodriguez-Garcia from the World Bank and we are in fact engaged in an evaluation of the community response to HIV/AIDS right now.

I have two questions for you. One is methodological. I notice in the tables that you include figures, data on study communities. Do you have comparison communities as well or not?

My second question has to do with findings. Because we are so interested in the community response to HIV/AIDS, have you through this work that you have done, this fantastic research that you have done, have you learned anything about -- that could help answer this question of what has been the contribution of the community response to halting HIV/AIDS?

Thank you.

MR. ARYEETEY: Question?

MS. NELSON: Joan Nelson, Woodrow Wilson Center of the Smithsonian at American University.

I was intrigued by the remark in one of the presentations that although there have been a large number of health and AIDS outreach workers, those outside of the

context of the people coming to clinics or hospitals for other kinds of treatment don't seem to be very effective. I'm not sure I fully grasp the point and I haven't had a chance to thumb through the report, but it's quite likely a rather important finding. I wonder whether one could elaborate on the nature of these outreach workers and perhaps why they are not particularly effective.

MR. ARYEETEY: (inaudible) in the blue top.

MR. BRIDEN: Thank you. David Briden with the Infectious Disease Society of America.

Number one, I wanted to commend your report. It's really interesting findings, important research. And in particular, I notice in your report you avoid the pitfall of pitting prevention against treatment. And in fact you call for earlier access to treatment. So I wanted to commend you for that as linked to prevention in terms of reduction of viral load.

But I wanted to ask you about how you would suggest that Nigeria address the problem of co-infection with tuberculosis. Are there opportunities in the expansion of HCT to do intensified case finding, for instance, for tuberculosis? Would you recommend, for instance, that people gain access to cotrimoxazole at an early stage? What about infection control in health care settings? And the reason I ask is that when we think about HIV/AIDS we can often overlook the fact that what most people die of who have HIV/AIDS is actually TB, right, as the most common opportunistic infection.

MR. ARYEETEY: Thank you. For the last one.

MR. PAUL: Thank you. Rodney Paul from the Global AIDS Alliance.

One of the presenters, I believe it was the gentleman on the left, mentioned that up to 80 percent of respondents said they would be interested in treatment if there was assurance of testing. Would you please expand on that idea?

SPEAKER: Thank you very much. Let me respond to maybe two.

Chris raised an issue about the little children. In Nigeria, some states are mainstreaming HIV in the school curriculum. Actually, there are trials in some states right now going on. But the idea is to, as a part of if you are teaching English, (inaudible), mathematics or whatever. So it's taking place right now and a lot of NGOs are out there in the community are trying to project this.

In comparison, I think maybe what you mean is whether there's a control group. We didn't have a control group, but we have studies done in high prevalence areas and low prevalence areas. We're comparing in kind of those two settings and see why. You know, try to understand why. Why is it low here and high here? That's exactly what we did. We didn't have control groups as such.

And the employment pattern, in urban areas, of course, women go out to work normally and come back, but in rural areas in a cultural setting the setting is kind of different. I guess (inaudible) shared that with, you know, behavior or sexuality or whatever. In the rural areas, people go out in family groups to work on the farms and come back in the evening or go to market. In an urban area women are on their own. Everybody is on his or her own.

Thank you.

SPEAKER: Thank you very much. I would like to attend to two of these questions. One specifically directed to me, treatment assurance, and the other is the ABC controversy. I will start with the ABC controversy issue of Uganda.

Oka has actually said a lot about these and I would just corroborate it. In Nigeria, I think the thinking is that ABC is flopping. It's not working as we expect for the reasons of gender discrimination -- sorry, gender inequalities between men and women for the reasons of stigma and discrimination; for the reasons of sexual violence. I will explain these, but the point why we say it's not working really is statistics.

We just did -- Nigeria just did a mode of transmission study which was completed in 2008, and it was surprising to everyone that 42 percent of new cases come from monogamous relationships, from people who are married, living together or those that are dating. They were traditionally regarded as low-risk groups, and upon investigation we realized that in many of those communities there are lots of submissiveness on the part of women. Women are not expected to be sexually -- women don't have power to negotiate sex, even when it is -- even when it is almost -- when they are most sure that they are going to be infected. Women don't have power to negotiate condom use even in transactional sex. Whether they're in transactional sex or a dependent sexual relationship they find it difficult to negotiate protection. It's difficult for a woman to tell the husband that I want to abstain from sex, even when the husband has traveled and all of that and you discover that he's infected, you cannot call a man (inaudible) be faithful. You know, so those are some of the reasons why ABC seems not be working in this regard. But it can be straightened.

SPEAKER: (inaudible)

SPEAKER: I'd like to talk about the difficulties with the community response. That's linked to what -- arising from this study, one of the papers that we hope to publish on it. We are conceptualizing as a cultural template of stigma because stigma has implications obviously for whether people test, whether they report, whether they notify, and what have you. So the community response is affected by that. And when we talk about reducing or eliminating stigma with regards to HIV/AIDS, we forget that it's not the AIDS pandemic that created stigma. There was already a cultural template for stigma and historically it had been applied to conditions like leprosy, like mental illness, like what have you. What else is there?

So we need -- this community focus of our investigation shows that we need to engage these communities in a dialogue that actually confronts their superstitions,

their knowledge base, their anxieties, their fears. And we will not be able to reduce stigma against AIDS patients, for example, without simultaneously eliminating stigma against all conditions that have been stigmatized in this community. So that's something that we are not aware of any program that is currently dealing with that. So it's an enormous amount of work. This is one of the implications of the kinds of methods and results that we have come up with.

SPEAKER: Well, I think I would like to comment on the issue of family life. I think Nigeria is growing rapidly. Urban centers are expanding. The population is drifting from rural to urban, and there is a disconnect between resources that are required, like housing and so on, and population growth, which leads to the fact that there is high density, a lot of people living in overcrowded housing estates or homes, which in turn means that they are likely to be exposed. The children are likely to be at risk of observing behavior patterns and the process begins to behave, at least adopt some of the behaviors that they are able to witness at firsthand. So also the issue -- common with this is the issue of poverty. Okay. Or combined together to at least drive the problem in Nigeria and we should pay attention to this particular issue.

The other thing is about (inaudible). Of course we do. We have learned lessons from this study. And one important lesson is the fact that we -- when we talk about prevention it's important for us to do our study much more differently than we normally do. It's important for us to do community-oriented grassroots ethnographic kind of -- such studies are time consuming and they take a lot of resources.

MR. ARYEETEY: Thank you very much. We should be welcoming at this point the deputy assistant secretary of state for African Affairs, but I think she's been delayed. So we'll continue the program and then when she comes will join us. Let me take a few more questions and comments.

MR. FREEMAN: Lawrence Freeman from ER Magazine, African desk.

The last speaker mentioned one point which I think seems to be overlooked. I would amplify it, which is that there is a common driver for AIDS in Nigeria, as there is in South Africa and other countries. And economics is a co-factor and a driver. There's no question about it. So unless you're dealing with the poverty of 100 -- or 90- to 100 million people living on $2 a day, unless you change the infrastructure, AIDS is a disease. It's a virus. If you weaken the immune system, that virus finds a propitious host. And unless you're going to deal with these economic questions, I don't think we're going to solve the problem. Aside from the fact that economic life, let's say in the Niger Delta where I was, is so demoralizing and so pessimistic that no one has any concern for what the consequences of their future action is because they don't have much hope. But if you don't treat economics as the major co-factor, I don't think we're looking at the problem adequately and I'd like your responses on that.

MR. ARYEETEY: I spoke too early when I said I guess she was delayed, but she's here now. And I think it's only right that we don't keep her waiting for too long. So I'll let one of our colleagues respond to that and then we'll move to the next. Who is going to respond to that?

SPEAKER: I agree with you. I think the issue of (inaudible) is very vital. I mean, I think the issue of governance, too. I mean, there's a relationship between human development and HIV/AIDS. And if you look at the world you see that countries that have a high quality of life are less likely to have a high incidence of HIV/AIDS. And it's no accident that economics is very important and we need to address this as part of the driving force in HIV/AIDS.

MR. ARYEETEY: Thank you very, very much. It's been a very lively panel. The discussion has been extremely rich. One thing I've learned is the fact that the diversity

of Nigeria, because of the prevalence of HIV/AIDS, is huge and what it means to me is that governance then becomes a very important issue. States have to play an active role to deal with (inaudible) in their own state, look at government what has become very, very important. And then the central government -- the federal government also has a major role to play with an issue that cuts across different states.

That's a lesson that we can really apply to (inaudible) African country. And I do hope that with the lessons that we are seeing from Nigeria, those of us from Ghana and Uganda, South Africa, et cetera, can learn from these and begin to think much more seriously of how we can tackle the pandemic.

Thank you very much.

Now, let me (inaudible). Let me now welcome a distinguished guest, Ms. Susan Page. Susan is the deputy assistant secretary of state for African affairs at the U.S. State Department, principally covering Southern Africa. Ms. Page is a Harvard-trained lawyer with 22 years of experience and spent 15 years living and working in sub-Saharan Africa. She has served as a political officer, legal advisor, and diplomat with the U.S. State Department, USAID, and the United Nations. Prior to the assignment, Ms. Page was regional director for South and East Africa at the National Democratic Institute for International Affairs.

So please join me in welcoming Ms. Susan D. Page. (Applause)

MS. PAGE: Good morning. And I'm sorry to disappoint you by not being Ambassador Carson. It's always a pleasure for us even in the State Department to hear his words, his words of encouragement and to listen from his experience. But I will try to do my best to represent him well, and I will also apologize for my voice which I am suffering from some laryngitis that just will not quite go away because I think I keep getting asked to speak at all of these events. So I'll try to be brief, but I'm happy to take questions.

Maybe just to correct the record a little bit, I actually cover both Southern Africa, as well as Central Africa at the State Department. We did a little bit of a reshuffle and so I have a larger portfolio. Also, I was on the trip that Under Secretary Burns undertook to West Africa and Southern Africa, including a stop in Nigeria. So I think that was one of the reasons I was put as the stand-in for Ambassador Carson today.

The United States is the world's leading contributor to the Global Fund to fight AIDS, tuberculosis, and malaria. We are also the largest donor country to the Global Alliance on vaccines and immunizations. One year ago, President Obama launched the Global Health Initiative, a $63 billion commitment over 6 years to improve health outcomes with a particular focus on improving the health of women, newborns, and children. The next phase of U.S. assistance will address health outcomes through strengthened health systems and better address particularly infectious disease, nutrition, maternal and child health, as well as safe water.

Deputy Secretary Lew traveled to Abuja and Kano. Actually, he is just wrapping up his trip. It was May 25th through the 27th, which is today, in particular to take a personal look at our health programs, including PEPFAR. In terms of HIV and AIDS, we have provided over $2 billion in PEPFAR funding for Nigeria since 2004, and over $450 million this year alone.

We congratulate the Nigerian government on the recent completion of its national strategic framework for the control of HIV and AIDS and continue to work with them in true partnership. We would like to see the government of Nigeria increase its HIV/AIDS budgets so that Nigeria funds 50 percent of the U.S.-Nigeria partnership framework by the year 2015. A key component of this framework is the improvement of the policy environment underpinning the provision of health services. And although I didn't hear much of your discussion from the last panel, it sounds like this is some -- these are some of the

issues you touched upon.

We applaud Nigeria's desire for universal coverage, however, only 14 percent of Nigerian adults have access to counseling and testing, which is a key component of comprehensive HIV prevention. One of the key goals of the PEPFAR program over the next five years is to support a sustainable, country-owned response to the disease, including management of the supply and distribution of lifesaving anti-retroviral medications.

In December 2008, Nigeria reported 798 polio cases, which at the time was about half of the total number worldwide. But by the end of April of 2010, there were only two confirmed cases in Nigeria. That's a huge difference. Nigeria is very close to interrupting polio virus transmissions due to the indispensable leadership by political, traditional, and religious leaders, particularly their health education efforts. The President's Malaria Initiative has chosen Nigeria as a focus country, and through USAID and CDC will promote insecticide treated bed nets, special therapy targeted for children, and preventive treatment of malaria for pregnant women.

We appreciate and comment Nigerian civil society organizations for their commitment to improving the health and wellbeing of Nigerian society. We appreciate their wide scope of effort, which includes the full range of primary health care measures for women and children, along with HIV prevention, care, support, and tuberculosis control, as well as other key health interventions. We seek the support of civil society organizations in expanding stakeholder knowledge at all levels to improve institutional capacity and ensure the best quality of services for the beneficiaries of our collective efforts.

The U.S. Government will focus on women and girls as an entry point for health improvement and to bring all the capabilities of the U.S. government to bear on assisting nations. We must be committed to positive health outcomes beyond the provision of HIV/AIDS services, translating our successes in HIV/AIDS treatment, prevention care and

support to improve upon the ways in which we provide all health interventions. The structures built to address HIV/AIDS serve as a platform for expanding health services not only for HIV and AIDS, but also for diseases such as TB, malaria, and other maternal and childhood illnesses.

HIV/AIDS centers are increasingly integrated with other functions, such as for education, microenterprise, and other community-based services to improve not just the health, but also the livelihoods of families and communities impacted by HIV and AIDS. I am particularly heartened by the robust response from the private sector to work in partnership with the public sector and with communities to address HIV and AIDS. Public-private partnerships are a key component to the HIV/AIDS response and we look forward to collaborating with local partners in this area.

Thank you very much. (Applause)

MR. ARYEETEY: Would you like to take questions?

MS. PAGE: Sure. I'm happy to take questions. But only ones I can answer. (Laughter)

MR. ARYEETEY: (inaudible)

SPEAKER: Perhaps is it informing, hopefully, should I say the Global Health Initiative that is currently underway in this country?

Thank you.

MS. PAGE: Okay. Thank you very much. Let me try to take them in order. In terms of civil society involvement in either the negotiations or the discussions, whether it's on PEPFAR or related activities, negotiations for continued assistance, I can't speak specifically to whether or not they're involved. I would guess not in terms of the formal negotiations on the strategic partnership. However, I know that there are a number of indigenous as well as international NGOs working in this field that are trying to influence how

the government negotiates and includes what areas to include in their PEPFAR agreement with the U.S. Government. I would certainly encourage more of that to continue -- that it should not be one-sided. It should not just be a government-to-government proposed initiative, but taking onboard, whether it's drivers of the epidemic, all the actors that have something to say about HIV and AIDS.

In a number of countries there have been problems with getting the anti-retrovirals off of the shelves, so in some cases it's not actually a lack of the medications. It's sort of a lack of distribution abilities and capabilities. So I would certainly encourage that involvement, including not just with the health ministries, for instance, but also with the legislature which often is responsible for the funding and what goes along with that. So I hope that that would continue. And to the extent that you might be able to play a role in that is to encourage civil society organizations, NGOs, to in fact be more active and proactive in that arena.

Addressing the Global Fund and PEPFAR's inability to meet the needs because of the lack of funding, I think that this goes along with what I said towards the end of my remarks which is I think that we really need civil society to partner up, I mean, governments to partner up with civil society, as well as with private partnerships, private organizations, that in many cases have the most vested interest in protecting civil society to make sure that their workers can get to work, that they have treatment that they need so they can continue with their businesses, but it does have to be seen as something. I mean, government funding, as broad as it is internationally, whether it's through PEPFAR, Global Health Initiative, the President's, the polio, et cetera, you know, we can't do it all. And governments in African countries cannot do it alone either.

So we do need to help to create the resources that together we can try to fight some of the need. But the reality is, you know, worldwide we're in a global recession.

You know, funding -- State Department funding has been flat lined for a lot of initiatives, so we're trying to maintain the progress that we've had, but it's not going to be able to continue for a long, long time.

Maybe just to address the drivers of HIV and AIDS. I think that this is where we do receive a lot of information from non-governmental organizations, civil society organizations, the Centers for Disease Control. All of the various health organizations that help to provide the research and the data collection. I know that there's the program that is done, REACH, and other institutions that are partnering up with universities to try to make at least information available about some of the drivers so that if you know how it's coming into play, how it's being spread.

I remember when I was posted to Botswana several years ago I was reading an article. It was actually in one of the South African newspapers about older people getting HIV and AIDS. And as a relatively younger -- youngish person at that time, I remember thinking to myself, wow. It had never really occurred to me that older people would be, you know, because we often talk about sex trafficking, prostitutes, truck drivers, you know, cross-border spread, women, you know, men who are perhaps, you know, out there with other partners, women with other partners, et cetera, but you don't often think of older people. So people our parents' age who are, in fact, still sexually active and the fact is that a lot of couples that either are divorced or one spouse has died and they're engaging still in behaviors that are obviously normal activities, and they may remarry. But because they are no longer using birth control, they can't get pregnant anymore, and they have -- they are now with somebody who was married for 30, 40 years whose spouse has died, they're not concerned with the HIV/AIDS spread. And yet this is one of the areas where it has started to increase as well. So we do have to look at the drivers and where the new incidences are occurring. So this is differently part of what goes on. (Applause)

MR. ARYEETEY: I would like on behalf of Brookings, all of you, to thank Ms. Page for taking time to come and talk to us. We really appreciate your coming and I think your words have also meant a lot to us. Many of us are going to think deeply about what the new trends are, what the new data is saying, and how therefore we can involve the discussion in the countries of what to do and how best we can collaborate with the U.S. in this course.

Thank you very much. (Applause)

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

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THE BROOKINGS INSTITUTION

ENDING NIGERIA'S HIV/AIDS PANDEMIC

Washington, D.C.
Thursday, May 27, 2010

PANEL TWO: POLICY RECOMMENDATIONS -- HIV/AIDS PREVENTION IN NIGERIA AND OTHER AFRICAN STATES:

Moderator:

JACQUES VAN DER GAAG
Senior Fellow and Co-Director
Center for Universal Education
The Brookings Institution

Panelists:

NKEM DIKE
Associate Project Director, REACH
Northwestern University

RICHARD JOSEPH
Nonresident Senior Fellow, The Brookings Institution
Principal Investigator, REACH
John Evans Professor, Northwestern University

PHILLIP NIEBURG
Public Health Epidemiologist, REACH
Senior Associate, Center for Strategic & International Studies

GBENGA SUNMOLA
Principal Research, REACH
Research Coordinator, National Agency for the Control of AIDS, Nigeria

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P R O C E E D I N G S

MR. VAN DER GAAG: I'm listed as a senior fellow at Brookings and co-director of the Center for Universal Education, which is true.

But the real reason I'm here is that I'm also co-director of the Amsterdam Institute for International Development, which is involved just like REACH in health care -- health insurance and HIV/AIDS work in Nigeria. So for me, this is also a real treat to get a good view of what REACH is doing there and I'm sure that in the near future we will compare notes. We have projects in Lagos, we have projects in Klaga state. So, we can compare the results with the results you have already heard.

On my far right is Ms. Nkem Dike --

SPEAKER: Dike.

MR. VAN DER GAAG: Dike? Assistant project director for REACH. You already met Richard Joseph, the PI for REACH. On my left is Mr. Nieburg, public health epidemiologist at the Center for Strategic and International Studies here in Washington, I believe. And then we have, as you have already seen, Mr. Sunmola, who is principal investigator in REACH. And also associated with the National Agency for Control of AIDS in Nigeria.

In the previous panel Ernest has shown how to be really tough on people and let them talk no more than the seven allotted minutes. So I'll try to improve on that or at least compare with it.

The microphone is yours, and you have -- according to my notes -- seven minutes.

MS. DIKE: Good morning. I'm just going to take a few minutes to talk briefly about one of the REACH's main goals of influence in how policy in Nigeria, in addition to data collection and capacity building.

When REACH was set up one of the main goals that were identified was after the data collection was completed making sure that the findings were shared with the HIV/AIDS agencies, the national government, local and state governments in Nigeria to somehow influence as much as possible policy in Nigeria. Because we all know how important evidence-driven help policy is, particularly social science research.

And one unique thing about the AIDS -- the REACH project is this use of social science methods and community-based research to find information that could help impact HIV/AIDS policy in Nigeria. In Nigeria currently the health policy that exists regarding specifically HIV/AIDS is not evidence-driven or data based, especially at the grassroots level. So one thing that we hope -- we've been working to do is, we mention was that we are to some nation began an ABUJAD , national AIDS conference.

And we've been working since the inception of the project with local and state agencies getting their ideas of what they were interested in. And at the end of the project going back to them to share with them our information. And we will continue to work with them to see how we can shape health policy in Nigeria based on findings that we have, especially since it's social science. And this point when no longer just answering how many persons -- how many people are getting tested for HIV/AIDS as you saw, but in addition why people are not getting tested. And that could really go a long way influencing effective health policy, HIV/AIDS.

So, I'm not really -- it's really brief, I just wanted to introduce that and so that you get an idea. Most of the speakers are going to expand on how we do that and finally, Professor Sunmola will now elaborate on the role of NACA, which is the National Agency for the Control of Aids in Nigeria, and the role they will play in how we will move forward, the findings that we've found from the REACH project. Because it's very important in research not to -- which we've seen largely where findings -- we have findings but they are not necessarily shared with the important people, the policymakers so that it can influence policy in Nigeria.

Thank you. (Applause)

MR. JOSEPH: Okay, thank you very much. I think that was like three minutes that we've got now in the bank, right? Okay.

MR. VAN DER GAAG: We're ahead of the game.

MR. JOSEPH: All right, thank you all very much.

You know, for those of you who are runners or maybe swimmers and so on, you know, you know what it's like when you finally can actually see the finish line. And so this is where we are. This is really the last lap, because I said this is -- we've had -- this is our fifth dissemination

event and that is -- this kind of skill dissemination event. Not to mention dissemination events in all the communities that we went back to and literally the next hour is very much the last lap. So, it's a wonderful feeling. Before we move on, of course, to what comes next in this program.

But as I was sitting there thinking about starting, a good friend Steve Morrison had come in. We're very delighted to have him with us. As you know, he's a senior vice president of centers for strategic and international studies and he also directs the very important Global Health Policy Center at CSIS. But what he brought to my mind, you know, was a John F. Kennedy saying that failure is an orphan and success has many mothers and fathers. I don't know what that has to say for HIV, but the REACH program has many mothers and fathers.

And there are a number of them who are in the room here, and I want to indicate that, you know -- the actual starting point for this actual was, in fact, the task force on AIDS that Steve Morrison directed. And I was here as a visiting scholar in Washington, both at USIS and then at USIP and then National Endowment for Democracy. And before going to Northwestern I actually attended a meeting -- a conference -- of that task force. And it was at that meeting that I first met Phil Nieburg, and I saw presentations being put up by Alex DeWal and Alan Whiteside , who has been in South Africa. And I said, hey, you know. Hey, we can do that. And I literally went to Northwestern, saw the president of Northwestern, Henry Bienen, and said hey, you know, I think we should -- this is some of the things we should consider doing. You know, and it's really taken on after that.

So people who can't be here with us, like Helene Gale and Lisa Conti -- you know, both who've only worked. But certainly it's good to have Morrison, and it's good to have Nieburg here, who are very much count among the fathers of what we really feel, you know, has been the success.

The purpose of this program, as we said all a long, from the very outset, was to make a difference. At the time in which it got started -- and here again I have to go back to the work that started here, people like Jennifer Cates and, you know, and Phil and Steve -- they had HIV prevention group. And the idea that -- in fact the notion was, you know, in this age of treatment that prevention could tend to be marginalized and minimized. And so we got started really a long that track that we really have to get going with prevention.

And then one of the concerns at the time -- and it's really something to see the foresight -- was that southern Africa -- Uganda had made a lot of progress. But in the case of southern Africa was where -- was very much the vortex. And a concern was -- and again, was a policy decision on the part of the Gates Foundation -- of, you know, trying to avoid another major country or major region, you know, falling in that way. And hence the focus on countries like Ethiopia, China, and India, and Russia, and Nigeria. And that's how we really came on board.

I've had a long involvement with India, but I can tell you very frankly, I really wanted to be working with Aryeetey and, you know -- I see me here in, you know, places like Ghana. Nigeria is a challenge. And so -- anyway, that was the orientation.

So where we are now is being able to pull together some of the policy recommendations. Some of it already had been mentioned earlier on. We're very fortunate that my colleague here, Sunmola -- he is wearing two hats. You don't see them -- I mean, he has them on here invisibly. He has both a REACH hat on and he also has a NACA hat on because he's our principal researcher. But he's also now the coordinator for research in the National Agency for Control of AIDS in Nigeria. And professor, he -- they're going to steal his thunder, so I'll let him talk about NACA.

So, the ideas that we are putting forward at this point and going -- you know, the next several months -- is going to be working with the Nigerian agencies at the national level -- state and local levels to roll out what must be a major Nigerian initiative. And in that initiative, obviously prevention is going to be key.

Now, I have a power point that I did on all the presentations. And all I've done here is pull out two slides from that presentation. So I'm really skipping straight to, literally, you know, what would be almost my wrapping up of it.

But here I've summarized some of the aspects of what is being called an enhanced HIV prevention strategy, and I'll just go over them very briefly. The optimal HIV counseling and testing scenario, that's in Chapter 7 of the report that all of you have. And we have Phil Nieburg who's done an incredible job -- it is incredible. And he never stops working -- incredible job of working with the data that we have. And as he will point out is that we're only beginning to skim that

data. Because altogether we had 3,500 respondents. It's a lot of rich data. And so the counseling scenario that is being put together is a scenario that we think will drive the next phase of this kind of research.

Next, KYS -- you know, for the person who coined the term REACH -- and in fact I coined the term REACH when we had the task force on AIDS, again, with Steve in Nigeria. But KYS means, appropriately -- kiss, as we know it. But it also means, know your status. And this is going to be very important. Do you know your status.

In fact, when I presented this in Abaden a few weeks ago, the person chairing the meeting turned to the audience -- many of them students, graduate students -- and said, do you KYS? And it was, do you know your status? So we've got something to move forward with.

RUN HCT is the need to routinize, universalize, and normalize HIV counseling and testing. And that very straightforward and again I'm going to leave it to Phil to fill in a little more of the details of what it really means for Nigeria to move towards routinizing, universalizing, and normalizing HIV.

Then, PTC for post-test counseling. One of the things we discovered was in fact very unsatisfactory percentage of people who actually took the test. But what was perhaps even more disappointing is what percentage came back for their results. And one of the most disappointing of the disappointing statistics, for example, has to do with pregnant women. We have, of our sampling, only 62 percent of pregnant women actually got tested for HIV in our sample. And of those who did take the test the percentage, about a third, did not come back. You put it together, something like 73 percent of pregnant women in our sample did not have access -- to which everybody here knows is one of the most effective prevention methods we have, you know, of prevention to newborns, to births. And that is why Nigeria has over 50,000 newborns HIV positive. And so this is a huge area.

Community level focus. We were able to do this work because of the nature of our colleagues that you are all able to see. These are some very impressive colleagues from Nigeria. Many of them -- the communities that they've worked in and being able to gain access to the communities and mobilizing the communities and research. But we also see a community focus as

being part of the whole implementation and rollout of that strategy.

And then, vulnerable children it was mentioned, especially girls. Our colleagues mentioned what is the age of sexual debut in Nigeria, the vulnerability of girls in so many context -- in fact, we weren't able to do -- we weren't able to get it done. We might try to get it done before we wrap up. We wanted to draw a separate brochure, we even have the title there, no safe place in terms of the vulnerability of girls in so many contexts. Not only in homes, overcrowded situations, you know -- as hookers on the streets and so on.

And then REACH plus. And this is the, you know, the work that we have done and how we carry it forward. The further in-dept epidemiogical analysis that has to be carried out, both on the data that we already have and what has to be done. And there's a buyer statistics collaboration center in Nigeria which is working with us on this.

How many more minutes do I have?

SPEAKER: (inaudible)

MR. JOSEPH: All right, okay. This is my last slide.

Enlightened and sustained African leadership is actually key. So very important. And I only have the major leaders here, political leaders. But we have leaders at all levels in terms of religious leaders, traditional group leaders. You really have to be able to mobilize those, it makes a great difference. And so the South African government has stepped forward with a major effort, everybody knows here. South Africa is now following -- Botswana has already taken the step about five years ago -- to make, you know, HIV tests routinely available in the public health system.

And if we just -- I just put down these three countries that you'll all be familiar with. In the case of Uganda, when Museveni came forward with very strong leadership we saw significant gains in Uganda. With those prevalent -- it really just came right down. Museveni has been wobbling in recent years and we're seeing the Ugandan slippage.

In the case of South Africa, Mbeki Thabo -- for years in terms of his denials which are known to everyone. And we know that that is reflected in South African deaths and has actually been computed, the number of South Africans who are dead because of that policy. In the case of South Africa, Zuma has now stepped forward with his commitment, hopes now are rising that maybe

South Africa will (inaudible).

In the case of Nigeria, Nigeria really wasn't doing very much for a long time. And President Obasanjo, when he came in, in his second term in 1999, he stepped up the effort. And so Nigeria really had a much more vigorous Nigerian national response.

Nigeria now has a new president -- wonderful name Goodluck. But his wife also has a wonderful name, Patience. And so the question is, will we see a bold and comprehensive Nigerian AIDS initiative from Goodluck Jonathan? Obviously he's going to be hearing from us. We're proposing that Nigeria is having its 50th anniversary on the first of October. And in fact, Professor Doku is already on board. We want to have a freedom from AIDS conference in Lagos sometime close to the Independence Day. And by that time, we hope to have this new national strategy ready to roll out.

Thank you. (Applause)

MR. NIEBURG: Okay, thank you. I'm going to be talking for a few minutes about what's been learned from this REACH project in public policy terms about HIV prevention and control efforts. And the focus -- because there was a focus on testing and counseling in the report -- preliminary report that you got, we'll be focusing on that in the discussion, too.

And there are really three topics that I'm going to hit briefly. First of all, the low rates of uptake of HIV testing and counseling are related to a mix of issues, some of which are surprising and some of which are not so surprising. And the second one is that community level social science research -- that is, operational research -- can be used in an ongoing way to study and improve HIV control efforts and in a way that influences policy.

And finally, based on what we've learned about specific obstacles to HIV testing and counseling, and incentives to testing and counseling, approaches that have been used elsewhere can have a large impact relatively quickly on improving prevention efforts in Nigeria.

So, first is the mix of structural socio-economic attitudinal and systemic issues that are influencing HIV uptake. Dr. Sunmola and others mentioned a number of them, and I'm not going to cover any in detail. But issues like poverty and gender and education are critical in terms of determining low or high uptake levels.

And actually, let me echo a comment that was made earlier about the critical role of gender, which is a much larger issue than you would think from this report. We actually did not have time to begin to dig into the data, but gender is a critical issue that needs further exploration.

In terms of perceptions and attitudes, there are issues such as fear of blood drawing that have had an impact on uptake. There are system issues, health care system issues that are interesting. And one example is that among the youngest group of respondents, people of the 18- to 24-year age group had much higher recent testing and counseling rates -- that is, over 20 percent -- than the group just below them, the 15- to 17 year olds. And in Nigeria the age of consent is 18 and so what we may be seeing with these data is a situation that is similar to what was seen in Botswana when they first started to scale up HIV testing and counseling 10 or 12 years ago, which is that young people under the age of consent were turned away from places where counseling and testing was done unless they had parents' permission which, obviously, they're not going to spend a lot of energy trying to get. So some of this lower rate, obviously, may be due to the youngest people who are not yet -- who have not yet initiated sexual activity, not really needing testing and counseling. But I think there's a reasonable chance that the consent issue is an obstacle here. And that's something that needs to be further explored.

Secondly, the use of social science research at a community level is both doable and important. And as several people have mentioned, this is a large data set and we've just scratched the surface. There's a lot of additional analytic work that needs to be done on this data set. And there's actually -- there's really the possibility of developing a simplified form of this that can be used at local -- at community levels.

One of the concepts that UN AIDS and WHO have used about control efforts for HIV/AIDS is, know your epidemic. It's for policymakers at local levels. And I just wanted to comment briefly on an earlier question in the earlier session that relates to this. And it relates to the concept of evidence based policymaking.

That is, the ABC issue that several people asked about was a policy that was implemented without the use of the kind of local data that we're talking about, in terms of what might work, what might be acceptable, what might not be acceptable. And the kind of methodology that

was used in this survey can be used to avoid the confusion about effectiveness of interventions such as ABC, if that contextual information is collected at the beginning of those kind of interventions.

The third and final issue is the potential to use prevention approaches that are currently used elsewhere. And I'd refer to some of the obstacles and incentives to testing that were mentioned by several other speakers. So, for example, rapid HIV tests can be used to reduce the need for a second visit to a counseling and testing site that may be a long distance away. And reduce the need for post-test counseling at a second visit. There's now tests for HIV that are based on either use of saliva or use of finger stick blood that can be used to address the obstacle of the fear of blood drawing that many people expressed. There are an issue of mobile clinics, including door to door clinics that could be used to take advantage of the incentive of the interest people had in having the increased privacy and less fear of confidentiality issues that people seem to have about hospitals.

Couples counseling can be used to address the fear of disclosure that many people used as a reason for not being tested. Fear of having to disclose an HIV infection to a sexual partner. Provider-initiated testing and counseling --which is also called opt-out testing or routinized testing -- again, has the potential as it has done in almost every country where it's been tried to markedly raise the acceptance and uptake of HIV testing.

Disclosure support is the last one -- example where, again, the fear of disclosure is a very real one in these data. And it's not surprising, in a sense. But implementing a policy where counseling -- post-test counseling includes an offer of support for disclosing to spouses and other sexual partners would be important.

And some of these interventions are already being contemplated by authorities in Nigeria. But I think all of the obstacles that were identified -- and the potential incentives -- deserve at least a pilot test of some sort of response and then a rapid scale up of that kind of program if it's found helpful in increasing uptake.

And finally, there's some issues that were not addressed in REACH because of the way the interviewing was done that need to be addressed in future research. So, one is the gender issue which even -- although it wasn't addressed directly it's clear that there are large gender

problems that are involved with -- or gender disparities that are involved with HIV transmission. And structural issues such as laws that are in place or laws that might be in place, for example, against discrimination. And then issues such as injection drug use, which was simply not a focus of this clinic -- or of this survey. But is a problem in all of Africa as it is here.

Thanks. (Applause)

MR. SUNMOLA: Good morning, again.

What's -- I've been introduced as the coordinator of research for NACA, so I'll be speaking in that capacity now. I have a dual personality, that's what it means, yeah, you know.

But I try to do something that is helpful, you know. The -- what I'm supposed to speak to this morning is about NACA role in research and NACA role in terms of what is to be done with REACH findings.

What I did hope for is that I did not want to talk from an idiosyncratic point of view for my personal feelings. So I have to put across to the DG of NACA yesterday and who eventually responded by calling me at midnight today and then he said that he has a message for you all. And so what I'll be discussing now is a national position about towards all of these things that I've been asked to speak to.

He sends his greetings, and he feels a deep appreciation of this gathering. A deep appreciation of the gathering that is going to be talking about the future of Nigeria, about the future of the epidemic, and about coming out with ways in which these -- our ideas can help to shape the course of the prevention of HIV in Nigeria.

He's very gratified, you know, and I could feel his heart. It touched his heart. But the other part of it also is that he says that he looks forward to the outcome of our meeting. He wants to see how we can implement or being to implement or see to consider the outcome for the potential use of it.

So but the point I would also like to say is that in terms of the major last message he sent, which I think is crucial, is that after reading through what REACH has done, after going through discussions with the members of REACH team, after the national AIDS workshop conference that REACH participated in, in the beginning of this month at Ata Buja , the leadership of NACA has

come to the conclusion that they will have to partner with REACH in terms of implementing some of these major recommendations that have been put forward. And that is very significant.

The realization or the conclusion of partnering with REACH did not come from the blues , because it connects the REACH agenda -- the agenda of community based agenda of REACH. The intention of REACH to combat HIV, the correspondent and the connect with the current thinking of the national response in Nigeria as of now. You know, so it is very important, this momentous -- we should realize that what REACH -- what NACA is doing with audastic orders which World Bank and development partners and the rest of the sub-national agencies -- is to put prevention at the front burner. Prevention is at the front burner now.

Unfortunately, resources that we have received in the last three, four years is tilted or skewed towards treatment. 70 percent of the resources were spent on treatment, 30 percent on prevention. What we've found now that is very scary at the beginning of this month was the UN AIDS (inaudible) that you -- every two people that is put on antiviral, about additional three people get infected. So, he turns us to think and to be consistent with our thoughts that prevention is the way out.

So, we plan to invest a lot of efforts on prevention. So, that is -- in that regard, what we are doing now at the national level is to develop a research agenda and a research policy. Nigeria doesn't really -- we don't have, as of now, a strong research agenda to be able to understand the epidemics in ways that we can slow it down or minimize it. You know, a number of our colleagues participated in trying that research agenda and eminent researchers in Nigeria and (inaudible), so it was a broad-based thing.

So in the next three weeks or thereabouts we are going to do a stakeholder validation meeting on that research agenda. And what that research agenda shows for REACH is that it coincides with the vision of REACH. The trust of that agenda is community based intervention. Community is central to prevention. Community -- when we look at our data now before us, we realize that the new epidemics we are having community (inaudible) in the new epidemics. You know, so community plays a role in terms of how the epidemic comes. The community plays a role in terms of knowing the needs of the community about how to combat the epidemic. Community

plays a role in terms of capacity, more than even government agencies. In terms of talking about the vulnerabilities, gender inequality, stigma, and discrimination -- the roots are in the community.

Community can reach if they are well mobilized, they can partner with NACA, partner with REACH in terms of all of these -- in terms of our combating many of these problems. You know, and for social change and social mobilization they are very important in prevention. So, that is where the interest lies and that is where NACA is embracing REACH and is inviting REACH.

It's going to be mutually beneficial role that we are going to be having if REACH totally accepts that. The role is beneficial, but more to the national interest, you know.

So I think that I would also like to say that vaccine is one of the research area -- vaccine development is one of the research areas that we are focusing upon now. You see, we abandoned the project about two years back for resources. You know, science, of course, has not come out with a magic bullet with regards to kill or treatment. But Nigeria is not considering science to have failed.

So, what we are doing now is to -- with the Canadian government that just recently, about two weeks back, came to the aid of Nigeria with huge grants to be able to find a way to resuscitate the vaccine trial that we started, which was promising because many of our people from the north are becoming technical partners and local. So that is by design, the trust of our policy now is prevention. And the DG says -- the director general says -- which is (inaudible) delegations.

Thank you very much. (Applause)

MR. VAN DER GAAG: Well, thank you very much. You all make the role of chair of this panel fairly easy. We are right on time.

We have a nice chunk of time for the audience to ask questions. And please, when you get the microphone, introduce yourself.

MS. OKOE: My name is Oge Okoe with the National Endowment for Democracy. And I have two questions for you.

The first question is what role if any did looking at religion play in coming up with some of the figures -- or coming up with the data that you came up with, as well as making some of the recommendations that you've made in your report.

And then secondly in terms of looking at policy formulation and passing laws, I guess -- will you be putting forward recommendations to ensure that -- and looking at Nigeria's federal system -- will you be putting forward recommendations to ensure that the state legislatures have some independence from the national legislature to pass or to domesticate bills such as anti-stigmatization bills in their respective states to ensure that they tackle the problems and the prevalence of HIV/AIDS in their own states based on the different -- based on the diversity of drivers -- the diverse drivers that you've mentioned.

MR. VAN DER GAAG: Thank you. I have one, two, three questions here. And then we go to the next.

MALE SPEAKER: I do agree that prevention is clearly the best solution. If you can prevent people from getting sick, then that is good.

But I would like to know among those who, unfortunately, have already become infected the extent of treatment, the extent of access to lifesaving retroviral drugs, and what the problems are that you may be facing of access to these drugs. Thank you.

MS. ROBINSON: Hello, my name is Rachel Robinson, I'm a faculty member in the school of international service at American University. And I have, I guess, a two part question.

One is about the response -- the national response to HIV thus far. And if there's any elements from the perspective of NACA, but also, in general, that you would highlight as particularly unique about the Nigerian response, things that have worked particularly well.

And then the second part is about the shift to the emphasis on prevention and what kinds of challenges do you anticipate with that. Particularly we've heard a lot about testing today, which is so important. But beyond the realm of testing, the question about religion, other social groups that will be important to bring in to the effort.

MR. VAN DER GAAG: Thank you, one more?

MS. FLEMING: Hi, my name's Camille Fleming. I'm with Schneidman Associates International. And I wanted to know, what role can the media play in pushing this REACH initiative?

In my travels abroad, I've found that young adults look to the west and our American culture and Hollywood and television. And also, these days how everyone is technologically savvy

and how technologically savvy are the people in Nigeria. And these days, everyone has a cell phone. Is there any way we can, I don't know, support this? Just have billboards up or commercials? Just talk -- trying to educate the people so they know where to go to get tested or what to do or anything like that?

MR. VAN DER GAAG: Okay.

MR. SUNMOLA: One of the questions on policy formulation, the role of local legislatures in domesticating (inaudible), I think that's very crucial in terms of all what we are saying.

The -- unfortunately, there is a disconnect between policy, between knowledge and the use of knowledge in the country at every level, national, sub-national. There is a clear disconnect, and that is what we are grappling with, with our research agenda. How do we ensure that the knowledge that we have is used in policy? How do we ensure that the knowledge that we have is used by the legislators? You know?

So, some of the things that we are doing in the past two years is to make advocacy visits to legislators to even let them know that HIV/AIDS is a development issue. In many of these things that you went, they think HIV/AIDS is the business of the Ministry of Health. So, the (inaudible) the legislators are trained -- are informed. Many of them are informed now about stigma and discrimination and about all of that.

But the problem -- the issue is that they have not been able to -- most are -- to really come up with important legislative legislations that will slow down stigma and discrimination. Only two states out of the whole states in Nigeria -- Edo and Enugu -- are those that have clear legislations on stigma and discrimination.

So what that means is that for many other states, people who are infected or who needs to seek redress because they are stigmatized or because they are discriminated -- sent away from jobs, for example, because of HIV. Sent away from schools, for example, because of HIV. You know, people who have that problem, they don't -- there is no formal procedure of seeking redress. That is what we are grappling with now.

And in terms of -- I will just take the questions randomly, and -- yeah. In terms of media, the role of media in putting across REACH initiative. And I think you also talked about

technology. I will tell you that that is very vital, and very important part of the initiative NACA has started to take in the last two months.

In the last two months I was sitting in a hall like this with our celebrities, those that are in the media, in the filmmaking industry, the (inaudible) of Hollywood. I was fascinated in the meeting with them, and we -- and the thrust of the meeting was how can you mainstream HIV, sexual violence, into the films you are making? Because the films that are being made, they are seen in nooks and crannies of the country. Even in rural areas, you know.

The actors that we -- admittance, they are not just rising. They are risen stars already. So people would like to watch and listen to them. And the message it communicates are going to be very important. We are on the joint board with that. Where we are is that you cannot just construct your scripts and go to the film industry. We have to see it as you are making standard prescription -- standard information that are correct for the people, and accurate. You know.

But in terms of technology, Nigeria is waking up, really. In terms of what is being done with technology. And the initiative is coming from private sector. Fortunately in terms of the use of, for example, cell phones. Now cell phones are being used to tell people about every -- you see, periodically, there is a network that they call Zane in Nigeria. I don't know the equivalent here. Zane and MTN. Regularly, Zane sent messages out, so those that use the network -- like, every two weeks, about the importance of HIV testing. About the importance of reducing stigma and discrimination. About the importance of if somebody is HIV infected, do not discriminate.

You see, that is going on. You know, that is going on. And there are all lines that are being maintained in Nigeria at national level. If there are issues with HIV, call this line. The lines are well advertised. You know, but we know that there are limitations with that. You know, so limitations in terms of the rural epidemic that we have. They may not be able to have access to telephones to call and all of that, but is working well in the urban areas.

I don't know if I can state it more (inaudible).

MR. NIEBURG: Yeah, I'd comment quickly on two points. One is that issues such as religion and other socioeconomic variables have been collected in great detail and are waiting to be analyzed. So, in general there were no large differences between various Christian groups within

the Christian community, and for some issues there were differences between Islam and Christianity. But there was no opportunity at this point to focus on that yet.

The second issue is the issue of lack of resources and antiretroviral drugs, and, you know, in general -- and I'm not in a position to make recommendations to the government of Nigeria, and I'm actually not interested in doing that, but the public policy approach to infectious disease in general over history has been on stopping transmission of various organisms, and smallpox is the classic example, but if you think about diseases such as measles where a vaccine is used and tuberculosis where treatment is important, but the major focus of treatment is making sure people are not contagious anymore. And HIV is an exception to that general rule where the focus of resources to this point has been heavily on treatment without an effective focus on prevention, and, you know, it makes you think that there's possibly an unending line of people coming along who are going to need treatment, and so the question really is: Is the community, the local community, the global community, the national community going to have an impact on the spread of HIV or not?

And there was a question earlier about -- someone made a comment about he was glad that the report didn't set prevention and treatment in a competition with each other, and I guess my sense is that avoiding that conversation is a big problem, that they are in competition with each other in reality and that there needs to be more public discussion about that, that we are in a position where there is not enough -- there are not resources to do everything, and so the community at whatever level you're at needs to make a decision about how that kind of rationing is going to be done.

SPEAKER: Let me come in here. In fact, one of my points picks up but in a different way from where Phil left off, and I was going to refer to that earlier question about prevention/treatment. In fact, and this is your question, Rachel, about prevention, that, yes, we have to focus on prevention and how much needs to be done on all the challenges. But we also have to recognize that Nigeria also has a huge treatment and financing gap, and the two, for me, are going to be going hand in hand. And let me just try to illustrate a little bit. And I don't have all of the slides as shown, but at the Abuja conference, my colleague, Robert Murphy, from the Northwestern Medical School, who's been very important in setting up PEPFAR in Nigeria, he talked about the fact that we

now have effectively a dual system globally in terms of treatment; that in the richer countries, people are able to begin on treatment when their CD4 cell count, you know, is under, you know, 350. But in Africa, where Nigeria falls in this, it's, you know, your immune system has to be impaired to a much further point, which is 200 and below.

Now, even at that 200 CD count, there are currently 350,000 Nigerians on antiretroviral. 300,000 of that 350 are paid for by United States, right? So, that's really one particular issue, and even with those 350,000 currently, Murphy points out that in fact there are 200,000 at that level who are not receiving treatment. Now, if Nigeria were to go to comply with the WHO UN aid standard of 350 now, he said there's 1-1/2 million Nigerians who would be doing it. So, we really -- so, we're not -- everybody who should have, even at the present rate, is not being done so. If you try to be able to move forward, if you're talking about astronomical costs, and you know, one of the things that I've learned so much from Phil is, in fact, the earlier you train people in terms of the infection is how in fact that becomes a very important prevention element. So, I really feel like these two things are going to go hand in hand. So, in terms of the challenges that we're facing, we have two simultaneous challenges that Nigeria has to do.

I also happen to -- I really look upon, you know, what we're really talking about, and we were all at a dinner last night, and I basically said this, you know, that I really see what Nigeria is facing. It was actually going to really be able to turn this thing around as basically equivalent to the kind of national campaigns that were made against colonial rule, that were made apartheid, that were made against segregation in the United States, that were made against a lot of the authoritarian military governments we had in Africa that is really going to be of that level of a change if we are going to be able to deal with it. And you have then to be able to get the national leaders, the religious leaders, the civil leaders, all of them mobilized.

And then the last question about media, you know, when I think about -- and I'm one of those people who are kind of like eternal Nigerian optimists, right? And with regard to this, one of the -- when I think of Nigeria actually embarking on this campaign, are we actually going to be calling for that campaign. I mean, I'm literally, you know, hoping I'll be speaking in Nigeria around independence time on a number of issues, but I hope to be also speaking about this issue. And part

of Nigeria has resources to mobilize for this. And if we just take one of them -- there are many of them, but if we take media, I mean, the Nigerian media is -- anybody if he's new, it's incredible; it is huge and fast, all right? And so being able to mobilize all of those results is, in this kind of a campaign, I think is important. Fortunately, I think that Nigeria is in a position.

And just finally on the financing it's rather interesting to hear from the deputy assistant secretary -- you know, we get a concrete date and a figure -- that by 2015 part of the U.S. approach to Nigeria is that, if I understood her correctly, Nigeria will absorb 50 percent of the costs of this treatment. And that's fair enough, that Nigeria has the resources, that the U.S. Government, you know, shouldn't be the one carrying, you know, 80 to 90 percent of the cost of this kind of a treatment. Nigeria should call on its resources, and it's good to put it forward like that, and it's unlike other countries; and Uganda and other countries, you know, also have the resources to be able to do more.

MR. VAN DER GAAG: Go ahead.

SPEAKER: Just quickly to answer the media issue. An interesting thing that we found from our data was that most people got their information on HIV/AIDS from radio and some from TV, but radio was a lot more common. But when we probed further to find out comparison of correct information that they had, most people who had correct information about HIV/AIDS actually got it from written media, from billboards and from newspapers; and, further, we found that women were less likely to have information about HIV/AIDS compared to men, but men were more educated. So, in thinking about the (inaudible) and policy, it's important that something that we will, you know, want to put forward in Nigeria is that whatever is being done since people listen to radio a lot more literate or illiterate that the information on these media are, you know, expanded so that it's more media or coming up with creative ways.

For an example, when we went to communities to give our dissemination, because we knew we were going to a lot of the rural communities and the epidemic had just come in (inaudible) in Nigeria. We went with a Jama troop that acted out a lot of the information that we had, so it wasn't just giving reports or writing billboards, because there are lot of people who are not able to read this information. So, although the information may be out there, they don't have access to

that information.

MR. VAN DER GAAG: Thank you. Before I give the floor to you again, I think there's one question still unanswered that I believe came from you; that is, if you go all out on prevention, people need to have access to, you know, to a clinic or to a doctor. If there's a provider-induced treatment, then there has to be a provider. And as I say, I work on some project in Cuava state. Cuava is a very large, a very poor state, but very sparsely populated. It's not hard to drive for hours, even days, without seeing any health care infrastructure, so that is impediments to both treatment and especially probably to prevention since prevention needs to reach in an easy way as much people as possible. What is being done about the building up of support of infrastructure, health care infrastructure that would be supportive for an HIV/AIDS campaign?

SPEAKER: I think you -- well, that's not part of the question. The issue has to do with structural issues, largely in terms of access to shipments and the obstacles. Isn't that the crux of our question?

In terms of access, I will say that as of 2006 the government declared -- (inaudible) declared that there should be free access for everyone who needs to take anti-retroviral. They were discovered from research in 2008 that only 48 percent of those who needed to take the test were able -- I mean, who needed to take the RV were able 48 percent. So, there are a lot of people who did not have access. Some of the reasons are infrastructure reasons, but the large part of the reasons are structural issues, vulnerability issues like stigma and discrimination. And the other part of the reason is cost. And treatment comes in there. It is free to take the RV, but they have to do laboratory tests sometimes for their viral load, for their (inaudible). That is not free, and many people don't have that money to drop.

Infrastructures and types of facilities. Facilities are far, far from where people are staying. There are 998 sites now by PEPFAR, by Global Fund , you know, by some development agencies, but not other than its sites in the country. And, you know, it's like we have 700 and 77-something -- 774 LGAs, local government areas. If you look at that, you know, some LGAs don't have sites of treatment. So, people have to travel long distances to be able to access, as they don't have funds much. We are talking of marginalized war to most of them that are afflicted and infected,

you know, so the issue of infrastructure is very important, and through some of the things that we are doing as around eight of Global Fund is to see how they can improve in terms of integrates RV treatment into primary health care. It is not in primary health system, not in Nigeria. You know, that could be one of the issues that we are looking at. That could try to elevate our problem in the short run.

MR. VAN DER GAAG: Thank you.

I see one, two, three, four, five hands, and a sixth one in the back.

SPEAKER: Thank you, and thanks you once more to this panel. I think we don't have the luxury of failing the DG of NACA in terms of these expectations of our deliberations this morning. I don't think we're doing badly. I'm not inferring that we're doing badly. But listening to the first panel in terms of what the findings of the research were.

I'll specifically to the barriers for testing. It's partner or position; it's disclosure, difficulty; it's cost consents . Yes, it's death sentence, which I think the colleague from Nigeria is eloquently putting together as stigma related and antidevelopment related. So, fundamentally in my view, those are the problems that we're struggling with, and I think, as we discuss and make recommendations to the NACA of Nigeria, we should be speaking to those problems.

I listened to Mr. Joseph outline some of the recommendations in terms of policy -- ACT keys , PCT. Yes, those things needed to be done, but they still remain the question. I think we could take it further, the question as to whether those things would address the fundamental problems of stigma and antidevelopment, and I think in my view we should begin to get to understand the question of stigma, which in my understanding is based on fear. It was defined anyhow as a concept of fear for condition, and in this case HIV, which is seen as a disease that is not preventable, that is not treatable.

I think that science has moved a lot of ground, and I don't think that we've done well in communicating the findings of science to the communities so that they understand this disease better as a disease that is manageable, that is treatable to some degree. But not only reaching communities with that scientific information, supporting -- I was happy to hear reference to the revival of the vaccine research in that country, and I think that we need to, as we make recommendations to

NACA, to ensure that we support the research towards vaccine development. Not only vaccine development, we should support research towards the finding of a cure for this disease, and as we communicate the confidence of the scientific community in terms of the knowledge and the things that are being done, too, in terms and the nuanced terms that committees will understand, then communities get the confidence of being able to deal with the challenge.

Going back to the question of antidevelopment, there was a question that was raised earlier about the economic situation in the African continent. That I think is strange that this disease is where it is right now. I think that we should, as we make recommendations here, put as one of them supporting economic growth with a focus on human capacity development, especially in showing that empowerment of women as part of that. We can do all of these things -- ACT, PCT, all of them -- but I don't think that we should have dealt with the fundamental issues if we don't go a step further to say as we formulate this program then it should be part of a broader kind of development strategy.

MR. VAN DER GAAG: Thank you.

SPEAKER: Thank you.

MR. PATTERSON: Yeah, hi. Rob Patterson, self-management consultant in International Health Systems. The question is directed toward NACA. Does NACA intend to implement any kind of sort of strategic plan, strategic actions to increase the incidence of male circumcision among infants, and also the prevalence of circumcision among young men and men throughout the population as a preventive measure toward blocking HIV transmission?

MR. EGBULEM: Chris Egbulem, *Action Africa*. My question has to do partly with the recommendation that has just been reechoed here about development -- research and development for vaccines, but I want to ask this question with regard to traditional health assistance -- traditional medicine within Nigeria and societies. What kind of integration has been made in this search for a cure and search for prevention, and how have they been brought in as partners in the search, sort of -- we're not continuously looking outside for some, you know, chemical means alone for a result in this crises?

MR. VAN DER GAAG: I think those two and then the panel.

MR. CHUBU: Hi, Chinet Chubu . I'm a Nigerian physician. I just want to echo, you know, the sentiments of my South African sister, sir -- I don't know your name, but -- about getting actionable, I guess, policy recommendations across the NACA. I think, Dr. Sunmola, you sort of hinted at the frustration you feel about the disconnect between, you know, research and, you know, evidence and natural policy, and I think the one thing I'm struggling with today is -- I don't know if you guys have thought through this in your research, but the top things your highest conviction ideas for NACA to do that could, you know, affect, you know, the curve, you know, of HIV prevalence.

And just thinking about that, I'm not sure that NACA is well equipped to address issues about economic development, for instance, you know, even though they're important, right? But I'm sure if I could guess, you know, that NACA probably receives what, you know, 1 percent of the national budget would be a big stretch. I just don't think they can influence economic development in any meaningful way.

So, I think we should focus on the one, two, three things, you know, that NACA could do based on the research that REACH has done to affect, you know, the prevention of HIV in Nigeria. And I wish you would and if you could narrow down your thoughts to those, you know, top two or three things.

MR. VAN DER GAAG: All right. I forgot, Rene and then the gentleman in back there.

MR. BONAIRE: I just would like to -- I'm sorry, I'm Rene Bonaire from the World Bank. I just would like to ask a question on the cost of the testing. The reason I mention that because when I look at the data included in your very interesting report, it seemed that already Nigerian households are spending a very large amount of money on health expenditures. Maybe I understand not correctly, but when I look at it, it seems that health expenditures -- about half of food expenditures. Now, that seems to indicate, you know, it's already a large share.

Now, the question is then if you ask a household to spend more on testing, whether it is physical or not, and I suspect as you indicated in last part of the report, it may not be physical because only about 30 percent of people negate the doctors because of the cost. So, the question then is what can be done?

And I'm just wondering in this context whether you have the possibility of the example of conditional cash transfers, giving money to people so that -- in exchange to get tested. But I would think they may need to have some financial incentive. It's really you ought to shift more to other testing on the general scale.

MR. BROADWIDTH: Yeah, David Broadwidth from Infectious Disease Society. Just two recommendations for NACA. One is to take directly to the President if at all possible this recommendation of using a portion of oil revenue to expand these programs.

And No. 2, when you talk about research I would urge you to go beyond vaccines to think about things that will have potentially an impact sooner, and I'm thinking particularly of microbicides, which are showing enormous promise, and I think we've going to be seeing this coming July some really important results on that.

And just No. 3, in terms of this prevention versus treatment dialogue, I think it's important to recognize that the HBA is actually not an exception when it comes to provision of treatment, that's the drive to get TB and malaria treatment and other treatments out there, is not only for prevention, but also to save lives.

And to take fully into account -- NACA must take fully into account what would be the potential costs, including economic cost, of a stall in the expansion of treatment -- and I'm talking about enormous numbers of orphan children, numbers of dead health care workers, dying patients flooding the health care system. And actually according to your own research, people are not uptaking VCT -- or voluntary counseling and testing -- because they're not sure that they'll gain access to treatment. So, the overlap with prevention and with health care system impact is actually really important to take into account as you wrestle with these difficult resource questions.

MR. VAN DER GAAG: Thank you. Let's ask the panel to precisely answer these questions in a short period of time.

SPEAKER: Okay, thank you very much. Several questions here now, one on costs. What can be done with testing?

Yeah, I agree really, certainly, that cost plays a role. But I must say that there are many testing centers, to be fair, that's cost free. There are many testing centers are cost free.

Majority of those that charge costs are private institutions -- institutes for testing. But the issue -- if you look at the research, what can be done, you know, with costs, is that people know where to get tests, but they don't go there to test. Well, you could see that there is a gap between knowledge and behavior. Seventy percent of the people know where to get tests, but only 20 percent actually went. Many of those places didn't know. Many of those places are cost free. Therefore, the reasons that we have said which goes to stigma discrimination, which goes to the likelihood that they will die soon, which goes to the likelihood that they would not be able to have treatments guaranteed, you know.

Some of those issues: confidentiality, barriers. We need to work on those barriers. Very important. I'm not sure I have time. There is a plan that we have that (inaudible) suggests about all of that. We begin to integrate those barriers into the messages that we sent across. There are so many IEC messages in town -- in Nigeria -- we cannot count them. They are not evidence driven. Some of those messages can tell where people can get cost-free testing. Some of those messages can talk about HIV not a death sentence. But then, something that they can manage and productively manage. Some of those messages can bring out people who already have HIV and who are doing very well and begin to talk to talk to people as models and champions, you know. So, we have not been -- we don't understand these barriers in their entirety, like (inaudible). And it's good (inaudible) now as we have it. If one has the mainstream HIV into media, we begin to say look at this barrier to really to work your scripts, you know.

So, there is another question on -- the question of stigma and discrimination, I think I can't agree with you for that. I don't want to spend time. Stigma is so (inaudible), it's causing a lot of problem. It's clearly modeled on the virus itself, you know. They are ejecting people from school because they know they are positive. They are preventing people from workplaces because they know they are positive. You realize that happened in Malawi about two weeks back? One of the judges sentenced those guys that were almost as well to 40 years imprisonment, you know. These are issues that are breaking down -- that are making people not to disclose their status if and when they know.

And because they don't disclose, they are likely to go underground. Their partners

may not know. They can be prisoners (inaudible) couples and then infects. So, stigma places a lot of rule in all of this, and I think it is the most important problem in the country, the most neglected issue in our agenda. So, it is growth in the forefront of our agenda now and our strategic policy in the country, and there is a pattern that is being constituted to look at how HIV stigma discrimination can be reduced. You know.

MR. NIEBURG: I was laughing before, because Richard and I have worked together for, like, six years now and he just found out a couple of nights ago that I have a curmudgeon aspect of my personality, and so let me express --

MR. JOSEPH: That's his word.

MR. NIEBURG: In terms of the concept that came up about vaccine research or the question and the need to express the confidence of the scientific community about vaccine development and cures. There is no confidence in the scientific community. There's a sense of optimism that progress will be made, but in terms of cure, there's certainly not a sense of confidence.

And vaccine development, we're still 20 years away from -- at least 20 years away from an HIV vaccine. Even if that's -- even if there is a vaccine, it's important to realize that this is an endemic disease. It's in every place, every country; it's in people's nucleic acids. And it's instructive to think about what's happened with measles. Measles vaccine became available in 1963, which is, what, 40-some years ago, 30-some years ago, and became available in developing countries in the late 1970s. And measles vaccine is very cheap. It only requires one dose, and people are permanently immune. There are still hundreds of thousands of measles deaths in the world. So, it's -- I think vaccine development needs to go on, but it's important to keep that concept in perspective, to have reasonable expectations.

Aspirational goals are good for lots of reasons but not if they get in the way of realistic goals, and in terms of controlling the disease, it's -- you need to remember that prevention of transmission in the end -- it either is going to work or not. We'll either learn how to prevent transmission from one person to the other or not. The answer to this disease is not going to be treatment, and it's unlikely in our lifetime to be vaccine.

MR. VAN DER GAAG: (inaudible)

SPEAKER: Yeah, right. Just listening to -- I said to Phil he'll have another title, you know, which is our senior tutor, because he keeps tutoring us. We know he -- almost a day doesn't go by when he isn't printing something to give us.

But part of -- no, but part of REACH, again, you know, is that the idea first of all of preparing a REACH manual, because of all that we have done and learned in terms of training and carrying this out and also thinking of a REACH institute because we've been training people all along and we can make that part of the whole process assuming that we're going to all be scaling up. You just heard from the director general of NACA officially, you know, about, you know, moving forward about REACH and NACA collaboration.

I just want to -- and again, the lady from South Africa -- I just want to respond to two things that you said -- well, sort of respond to it from the standpoint of what REACH is bringing to the table. Now, when we had the dissemination event at Northwestern, the subtitle -- it had the same title as what we have here, but the subtitle was Designing Knowledge-Based Strategies. And a lot of the strategies -- and, again, I'm thinking this notion that Professor Sunmola has said. He said for 20 years a lot of the prevention program in Nigeria was very generic, right, all over the country. Somebody will come up with an idea, and then they'll get a poster, and a poster -- well, yeah, we got to aim at stigma, so let let's have some posters all over the country that you should not discriminate and don't stigmatize and so on. What effect does that have, right?

From the standpoint of our research is understanding when we say "stigma" the ignorance that people have. And in fact, you know, going to some of those sessions and listening to people tell you -- I mean, you're just amazed after all of these years of how people think about it. I mean, you know, one that comes to mind is a person saying well, you know, one of the problems now -- giving people anti-retroviral drugs -- is that we can't tell who is infected and, therefore, who to avoid, right? Well, you know -- well, to begin with, you know, to know that people could be infected and you can't know it and they're the most contagious, right, I mean, and on and on.

So, when you have so -- the part of the whole community action approach -- and I really feel like ignorance is one of the biggest problems when we call thing stigma and you sort of disaggregate what that is. Find out how much of it is ignorance and how in fact the kind of

approaches that could be used to get it. I can't go into it (inaudible) because obviously you don't have the time.

But let me just take another one, just sort of a general statement. And you stated, madam, and people have said to it, well, you know, it's really questions of economic development and it is poverty that is driving this. Well, you could say, well, okay, we'll solve the problem. You know, we'll get economic development going and we'll end poverty, you know. But when we'll actually look for example and, you know, Professor Sunmola pointed this out very clearly, you know, is the idea -- and also Professor Erinosho -- about transaction sex, right, and all the different forms of transaction sex that you'll have. And when you try to understand what that transaction sex is, I mean, I know one particular case of just providing schoolgirls -- I don't know if it was in Kenya or one of the countries that they provided schoolgirls with school uniforms, right? So, they're different ways of now being able to understand, breaking this down, of what is really driving some of these behaviors and then being able to tackle them in that way.

MR. VAN DER GAAG: (inaudible)

SPEAKER: Yeah, just on the question of second position. It's -- I don't know if that's a real big problem in Nigeria, because the majority of people in Nigeria, well, they're Muslims and they circumcise by (inaudible), and then a lot of other ethnic groups in Nigeria, also. I know, for instance, the Ibos, they all circumcise, so, it's not as big an issue as it is in maybe Southern Africa. Just to point that out.

MR. VAN DER GAAG: All right, you have the last one.

SPEAKER: Okay, thank you, sir.

Nkem actually dealt with circumcision and I wanted to talk about it. Nkem already talked circumcision. What (inaudible) just encouraging people to do at macro level is look, why don't you circumcise? We know it's (inaudible), but use sterile treatment and that is very important.

The point about oil revenue is well taken and is very informative. I will sit back again, as we are going to take (inaudible) back. But the point I want to raise about that is that it's already going on in the country, that there is a debate which almost causing the problem now. The PPP level -- public, private, partnership level -- they say look, we -- private sector -- we are doing

something on HIV, at our internal developmental business in the companies where we work. Are you now going to ask us to pay again (inaudible)? You know. Those are some of the issues.

So, double taxations could be a problem in all of that. Public sector same; NFPC same. (inaudible) we be paying tax again on audit where we are also indirectly doing something on HIV. So, it's a debate that is raging on, but is very useful.

Microbicides -- excellent points you have made. You know, the (inaudible) agenda that we have crafted -- and I'm happy that (inaudible) was consulted in part of the process for crafting such an agenda as the president of Africa's Psychological -- Sociological Association. He will testify that microbicides is at the front burner of our research agenda. It is something that is there that people -- that we are looking -- we are working on in terms of priority.

Poverty. In terms of privacy, there was a question about poverty and he said the recommendation to NACA. You are right. NACA is not a private institution. That's not the way you put it. NACA is not -- NACA is not in charge of poverty alleviation, per se. There is the ministry -- agency for poverty (inaudible) in the country. NACA work closely. In fact, we have regular meetings with them in terms of saying that look, for people that are HIV infected they cannot compete for macro credits the same way like orders. Preference should be given a lot of those issues.

You know, so NACA is working with the MDG goal on poverty. There is an MDG office at the president level. There is a NACA MDG for (inaudible). That goes to -- its business is to ensure that poverty is reduced to people that have HIV or to those that are affected through the framework of MDG forms. You know, so NACA is not doing -- is not working directly ,but indirectly in terms of all of these. Traditional (inaudible) Nigeria, they are problem. They are -- it's a problem that we cannot go around integrating them totally. We identified that as a policy gap, because they have potentials.

What they are doing now for -- that is very productive in the countries that -- there are nutritional supplements that have been brought that we -- that have been tested by scientists on (inaudible) in the country and they realized that it helps boost immunity. To that extent, traditional (inaudible) are contributing significantly. But in terms of cure, no traditional (inaudible) been endorsed. Many of them said that it's cured, but none has been endorsed by the (inaudible)

laboratory.

MR. VAN DER GAAG: I'm afraid that our time is up.

SPEAKER: That's right.

MR. VAN DER GAAG: This gentleman here wants to --

SPEAKER: Yeah.

MR. VAN DER GAAG: -- come to closure.

SPEAKER: Yeah, I want to -- got words of some closure -- I mean, thank you all for staying and being part of this. Like I said, we've really come full circle, you know, that this idea started off with a city. Seven years later, we come back to the city for what it is, but, you know, the -- but especially given Washington and the importance of the United States' engagement on this issue.

The Global Health Initiative of the Obama Administration, you know, for 2009, 2014, when you look at it, they have nine things they are focused on. HIV/AIDS is number one. But when you look at the funding that they projected, 70 percent of the funding is projected going forward. Now, this has, you know, tremendous implications, you know, for a lot of the other issues, as well as for these other countries, which will now have to pick up a lot of it when they're faced with a lot of these other issues.

So, the -- you know, the global -- the policy significance of all the things that we're talking about I think now is really at the really, really high level. And the good thing about it -- and, you know, the case of Nigeria, we do have the attention of the most important agency, and we're hoping that, you know, in due time we will have that, you know, of the national leadership.

But again, thank you very much. Thank you, Jack, and thank you, Brookings, for hosting this.

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