THE BROOKINGS INSTITUTION

ENDING NIGERIA'S HIV/AIDS PANDEMIC

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

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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 South African 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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