OPINION EDITORIAL

The Findings of the National HIV/AIDS Indicator and Impact Survey (NAIIS) Presents an Opportunity for a Pivot in the HIV/AIDS Response in Nigeria

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In March 2019, the Nigerian government in partnership with the U.S. President's Emergency Plan for Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (PEPFAR) released preliminary findings of the National HIV/AIDS Indicator and Impact Survey (NAIIS), showing that the HIV prevalence in Nigeria is now at 1.4%, with an estimated 1.9 million people living with HIV (PLHIV) [1,2]. This is markedly different from previous reports, which put the national HIV prevalence at 3.0% or an estimated 3.4 million PLHIV. Many had doubted the previous reports because they were based on surveys that mainly included women in antenatal care and over-represented people living in urban settings [3].

The NAIIS findings characterize the country's HIV epidemic more accurately [1,2], and have inspired rejuvenated efforts to meet the once seemingly insurmountable Joint United Nations Programme on HIV/AIDS targets for ending the HIV/AIDS epidemic by 2030 [1]. These efforts have, however, not necessarily addressed current policy and social barriers that hinder equitable access to HIV prevention, testing, and treatment services in a comprehensive way. Stakeholders such as PEPFAR and the Global Fund for AIDS, Tuberculosis and Malaria (GF-ATM) have focused available resources towards intensifying existing active HIV case finding efforts and widespread provision of antiretroviral therapy (ART) in what has been aptly named the HIV surge response [4]. This response aims to diagnose at least 90% of the estimated PLHIV and put at least 90% of those diagnosed on sustained ART [5]. However, if the social and policy barriers are not addressed concurrently, the plan to end the HIV epidemic is not likely to be effective.

To begin, multiple studies have reported that the high level of HIV-related stigma and discrimination faced by PLHIV is one of the most important contributing factors to new HIV infections, poor adherence to ART, and high rates of loss to follow up from treatment programs in Nigeria [6-9]. One study reported that up to 65% of PLHIV experience some form of stigma and discrimination within their communities because of their HIV infection [9], with attrition from ART being as high as 38.3% at 48 months after treatment initiation [10]. Women especially bear the brunt of this pervasive stigma; many express that they experience shame and fear [11,12]. Other women report having to lie to their families and partners while covertly accessing medical care because they risk losing their partners, homes, and livelihood if they disclose their HIV status [11].

Despite this reality, it seems rather counterintuitive that the major component of the HIV surge response plan is identifying active cases by index case testing (ICT) [4]. The premise for ICT is that because HIV is mostly contracted through sexual intercourse, it is cost-efficient to test sexual contacts of PLHIV. Health workers either encourage identified PLHIV to notify their sexual contacts to be tested (passive referral) or with consent, contact sexual partners of existing patients while attempting to maintain confidentiality (provider

assisted partner notification) [13].

Opponents have pointed out that this strategy is sometimes not in the interest of the patients who often resist any contact with their partners because of their fear of stigma within the community [14]. They have advocated adopting approaches that uphold human rights to privacy and autonomy in the HIV program, seeking to balance the interests of both patients and their partners [13].

Another limitation of the current HIV response plan is that funding for social behaviour change communication efforts has been on a steady decline over the last decade [9], as more of the funding has been allocated to HIV case finding and treatment efforts. This funding decline has resulted in the drastic decrease of HIV information in contemporary Nigerian media and in poor knowledge about HIV prevention among the public. For example, the 2018 Nigeria Demographic Health Survey reported that only 13% of people aged 15–24 years had a comprehensive knowledge of HIV/AIDS prevention [15], down from 28.9% in 2013 [16]. In fact, there are often misconceptions about the infection that continue to socially isolate PLHIV and spread the infection among younger adults. For instance, there are myths in Nigeria that HIV infections are the result of sin and that there are seemingly miraculous cures to the disease [17]. This often fuels attrition from HIV prevention and treatment programs as people assume that they are beneficiaries of this cure. Propagation of myths like these without a strong public education implies that the cycle of infections is guaranteed to fester.

Similarly, the criminalization of same-sex relationships through the 2014 Same-Sex Prohibition Act has further expanded barriers faced by the LGBTQ+ communities in accessing care [18]. The current response efforts appear to circumvent this issue and instead employ confidential contact tracing methods to reach men who have sex with men [19,20]. The Federal Ministry of Health, however, acknowledges that the depth of the HIV epidemic among men who have sex with men is not yet fully understood. Even with the NAIIS, it has been suggested that the data does not provide enough information on disease burden in this disenfranchised population [1], limiting the public health response.

Proponents of the current HIV surge approach are quick to point out that the strategies for active case finding and treatment as prevention are based on a large body of evidence [21]. They also point out that these strategies are largely the reason for the progress made with diagnosing the number of PLHIV currently on ART. While these are admittedly factual statements, it is important to note that there is limited evidence of the effectiveness of ICT at scale in the Nigerian context [14].

This progress has also come at a significant cost. Ensuring treatment without addressing the systemic social determinants of HIV has resulted in high program attrition rates with increasing risks for widespread HIV drug-resistant infection [22]. Programs have also incurred high operating costs in funding strategies aimed at identifying cases and retaining patients in care without addressing the social barriers highlighted, such that programs often have limited success [8,22]. More of the same approach would be akin to pouring water into a basket. Certainly, the commitment of the Nigerian government, PEPFAR, and GF-ATM to an AIDS-free generation is laudable. However, these organizations require more pragmatic approaches to achieve the ambitious targets of ending the HIV/AIDS epidemic in Nigeria. The NAIIS findings present an opportunity for a program pivot towards more equitable service delivery. In this light, bold strategies and policies that tackle social and systemic barriers to care for PLHIVs, especially programs and policies that support and protect vulnerable populations including young girls, women, and the LGBTQ+ communities, must be adopted. In addition, significant investments in social and behaviour change communication programs that seek to address stigma and discrimination at all social levels are needed to ensure that all PLHIV can freely seek care without fear of consequences.

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