



HIV Health Sector Program Report 2025

National HIV/AIDS, Viral Hepatitis,
& STIs Control Programme

Federal Ministry of Health and
Social Welfare, Nigeria



FOREWORD

The year 2025 marked a defining moment in Nigeria's sustained commitment to ending the HIV/AIDS epidemic as a public health threat. Against a backdrop of evolving global health financing priorities, the Federal Government of Nigeria demonstrated renewed resolve through the signing of the Five-Year Bilateral Health Cooperation Memorandum of Understanding (MOU) between the United States of America and the Federal Republic of Nigeria on 19th December 2025; a landmark \$5.1 billion co-investment commitment covering the period April 2026 to December 2030. This agreement, under the America First Global Health Strategy, represents the largest co-investment any country has made with the United States in health and signals an era of shared ownership, sustainable domestic financing, and accelerated progress towards epidemic control.

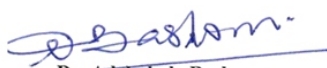
This 2025 HIV Health Sector Report provides a comprehensive account of the progress made within the reporting year, documenting achievements, persistent challenges, and lessons learned across all HIV programme areas: testing services, ART, PMTCT, viral hepatitis, sexually transmitted infections, PrEP, key populations, and programme estimates. The report draws on verified programme data from the National Data and Reporting System (NDARS) and Spectrum modelling outputs to present a credible and evidence-based account of Nigeria's HIV response.

In 2025, Nigeria sustained commendable progress along the HIV treatment cascade. Of people living with HIV (PLHIV) who know their status, 98% were on antiretroviral therapy (second 95), and 95% of those who received a viral load test were virally suppressed (third 95). These results reflect the dedication of frontline health workers, state HIV programme teams, and implementing partners, who have maintained high-quality services despite resource constraints. Significant gaps remain, however. Only 79% of PLHIV know their status (first 95), and viral load testing coverage stands at 74.2% of current ART clients, as at the end of 2025. Closing these gaps, particularly in the paediatric population, is the most critical priority for the 2026-2030 programming cycle.

Under the leadership of the Coordinating Minister of Health and Social Welfare (CMHSW), the year also witnessed significant milestones in HIV estimation and target setting. The 2026 National HIV Program Spectrum Estimation Workshop, held in Keffi, Nasarawa State, in March 2026, produced updated national and sub-national HIV estimates using the Spectrum software, including a projected decline in new HIV infections from 77,241 in 2022 to 63,591, estimated PLHIV of 1,985,284, and 1,550,000 as the PLHIV on treatment, for 2025. These estimates now serve as the epidemiological foundation for Nigeria's 2026 HIV programme targets, which were developed through an inclusive national target-setting workshop held in April 2026.

The findings and recommendations presented in this report reaffirm the unwavering commitment of the Federal Ministry of Health and Social Welfare (FMoHSW) through the National HIV/AIDS, Viral Hepatitis, and STIs Control Programme (NASCP) and the broader HIV response community to achieving epidemic control. As Nigeria enters the 2026-2030 programmatic cycle anchored in the USG-Nigeria Bilateral Health MOU, the focus remains on accelerating progress towards the UNAIDS 95-95-95 targets, closing the paediatric treatment gap, eliminating mother-to-child transmission, and ensuring that no Nigerian is left behind in accessing life-saving HIV services.

I commend the NASCP team, State Ministries of Health, the National Agency for the Control of AIDS (NACA), implementing partners, USG, the Global Fund, UNAIDS, WHO, UNICEF, and all stakeholders whose relentless commitment made the implementation of this programme and the development of this report possible. Together, we continue to build a healthier, more inclusive, and HIV-resilient Nigeria.


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ACKNOWLEDGEMENT

The National HIV/AIDS, Viral Hepatitis, and STIs Control Programme (NASCP) of the Federal Ministry of Health and Social Welfare expresses deep and sincere appreciation to all stakeholders whose collective efforts, technical contributions, and unwavering commitment made the development of the 2025 HIV Health Sector Report possible.

This report is the outcome of a collaborative report writing process that brought together representatives from NASCP, the National Agency for the Control of AIDS (NACA), USG and its implementing partners, Global Fund-supported implementing partners, UNAIDS, WHO, UNICEF, and state HIV programme teams. Their active participation, constructive engagement, and shared dedication to strengthening Nigeria's HIV response were instrumental in producing this comprehensive and evidence-based document.

We acknowledge with gratitude the leadership and guidance of the Director of Public Health, and National Coordinator NASCP, Federal Ministry of Health and Social Welfare, whose strategic direction and institutional support provided the foundation upon which this report was built.

Special recognition goes to the Strategic Information (SI) team of NASCP for their exceptional technical leadership throughout the data analysis, report writing, and validation processes. The rigour, dedication, and professionalism demonstrated by the SI team in ensuring the accuracy, completeness, and credibility of the programme data presented in this report are deeply commended.

We extend particular appreciation to the USG team, Centers for Disease Control and Prevention (CDC), U.S. Department of State (DOS), U.S. Department of Defense (DOD), and their implementing partners, for their sustained technical and financial support to Nigeria's HIV programme. We similarly recognize the critical contributions of the Global Fund and its principal recipients and sub-recipients, whose investments have been foundational to programme scale-up and sustainability.

We acknowledge the UNAIDS Country Office Nigeria for their technical support of the estimation process and national reporting obligations.

Special appreciation also goes to the 36 State AIDS/STIs Control Programmes (SASCPs) and the FASCP, whose diligent data collection, reporting through NDARS, and active participation in national review processes form the backbone of this report. The commitment of state M&E teams and facility-level data officers to data quality and completeness is particularly recognised.

Finally, we recognise the millions of Nigerians living with HIV whose resilience, dignity, and trust in our health systems continue to inspire and motivate all that we do. This report is, ultimately, a testament to their journey and our collective responsibility to serve them better.

Together, we reaffirm our collective resolve to strengthen data-driven HIV programming, improve health outcomes across the HIV cascade, and advance Nigeria's progress towards achieving epidemic control by 2030.



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CHAPTER 1

INTRODUCTION AND BACKGROUND

The National AIDS, Viral Hepatitis and STIs Control Programme (NASCP) is mandated to coordinate the health sector's response to HIV & AIDS in Nigeria. With this mandate comes the critical responsibility of regularly reporting on the progress of the national response to stakeholders across the HIV sector. The global HIV response has evolved significantly over the past decade. According to the UNAIDS 2025 Report, an estimated 1.2million [930,000–1.6 million] people acquired HIV in 2025 — a 44% decrease compared to 2010. Sub-Saharan Africa, which remains the epicenter of the epidemic, saw an even greater 58% decline in new infections during this period. In 2025, approximately 78% [64–91%] of the 40.8 million [37.0 million–45.6 million] people living with HIV globally were on antiretroviral therapy (ART), and 75% [68–84%] had suppressed viral loads — a major global public health achievement. In sub-Saharan Africa, where over 60% of PLHIV reside, access to ART has led to a notable improvement in life expectancy, increasing from 56.6 years in 2010 to 63years in 2025.

Nigeria accounted for about 5% of the global HIV population in 2024, with approximately 2 million individuals living with HIV. The country also bears 5% of the global pediatric HIV burden, with an estimated 65,000 children affected out of 1.3 million globally.

Efforts to reduce HIV infections have yielded notable results. Between 2010 and 2025, Nigeria recorded a 72% decline in new pediatric infections, from 22,001 to 6,172, and a reduction in the overall burden among children by more than 100%, dropping from 158,443 to 65,000.

By December 2025, 1550,000 people living with HIV in Nigeria were receiving ART. The country has made significant progress toward the UNAIDS 95–95–95 targets:

- 79% of PLHIV know their HIV status
- 98% of those diagnosed are on ART
- 94% of those on ART have suppressed viral loads these figures place Nigeria ahead of global averages and reflect strengthened national efforts.
-

However, disaggregated data reveals gaps among key populations, particularly pregnant women, children, adolescents, and young women. New infections remain predominantly driven by unprotected heterosexual intercourse, especially among young unmarried individuals.

Sustainability and Funding Challenges

Despite progress, Nigeria's HIV response faces growing threats due to potential reductions in donor support, particularly the United States President's Emergency Plan for AIDS Relief (PEPFAR). A withdrawal or reduction of PEPFAR funding could severely disrupt HIV treatment and prevention programs in low- and middle-income countries, including Nigeria — potentially reversing years of hardwon progress. To address looming financial challenges and ensure sustainability, Nigeria has initiated the Presidential Comprehensive Response Plan (PCRP). This strategic plan aims to tackle funding, health system, and coordination gaps through a matching grant model, encouraging shared responsibility between federal and state governments. The Federal Government has approved 4.8 billion for:

- Procurement of HIV treatment packs
- Strengthening health systems
- Advocating for increased domestic funding

Efforts are underway to establish an AIDS Trust Fund, while the Federal Ministry of Health and the

National Agency for the Control of AIDS (NACA) are actively engaging development partners to secure and expand domestic financing for HIV prevention and treatment. With a population exceeding 230 million in 2025, Nigeria continues to face a significant HIV burden. While progress is evident, especially in achieving global treatment targets, much work remains to close gaps among vulnerable populations. Sustaining this momentum requires renewed commitment, especially in light of potential funding shifts. Strategic domestic investment, strong leadership, and collaborative partnerships will be crucial to ensuring the long-term success and sustainability of Nigeria's HIV response.

1.1 Coordination and Structure

Governance and Leadership

The health system in Nigeria is structured in alignment with the federal, state, and local government framework, promoting effective financing and coordination. At the national level, the Federal Ministry of Health oversees the comprehensive response to HIV through the National AIDS, Viral Hepatitis, and STIs Control Programme (NASCP). NASCP plays a pivotal role in providing leadership and coordination for the national health sector's efforts to combat HIV, viral hepatitis and STI.

Organizational structure

NASCP is a Division under the Public Health Department of the Federal Ministry of Health and Social Welfare with the mandate to coordinate the health sector response to HIV. It is organized into nine specialized components which are further subdivided into units, strategically designed to enhance program efficiency. The components include Prevention; Treatment, Care and Support, Programme coordination and Administration, Procurement and Supply Chain Management, Laboratory; Advocacy, Communication and Social Mobilization, Strategic Information, Digital health, Hepatitis, and Finance. These components collaborate synergistically, working towards a common goal in accordance with NASCP's mandate.

Coordination mechanism

The National AIDS and STIs Control Programme (NASCP) is fully aligned with the Federal Government's sustainability agenda for the national HIV response. Ongoing efforts are focused on strengthening NASCP's institutional capacity to provide effective leadership and coordination within the division and across relevant stakeholders. NASCP collaborates closely with the National Agency for the Control of AIDS (NACA), the body responsible for coordinating the multi-sectoral response to HIV in Nigeria, in pursuit of a unified national response. To ensure internal effectiveness, NASCP conducts the following routine activities: Heads of Components Meetings, Weekly Component Meetings, Internal Review Meetings, development of Monthly Calendars, and Annual Retreats. For external engagements, NASCP convenes and participates in: Partner Coordination Meetings, National Task Team Meetings, Performance Review Meetings with the 36 States and the FCT, as well as collaborative sessions with stakeholders for the development of key policy documents, including Guidelines, Standard Operating Procedures, National Strategic Plans, Operational Manuals, and Training Toolkits.

State Ministry of Health

At the state level, the state ministry of health through the State HIV/AIDS, Viral Hepatitis, and STIs Control programme (SASCP) coordinates the health sector response to HIV, Viral Hepatitis and other STIs and works with SACA just as its counterpart at the National.

Composition of Health Sector Response in Nigeria

The national health sector response in Nigeria constitutes the largest in the multi-sectoral approach in Nigeria. This includes both formal and informal as well as public (federal, state and LGA), private for profit and private not for profit. Many players work in the national HIV health sector programme contributing in various ways to reduce the burden of HIV in the country. They comprise government organizations, multi-lateral and bilateral agencies and other development partners including

international and local implementing partners. The community-based organizations and the civil societies working in the communities are also making great impact especially in reaching the underserved populations.

National Sustainability and HIV Impact Programme (NSHIP)

NASCP partners with CDC Nigeria to foster a sustainable Nigerian HIV program by working directly with relevant Ministries, Department and Agencies (MDAs) at the national and sub nationals' levels to gradually transfer responsibilities for HIV/AIDS programming and financing to GoN. The program is dubbed "Nigeria Sustainability and HIV Impact Program" (N-SHIP).

The aim of the partnership is to increase the institutional, architectural, and human capacity of national and sub-national units of the HIV health sector response across 36 States and the FCT such that human resource at these levels can efficiently lead, govern, manage and provide the financial, operational and technical capacities in the national HIV/AIDS response to sustain HIV epidemic control. N-SHIP is employing a two-pronged approach

- i. Inter-collaboration which aims to strengthen collaborations with strategic partners and key stakeholders in HIV program implementation and
- ii. Intra-collaboration, which focuses on strengthening capacity and collaborations with Subnational Units via context-driven strategies. In addition, NSHIP adopted seven strategic approaches as shown in Figure 1 to achieve its set aim.



Figure 1. NSHIP Seven Strategic Approaches

Health Sector HIV/AIDS M&E and Surveillance Systems

Nigeria utilizes both paper-based and electronic systems for ART program monitoring and PLHIV management. Currently, three Electronic Medical Records (EMRs)—NigeriaMRS, LAMISPlus, and ViVA—are deployed across various health facilities and One Stop Shops providing ART services. Efforts are underway to expand EMR integration to other thematic areas. Facilities are required to submit monthly HIV service summaries using National Monthly Summary Forms (MSFs), compiled from service registers and EMR data. The National AIDS and STI Control Programme (NASCP) utilizes key innovations in monitoring and evaluation, including

the National Data Repository (NDR), which stores anonymized client level data, and the National Data Reporting System (NDARS), which captures aggregate data from all reporting facilities nationwide.

National Data Reporting System (NDARS)

The National Data Reporting System (NDARS) is an electronic platform built on DHIS2, developed and fully owned by the National AIDS and STI Control Programme (NASCP). It captures data on HIV/AIDS activities from all HIV service delivery points (SDPs), including health facilities and spoke/unconventional sites across the country. NASCP adopted NDARS as the official platform for aggregating health sector responses to HIV, Hepatitis, and STIs. SDPs providing services such as HIV treatment, PMTCT, HIV Testing Services, PrEP, PEP, Hepatitis, and STI management are required to compile data into National Monthly Summary Forms (MSFs) and report aggregate figures via NDARS.

As of December 2024, 36,913 PMTCT SDPs had been registered and fully onboarded on NDARS. State-level personnel have been trained across all 36 states and the FCT. Additionally, 28,691 conventional health facilities have been linked to the National Health Logistics Management Information System (NHLMIS) for PMTCT commodity consumption reporting. Monthly reporting is coordinated by State and LGA M&E Officers for comprehensive and spoke sites, respectively, with technical support from

implementing partners (IPs). Routine data reviews are conducted at the LGA, State, and National levels to ensure data completeness, accuracy, and use for program improvement. The diagram below presents the national health information system architecture for HIV/AIDS data management in Nigeria.

It outlines the structured flow of both individual-level and aggregate data from service delivery points to national platforms and onward to global reporting systems. It also highlights the feedback mechanisms implemented to support data quality and program oversight. HIV Data Flow and Feedback Mechanism Data Generation (Facility Level): Community sites, primary, secondary, and tertiary health facilities serve as the primary sources of HIV data. Facilities with Electronic Medical Records (EMR) submit patient-level data directly to the

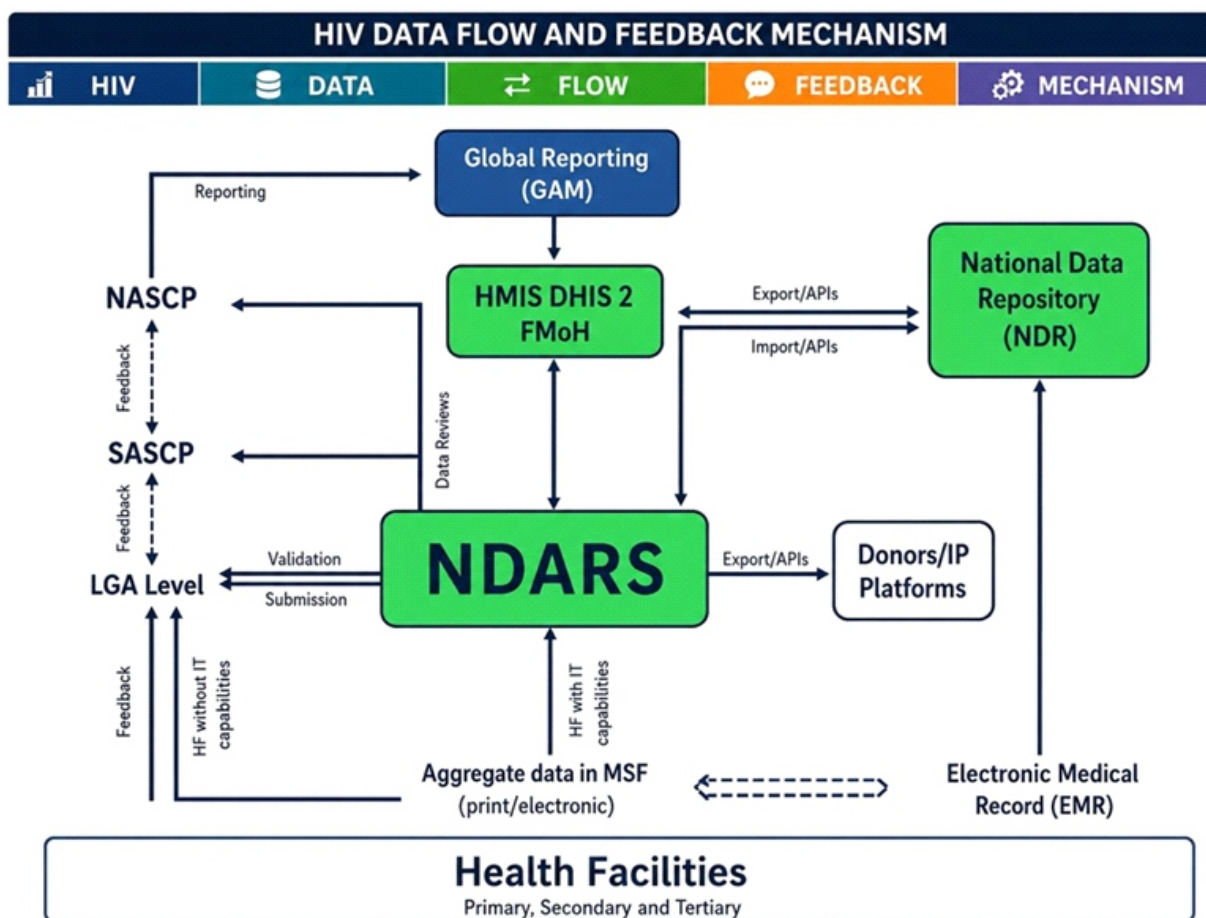


Figure 1. . HIV Data Flow Feedback Mechanism

National Data Repository (NDR)

Facilities with IT capacity aggregate data into Monthly Summary Forms (MSF) and submit electronically or in print to the National Data Reporting System (NDARS), NASCP. Facilities without IT capacity submit paper-based MSFs to NDARS through the Local Government Area (LGA) level. Feedback is provided to these facilities to support reporting quality.

Data Aggregation and Validation

LGA-level officers collect and forward facility-level MSFs to NDARS. NDARS performs data validation and provides feedback to both LGAs and facilities without IT capacity to improve data accuracy and completeness. National Repositories: NDARS receives and validates aggregate data from all reporting facilities. The NDR receives individual-level data from EMR-equipped facilities, performs

deduplication, and transmits validated aggregate data to the National Health Management Information System (NHMIS – DHIS2) through system integrations. National Health Management Information System (NHMIS – DHIS2, DHPRS, FMoH): NHMIS serves as the national platform for the consolidation and analysis of health program data.

It receives validated aggregate data from both NDARS and NDR. NHMIS conducts data reviews and issues feedback to NDARS. It also transmits data to external platforms including donor and Implementing Partner (IP) systems, DATIM, and other stakeholders through API exports. Program Oversight: The National AIDS and STIs Control Programme (NASCP) receives reports from NHMIS/DHIS2, provides oversight, and issues feedback to NASCP and SASCP. SASCPs receive feedback from NASCP to guide state-level implementation and data improvement efforts.

Global Reporting

The Global AIDS Monitoring (GAM) mechanism receives program data from NDARS, ensuring timely and standardized international reporting on HIV indicators. HIV M&E Systems Interoperability with NHMIS The Nigeria Health Management Information System (NHMIS) is the national platform for the collection, management, analysis, and dissemination of health data in Nigeria. It is built on the District Health Information Software 2 (DHIS2), an open-source, web-based health management information system, and serves as the backbone for routine health data reporting across all levels of the health sector.

The National Data Repository System (NDARS), a key component of NHMIS, is used for the submission of aggregate data on a monthly basis from health facilities across the country. It supports reporting for major disease programs and health interventions, including HIV/AIDS. Several standardized forms are available on the NDARS platform, including:

- Antiretroviral Treatment (ART) Monthly Summary Form
- PMTCT Spokes Monthly Summary Form
- Comprehensive PMTCT Monthly Summary Form
- HIV Testing Services (HTS) Monthly Summary Form
- PrEP Monthly Summary Form

Viral Hepatitis Monthly Summary Form Each month, health facility Monitoring and Evaluation (M&E) focal persons compile and complete the relevant paper-based summary forms for the preceding month. These forms are submitted to the Local Government Area (LGA) health office by the 7th day of the current month. At the LGA level, the designated M&E officer enters the submitted data into the NDARS platform by the 14th day of the current month.

Following review, the data is transmitted to the national NHMIS DHIS2 platform through an interoperable Application Programming Interface (API). This reporting structure facilitates timely and standardized data collection and transmission, enabling effective planning, monitoring, and decision-making at all levels of the health system.

Emerging Trends in Surveillance Systems

HIV Surveillance is the ongoing systematic collection, analysis, interpretation, and use of data to improve health determinants and disseminate information regarding HIV/AIDS-related events. In Nigeria, data is collected from client-centered monitoring throughout the cascade of clinical care to guide the national response and understand the trend of the epidemic. As Nigeria approaches epidemic control, three surveillance activities have been key in tracking the epidemic: HIV Recent Infection Surveillance, Casebased Surveillance (CBS), and Mortality Surveillance (MS).

1.2 Program Implementation and Progress Update

1.2.1 Providing Access to HIV Self Testing in Nigeria (Path II) May to December 2025

The National AIDS, Viral Hepatitis and STI Control Programme (NASCP) of the Federal Ministry of

Health, in collaboration with Wondfo and the Clinton Health Access Initiative, implemented the Providing Access to HIV Self Testing in Nigeria (PATH II) project from May to December 2025 across Nassarawa, Ogun, and Kaduna states. Using a Total Market Approach (TMA), the project assessed the market potential, acceptability, and feasibility of blood-based HIV self-testing (HIVST) kits, expanding access beyond the public sector.

Implementation prioritized private sector channels like community pharmacies and Patent and Proprietary Medicine Vendors (PPMVs), alongside targeted community-based organization (CBO) distribution to reach underserved populations. This model successfully reduced pressure on public facilities while improving user confidentiality. Data from May to November 2025 showed a high 93% reporting completeness rate from participating outlets and robust linkage-to-care outcomes for reactive results. These findings provide a strong evidence base regarding demand, provider training, and data capture, justifying the proposed PATHS III scale-up in 2026 to expand geographic coverage and institutionalize HIVST nationwide.

1.2.2 Training of Health Care Workers on the Protocol and Sample Collection Process for HIV 3-Test strategy Verification Study

NASCP, in collaboration with key partners including WHO, IHVN, ECEWS, and NMoD, conducted a two-day training workshop from August 25–26, 2025, in Abuja. The event brought together 36 participants, including representatives from MLSD, MLSCN, NHLTT, and six health facilities spanning Nigeria's six geo-political zones, where samples will be collected.

The workshop trained healthcare workers on the protocol and sample collection processes required for the HIV 3-Test strategy verification study. Key objectives focused on providing a study overview, detailing patient enrollment processes, and updating participant knowledge on conducting testing using the national rapid test kit algorithm. Additionally, the sessions successfully trained participants in specimen collection, processing, storage, packaging, transportation, and crucial quality assurance and biosafety practices for sample management.

1.2.3 National Training of Trainer on Bioline Syphilis Duo, Determine Syphilis TP, Bioline HCV

NASCP, in collaboration with ABBOTT, conducted a comprehensive training initiative to enhance diagnostic skills across Nigeria's six geopolitical zones. The program took place from March 19–21, 2025, in Abuja, and from March 25–28, 2025, in Ikeja, Lagos.

The initiative brought together state HIV laboratory focal persons, Viral Hepatitis focal persons, and PMTCT technical officers. Participants received intensive training on the use of key diagnostic products, specifically BIOLINE SYPHILIS DUO, DETERMINE SYPHILIS TP, and BIOLINE HCV. Additionally, the program featured a dedicated one-day masterclass for state HIV laboratory focal persons, which successfully familiarized them with mPIMA analyzer operations, device maintenance, troubleshooting, and data management systems





1.3 Strategic Interventions on Viral Hepatitis in 2025

1.3.1 The HEAT II Project

completion of the second round of the Hepatitis Evaluation to Amplify Testing and Treatment (HEAT II) Project. Implemented from January 15 to June 24, 2025, in Abia, Bauchi, Niger, and Rivers states, HEAT II was designed to build on the findings of the 2022 HEAT I study, which had revealed significant gaps in hepatitis B testing and treatment capacity. This intervention was critical for generating evidence to guide resource allocation and policy. By assessing current testing and treatment capacity, the project aimed to determine specific needs at facility and community levels and provide concrete recommendations for scaling up services.

1.3.2 Policy, Advocacy, and Mobilization: World Hepatitis Day and the Project 365 Campaign

commemoration of World Hepatitis Day (WHD) on July 28-29, 2025, marked a transformative moment for advocacy and public engagement. Under the global theme of "Hepatitis: Let's Break it Down," Nigeria used this opportunity to dismantle financial, social, and systemic barriers to elimination. The highlight of the commemoration was the official launch of the "Project 365" campaign by the Coordinating Minister of Health and Social Welfare.

"Project 365" represents an ambitious, nationwide initiative designed to bridge critical gaps in viral hepatitis prevention, testing, and treatment. The campaign was conceptualized to create sustained demand and offer services every day of the year, moving beyond sporadic events to achieve population-level impact. The event featured a ministerial press briefing, a road walk for advocacy, and a mass screening exercise. Key outputs included the screening of individuals for HIV, HBV, HCV, and syphilis; the administration of the first dose of the HBV vaccine to eligible persons; and the referral of all individuals who tested positive for any of the four infections to healthcare facilities for appropriate treatment. The event successfully galvanized multiple partners (WHO, CHAI, SFH, Abbott, etc.) and laid the groundwork for the campaign's implementation at all levels.

1.3.3 National TWG and State-Level Engagement

This began with the statutory quarterly National Technical Working Group (NTWG) meeting held from September 10-13, 2025, which brought together national experts to review program progress and provide vital technical guidance. The most significant output of this meeting was the development of the national level implementation plan and roadmap for "Project 365," establishing a definitive blueprint for the campaign's rollout with clear action frameworks, timelines, and resource requirements.

Recognizing that true progress occurs at the sub-national level, the programme then convened a Joint Coordination Meeting with State Focal Persons from November 26–28, 2025, in Kano State. This forum brought state viral hepatitis focal persons and the NTWG together to develop state-level implementation plans for first-tier constituency screening and vaccination outreaches under Project 365. Furthermore, the meeting provided expert clinical advice for the outreaches and facilitated the initial framing of a Viral Hepatitis Elimination Fund (VEF), marking a critical step toward domestic resource mobilization.

1.3.4 The National Summit on Strengthening Viral Hepatitis Response

In tandem with governance updates, NASCP convened a high-level National Summit on Strengthening Viral Hepatitis B & C Response in Nigeria through Greater Involvement of Communities and State Actors on October 23, 2025. This summit strategically engaged State Governors' First Ladies as a powerful constituency for health advocacy in Nigeria. The strategic rationale behind engaging the First Ladies was to mobilize political will and secure domestic resources directly at the state level. By leveraging their leadership and influence, the programme aimed to institutionalize robust hepatitis B and C treatment services and systematically integrate them into existing prevention of mother-to-child transmission (PMTCT) maternal and child health programmes.

1.3.5 National Expanded Prevention of Mother-To-Child (PMTCT)

Toward eliminating mother-to-child transmission of HIV, syphilis, and hepatitis B, the National AIDS, Viral Hepatitis and STIs Control Programme (NASCP), convened the Expanded National Prevention of Mother-to-Child Transmission (PMTCT) Technical Working Group (TWG) meeting on November 5th–7th, 2025. This three-day workshop served as a vital platform for cross-sectoral collaboration, policy validation, and strategic planning, drawing together representatives from government agencies, development partners, and implementing organizations. The deliberations focused on optimizing maternal health systems by integrating Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health (RMNCAEH) directly with PMTCT services.



Additionally, participants explored frameworks to incorporate malaria and tuberculosis interventions within existing antenatal care (ANC) platforms, while simultaneously strengthening data harmonization and monitoring frameworks. The primary milestone of the meeting was the successful review and validation of the National Triple Elimination Framework, Implementation Plan, and Roadmap, alongside the formal adoption of an official meeting communique. The event concluded with a unified commitment to advancing Nigeria's goal of ensuring no mother dies while giving life and no child is born with a preventable infection.

1.3.6 Introduction of Long-Acting Injectable Cabotegravir (CAB-LA) in 2025

PrEP Expansion and Long-Acting Injectable (CAB-LA) Rollout and comprehensive training session were conducted in 2025 for healthcare workers in four Global Fund states: Gombe, Anambra, Kwara, and Ebonyi. The training focused on the protocols and administration of Long-Acting Injectable



Cabotegravir (CAB-LA) to ensure safe and effective delivery at the facility level. Also, a detailed assessment of healthcare facilities was carried out in Lagos State to prepare for the introduction of CAB-LA. This exercise evaluated site readiness, infrastructure, and operational workflows to ensure the clinical environments are fully equipped to support and sustain injectable PrEP services.

1.3.7 National STI Governance and Landscape Assessment

Review of the National STI TWG Terms of Reference

The Terms of Reference (ToR) for the National STI Technical Working Group (TWG) were reviewed to strengthen its governance structure and clarify member roles. This update enhances multisectoral coordination and aligns the group's mandate with national strategic priorities and global guidance for STI prevention, diagnosis, treatment, and surveillance.

Landscape Assessment for STI Services

A comprehensive landscape assessment was conducted to evaluate the availability, accessibility, quality, and integration of STI services across the health system. The exercise successfully mapped programmatic strengths, identified service delivery gaps, and highlighted health system bottlenecks to guide evidencebased planning, resource mobilization, and the scale-up of integrated STI interventions.



1.4 TCS 2025 Activities

1.4.1 Family Index Testing (FIT), NDARS/Health Facility Data Validation Exercise Across 36+1 States February-April, 2025

The National AIDS and STI Control Programme (NASCP), through the TCS component unit, is leading the national implementation of the FIT initiative, which has successfully enlisted over 400,000 index clients on the NDARS platform. To ensure data integrity, field visits were conducted across selected health facilities to validate this FIT data. During these exercises, the team carried out comprehensive data validation and provided expert technical support to strengthen FIT reporting, ultimately driving sustainable improvements in state-level data management

1.4.2 Training of HCWs on Adolescent package of care using Age-Appropriate Disclosure Document held on 14th – 17th April 2025

Building on the Adolescent Package of Care (APOC) document developed in 2022, NASCP continues to focus on strategic interventions to scale up services for adolescents and young persons living with HIV. The document outlines essential guidelines for age-appropriate disclosure, transition to adult care, psychosocial support, sexual and reproductive health, and effective facility-based health services.

To operationalize these strategies, NASCP, with support from the Global Fund, organized a four-day training workshop. The initiative successfully built the capacity of all 36+1 National Clinical Mentors, equipping them with innovative tools to improve adolescent services and retention along the entire clinical service cascade.



1.4.3 Global Alliance Stakeholders' Workshop 5th – 7th May, 2025

To address low testing and treatment coverage among children and pregnant or breastfeeding women living with HIV, Nigeria joined the Global Alliance as a Phase 1 member. Since committing to these global targets, the country has conducted several high-level engagements to translate its political commitments into actionable national strategies.

A major milestone of this commitment is the development of the Country Paediatric Action Plan, which was built using a comprehensive, bottom-up approach. Under this framework, each of the 36 states and the FCT successfully crafted localized implementation plans tailored precisely to address their unique structural gaps and public health priorities.



1.4.4 Paediatric Case Finding Stakeholders' Meeting in Lagos 22nd -26th September 2025

Despite significant strides in the national HIV response, children and adolescents in Nigeria still face major challenges in accessing timely diagnosis and treatment. Although paediatric ART coverage improved remarkably from 29% in 2023 to approximately 74% in 2024, a large number of children living with HIV remain unidentified, untreated, or lost to follow-up.

To bridge these gaps, NASCP and its partners have prioritized the scale-up of innovative paediatric case finding strategies. Key interventions include the Family Index Testing (FIT) model to identify biological children of HIV-positive adults, line listing, Provider-Initiated Testing and Counseling (PITC), and intensified community testing via high-risk mapping. Efforts also include expanding Early Infant Diagnosis (EID) using Point-of-Care (POC) platforms like mPIMA and integrating testing into general child health services. However, persistent bottlenecks in commodity supply, service continuity, data utilization, and stakeholder coordination continue to challenge full-scale, sustainable implementation.

1.5 Activities Carried out by Strategic Information Unit

1.5.1 Revision of National HIV Monitoring and Evaluation Tools

The M&E Unit coordinated the comprehensive review and revision of the National HIV Monitoring and Evaluation tools to align with updated national guidelines, programmatic priorities, and reporting requirements. The exercise harmonized indicators across HIV programme areas and improved data collection processes.



1.5.2 Development of the Harmonized Indicator Reference Sheet (IRS)

The unit led the development and validation of the revised Indicator Reference Sheets to standardize indicator definitions, computation methods, reporting frequency, disaggregation, and data sources across implementing partners and states.



1.5.3 Development of the Revised HIV M&E User Guide

A comprehensive User Guide was developed to provide standardized guidance on completing the revised M&E tools, interpretation of indicators, reporting procedures, and data management processes.

1.5.4 Development of Standard Operating Procedures (SOPs) for HIV M&E Tools

Standard Operating Procedures were developed to promote uniform implementation of the revised HIV M&E tools and strengthen data quality assurance throughout the reporting cycle.

1.5.5 Revision of National HIV Indicators

The unit reviewed and updated national HIV programme indicators, incorporating new interventions, revised age disaggregations, and reporting requirements to improve programme monitoring and alignment with global standards.

1.5.6 Pilot Implementation of the Revised HIV M&E Tools

Pilot implementation of the revised tools was conducted in selected states and facilities to assess usability, identify implementation challenges, and generate recommendations before national rollout.

1.5.7 National Training on Revised HIV M&E Tools

The M&E Unit coordinated national-level training for state M&E officers, implementing partners, and programme managers to strengthen understanding and implementation of the revised monitoring and evaluation tools.

1.5.8 Supportive Supervision and Data Quality Monitoring

Routine supportive supervision and data quality assessments were conducted to improve reporting accuracy, strengthen adherence to national reporting standards, and identify areas requiring technical support.

1.5.9 Annual HIV Programme Performance Analysis

The M&E Unit analysed national HIV programme data to assess performance against annual targets,

identify trends across programme areas, and provide evidence to support strategic planning and decision making.



CHAPTER 2

HIV TESTING SERVICES

2.1 Background

Nigeria continues to scale up a comprehensive HIV prevention programme aimed at reducing new infections and improving health outcomes among key and vulnerable populations. These populations include adolescents and young people, pregnant and breastfeeding women, sex workers, people who inject drugs (PWID), men who have sex with men (MSM), transgender persons, individuals in correctional and confined settings, and HIV-exposed infants.

The national prevention strategy focuses on expanding access to HIV Testing Services (HTS), Prevention of Mother-to-Child Transmission (PMTCT), Gender-Based Violence (GBV) response services, and Pre-Exposure Prophylaxis (PrEP). Injectable PrEP (Cabotegravir) was introduced into the country and piloted in some States to better understand the workings of the new medication, providing alternatives for PrEP delivery.

HIV testing services are increasingly being integrated into routine healthcare delivery across multiple service points, with emphasis on priority populations and high-yield testing approaches such as index testing, social network testing, provider-initiated testing and counselling, and HIV self-testing, while expanded community testing was implementation reduced during this period.

Pregnant women are routinely offered HIV testing during antenatal care visits, while those diagnosed with HIV are promptly linked to antiretroviral treatment services. This is complemented by Early Infant Diagnosis (EID) and continued follow-up care for HIV-exposed infants. Similarly, GBV services, including post-exposure prophylaxis, psychosocial support, mental health services, and legal referrals, are being strengthened within both facilities and communities.

Nigeria continued to deliver PrEP services, which was partly interrupted by the USG Stop Work Order, which redirected prevention activities. Community testing became more targeted with a decrease in expanding testing (outreaches), and PrEP service delivery was targeted to pregnant and breastfeeding women, excluding other general population and key populations in the country. To normalize PrEP services, NASCP championed the supply of oral PrEP to facilities across the country, ensuring that all other general and key populations have access to oral PrEP services.

2.2 HIV Testing Services

Testing Services (HTS) serve as the critical entry point to the HIV prevention, treatment, care, and support continuum. In Nigeria, HTS is delivered using a client-centred approach based on the internationally recognised 5Cs principles: Consent, Confidentiality, Counselling, Correct Test Results, and Connection to appropriate prevention, treatment, and care services. HTS includes pre- and post-test counselling, confidential HIV testing, disclosure of results, and referral to relevant prevention and treatment services. To support comprehensive, integrated healthcare, HTS is also combined with screening for tuberculosis (TB), sexually transmitted infections (STIs), and viral hepatitis, facilitating early diagnosis, timely referral, and improved health outcomes.

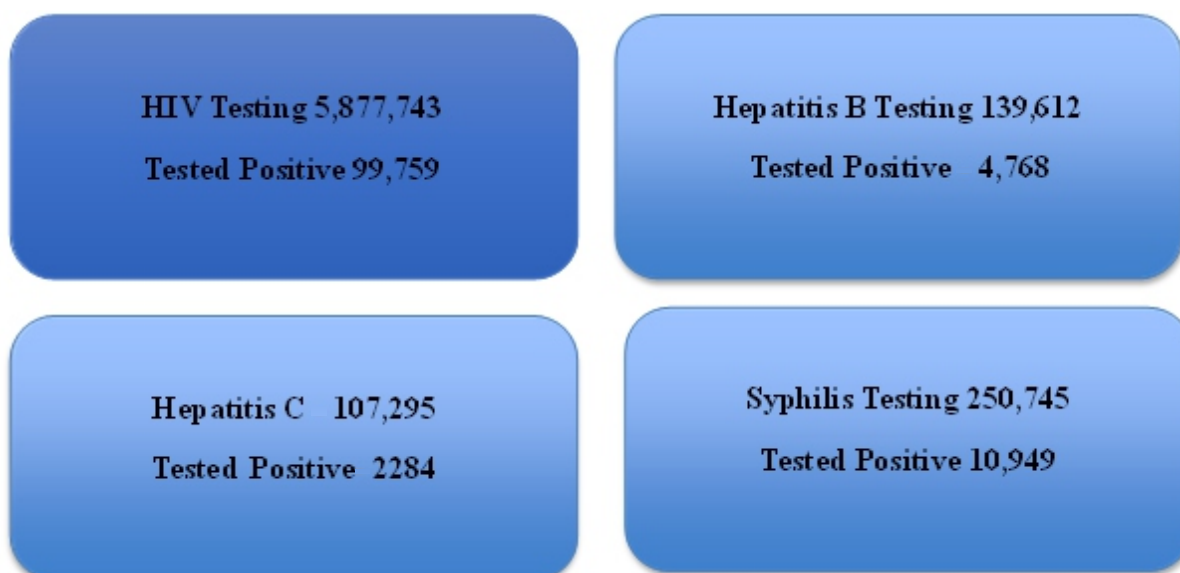


Figure 2.1 2025 Key Performance Indicators for Case Finding showing Integration of Syphilis, Hepatitis B & C alongside HTS

To accelerate progress towards HIV epidemic control, Nigeria has adopted innovative HIV testing strategies, including HIV self-testing, index testing, social network testing, and recency testing, to expand access among underserved and hard-to-reach populations. These approaches have significantly improved case identification and linkage to care. In addition, integrating syphilis and hepatitis B and C screening into HIV Testing Services (HTS) has strengthened comprehensive service delivery, enhanced case-finding efficiency, and advanced the country's efforts towards the triple elimination of HIV, syphilis, and hepatitis B mother-to-child transmission.

In 2025, a total of 5,877,743 individuals received HIV Testing Services (HTS), with 99,759 testing positive for HIV, yielding a positivity rate of 1.7%. Despite maintaining broad testing coverage, HIV positivity yields remained relatively low, highlighting the importance of further refining targeted case-finding strategies, improving testing efficiency, expanding integrated screening services, and sustaining evidence-based interventions to advance the elimination of HIV, hepatitis B, and syphilis as public health threats.

2.2.1 National HTS Achievement

In 2025, a total of 5,877,743 individuals received HIV Testing Services (HTS), with 99,759 testing positive for HIV, yielding a positivity rate of 1.7% against 1.6% in 2024. Furthermore, this represents a 19% reduction in HTS volume (1,390,241) and a 17% decline in HIV-positive cases identified (19,944) when compared to 2024. The incidence of SWO resulted in a shift from expanded community testing to more targeted, risk-based testing approaches. During the same period, 139,612 individuals were screened for hepatitis B, with 4,768 testing positive, while 107,295 were tested for hepatitis C, yielding 2,284 positive cases. In addition, 250,745 individuals were screened for syphilis, of whom 10,949 tested positive. All individuals diagnosed with HIV, hepatitis B, hepatitis C, or syphilis were linked to and initiated on appropriate treatment.

The observed decline in testing volume may be attributable to factors such as the incidence of SWO, which resulted in suspension of work for a period of time, and a shift from expanded community testing to more targeted, risk-based testing approaches. Targeted testing approaches and improved case-finding efficiency.

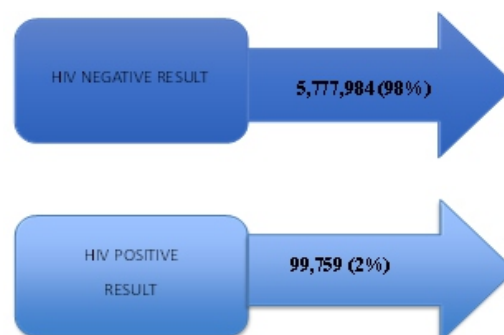


Figure 2.2 2025 National HTS Achievement

2.2.2 Trend in HIV Testing Services

Analysis of HIV Testing Services (HTS) data from 2021 to 2025 demonstrates significant changes in Nigeria's HIV testing programme. The highest testing volume was recorded in 2023, when 11,041,658 individuals were tested. Following the implementation of more targeted, risk-based HIV testing strategies, the number of individuals tested declined to 7,267,423 in 2024 and further to 5,877,743 in 2025.

Despite the reduction in testing volume, HIV positivity continued to decline over the five-year period. The positivity yield decreased from 4.0% in 2021 to 2.8% in 2022 and 1.4% in 2023, before increasing slightly to 1.6% in 2024 and 1.7% in 2025. Overall, the positivity yield declined by 57.5% between 2021 and 2025, reflecting sustained progress in HIV epidemic control while maintaining a more efficient, targeted approach to case finding.

The number of individuals diagnosed with HIV also declined substantially, from 306,489 in 2021 to 99,759 in 2025, representing a 67.5% reduction over the five-year period. This trend coincides with the scale-up of comprehensive HIV prevention interventions, including condom programming, pre-exposure prophylaxis (PrEP), social and behaviour change interventions, prevention of mother-to-child transmission (PMTCT), and other targeted prevention strategies aimed at reducing new HIV infections. Between 2023 and 2025, the total number of individuals tested decreased by 46.8% (from 11,041,658 to 5,877,743). This reduction reflects the strategic transition from broad-based testing to more focused, risk-based HIV testing approaches that prioritize testing among populations with a higher likelihood of HIV infection, thereby improving programme efficiency while sustaining case identification.

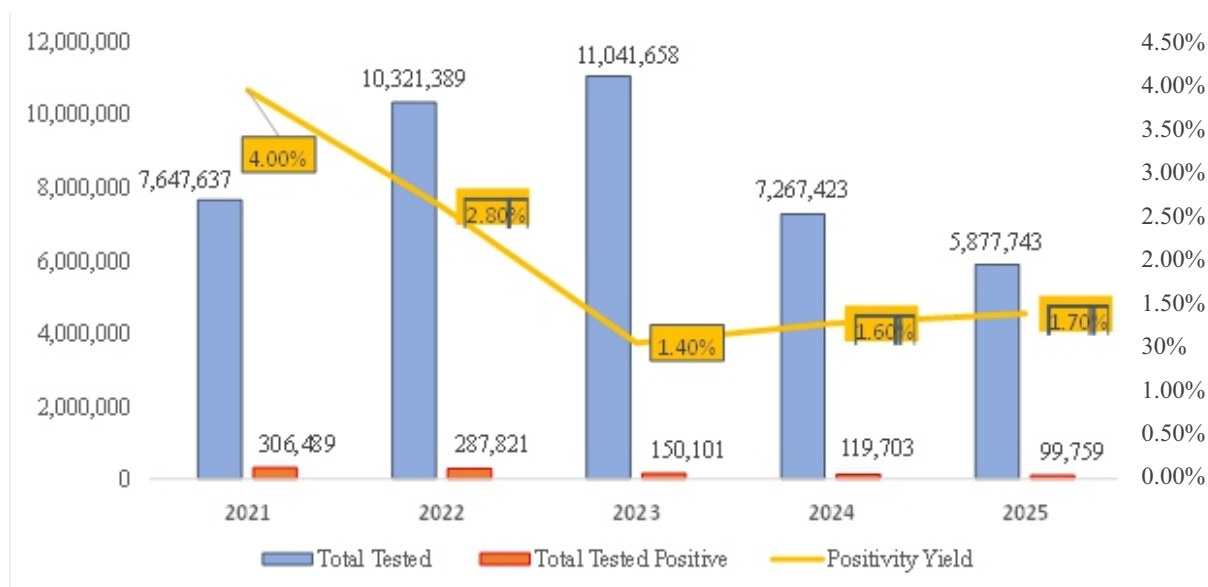


Figure 2.3 Yearly Trend in HIV Testing Services

The number of individuals diagnosed with HIV decreased substantially, from 306,489 in 2021 to 99,759 in 2025, representing a 68% reduction. This decline mirrors the sustained decrease in HIV positivity rates over the same period and reflects continued progress towards HIV epidemic control through strengthened prevention interventions, targeted case-finding strategies, and improved linkage to care. The lower HIV testing volume recorded in 2025 compared with previous years is likely attributable to the adoption of more targeted, risk-based testing approaches, enhanced case-finding efficiency, and earlier identification of people living with HIV among priority populations, resulting in more efficient use of testing resources while maintaining programme effectiveness.

2.2.3 First 95: Knowledge of HIV Status

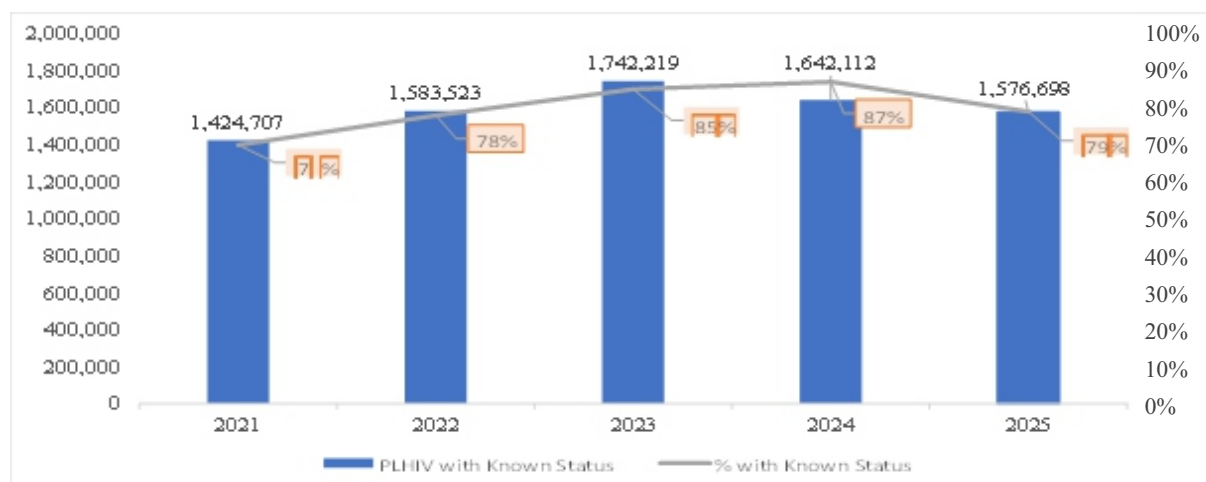


Figure 2.4 Trend in PLHIV Known Status

Knowledge of HIV status remains the cornerstone of the UNAIDS 95-95-95 targets and serves as the critical entry point to HIV treatment, care, and prevention services. Between 2021 and 2025, Nigeria made substantial progress in increasing the proportion of people living with HIV (PLHIV) who were aware of their HIV status. The number of PLHIV with known HIV status increased from 1,424,707 (70%) in 2021 to a peak of 1,742,219 (85%) in 2023, demonstrating significant improvements in HIV case identification and diagnosis. Although this declined to 1,642,112 (82%) in 2024 and 1,576,698 (79%) in 2025, nearly four out of every five PLHIV in Nigeria were aware of their HIV status in 2025.

The slight decline observed between 2023 and 2025 should be interpreted within the context of annual revisions to national HIV estimates. The first UNAIDS 95 indicator is derived from Spectrum model estimates, which incorporate multiple programme and surveillance variables, including the number of people currently receiving antiretroviral therapy (ART), HIV testing data, mortality estimates, and demographic information. Consequently, revisions to these inputs, particularly updated ART programme data and Spectrum assumptions, may influence both the estimated number of PLHIV and the proportion who know their HIV status. Therefore, the observed decline does not necessarily indicate a deterioration in programme performance.

The sustained improvement in knowledge of HIV status over the five-year period reflects the continued expansion and effectiveness of Nigeria's HIV response. Investments in targeted HIV testing services, community-based and facility-based testing, HIV self-testing, early infant diagnosis (EID), partner notification services, strengthened surveillance systems, and public awareness initiatives have contributed to earlier diagnosis and improved identification of people living with HIV. These interventions have strengthened linkage to treatment and care while reducing the number of individuals living with undiagnosed HIV infection.

Knowledge of HIV status remains fundamental to achieving epidemic control. Individuals who know their HIV status can be rapidly linked to antiretroviral therapy, leading to improved health outcomes and viral suppression. Achieving and maintaining viral suppression not only improves survival and quality of life but also prevents onward HIV transmission through the principle of Undetectable = Untransmittable (U=U).

Despite the progress achieved, Nigeria remains below the UNAIDS first 95 target, with 79% of PLHIV estimated to know their HIV status in 2025. This indicates that approximately 21% of people living with HIV remain undiagnosed or unaware of their infection. Closing this gap will require sustained implementation of targeted and differentiated HIV testing strategies, expansion of community-led

and index testing services, wider availability of HIV self-testing, intensified stigma reduction efforts, and strengthened linkage to treatment services. Continued investment in these interventions will be essential to achieving the first UNAIDS 95 target and advancing Nigeria towards HIV epidemic control.

2.2.4 HIV Testing Service by Testing Sites

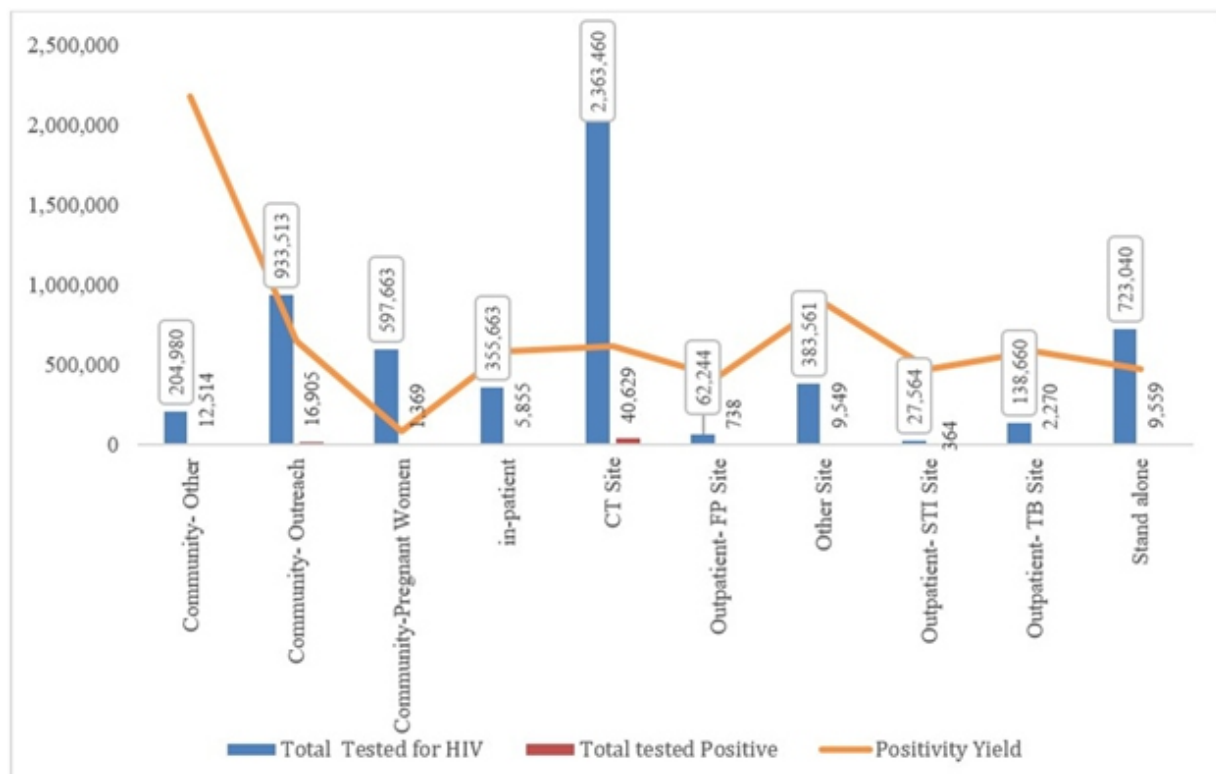


Figure 2.5 HIV Testing by Sites

Analysis of HIV testing and case identification across various testing points in 2025 reveals significant variation in testing volumes and positivity yields. Outpatient CT sites recorded the highest testing volume, with 2,404,089 individuals tested and 40,629 HIV-positive cases identified, yielding 1.6%.

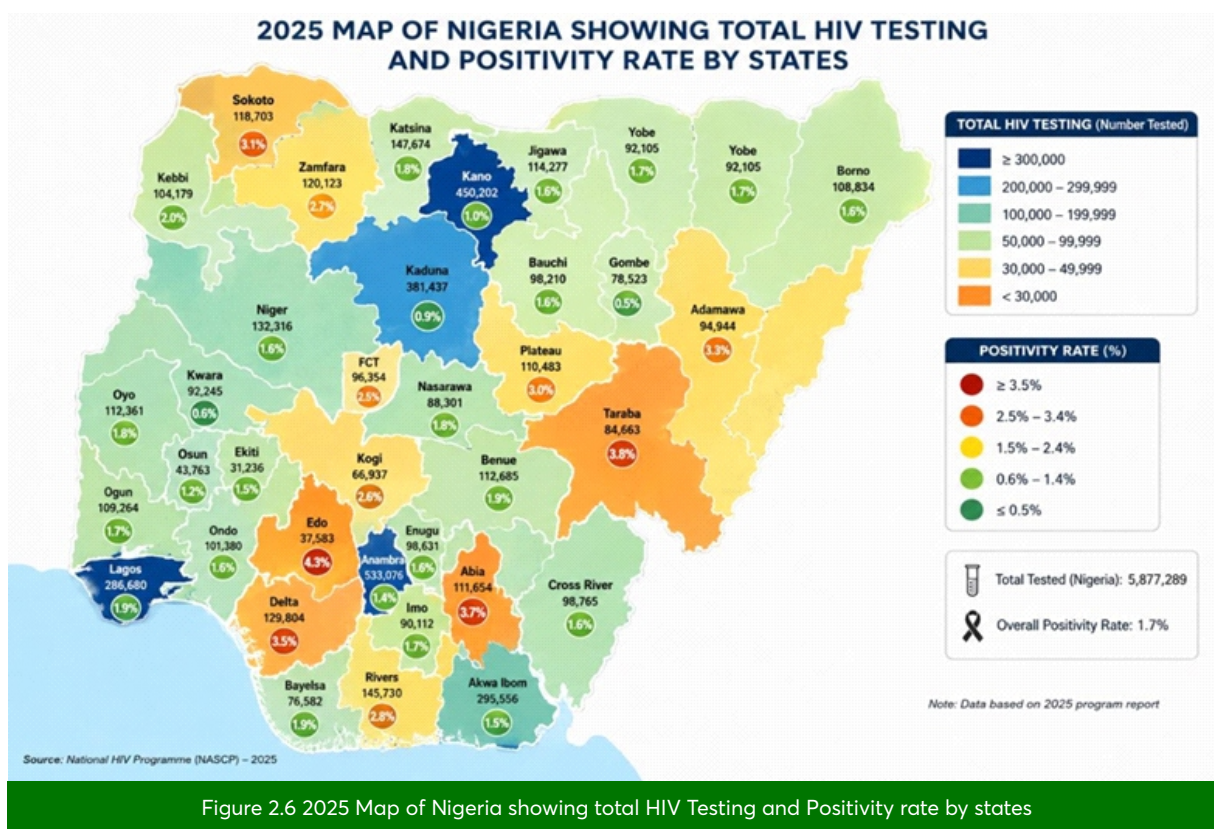
Community outreach sites followed closely, testing 1,744,474 individuals and identifying 27,836 positives at a yield of 1.7%. Stand-alone sites tested 732,599 individuals and identified 9,559 positives (1.3% yield). Inpatient settings accounted for 361,518 tests and 5,855 positives (1.6% yield).

Outpatient other sites, despite moderate testing volume (393,110), identified 9,549 positives with a yield of 2.4%. Notably, community-other testing points, though testing only 204,980 individuals, recorded 12,514 positive cases, the highest yield at 6.1%. Outpatient TB sites tested 140,930 individuals and found 2,270 positives (1.6% yield). Among pregnant women tested in community settings, 599,032 were screened with 1,369 positives (0.2% yield). Outpatient family planning sites tested 62,982 individuals (738 positives, 1.2% yield), while outpatient STI sites conducted 27,928 tests with 364 positives (1.3% yield).

Outpatient CT sites contributed the largest share of testing volume (41%) and absolute positive cases (41%), followed by community outreach sites (16% of tests, 17% of positives).

However, community-other sites recorded the highest positivity yield at 6.1%, reflecting a strategic paradigm shift toward community-based testing as an efficient case-finding approach. Outpatient-other sites also demonstrated a yield at 2.4%. TB, FP, and STI service delivery points recorded commendable yields, underscoring the importance of maintaining and scaling up HIV testing services across these platforms to optimize case identification and strengthen epidemic control efforts.

2.2.5 HIV Testing and Positivity Rate by States



In 2025, HIV testing across the states varied significantly in both volume and positivity rates. Anambra State recorded the highest number of HIV tests with 533,076 tested, Kano recorded 450,202 individuals tested, followed by Kaduna (381,437), Akwa-Ibom (295,556), and Lagos (286,680). In contrast, Ekiti State had the lowest testing volume with 31,236 tests, followed by Edo (37,583), Osun (43,763) and Kogi (66,937).

Notably, Lagos, which reported the highest number of tests in 2024 (627,182) now experienced a marked decline in testing volume in 2025. Analysis of positivity rates revealed a different pattern. Edo State recorded the highest positivity rate at 4.3%, followed by Taraba (3.8%), Abia (3.7%), Delta (3.5%), Adamawa (3.3%) and Sokoto (3.1%), Plateau (3.0%) Rivers (2.8%) and Zamfara (2.7%). The Federal Capital Territory (FCT) reported a positivity rate of 2.5%. Kano and Kaduna State, having the highest number of tests, recorded a low positivity rate of 1.0% and 0.9% respectively. The lowest positivity rates were recorded in Gombe (0.5%) and Kwara States (0.6%).

These findings highlight the need for differentiated HIV case-finding strategies tailored to state-specific epidemiological profiles. States with high positivity rates but relatively low testing volumes such as Taraba, Abia, Kogi, Delta, and Adamawa require intensified testing efforts to reach undiagnosed populations. In contrast, states with high testing volumes but low positivity yields, notably Kano, would benefit from targeted approaches like index case testing and provider-initiated testing and counselling (PITC) to maximize new case identification in absolute numbers. Similarly, states with moderate testing volumes and high positivity rates including the Federal Capital Territory and Rivers demand focused interventions to address ongoing transmission dynamics and strengthen epidemic control.

Overall, the data underscores the critical importance of implementing differentiated testing strategies across diverse settings. Approaches such as index testing, key population outreach, geospatial hotspot mapping, and community-based testing are essential to optimize HIV detection and ensure effective

linkage to care. Tailoring interventions to local epidemiological contexts will enhance efficiency, reduce missed opportunities, and accelerate progress toward national HIV epidemic control goals.

2.2.6 Key Population Testing

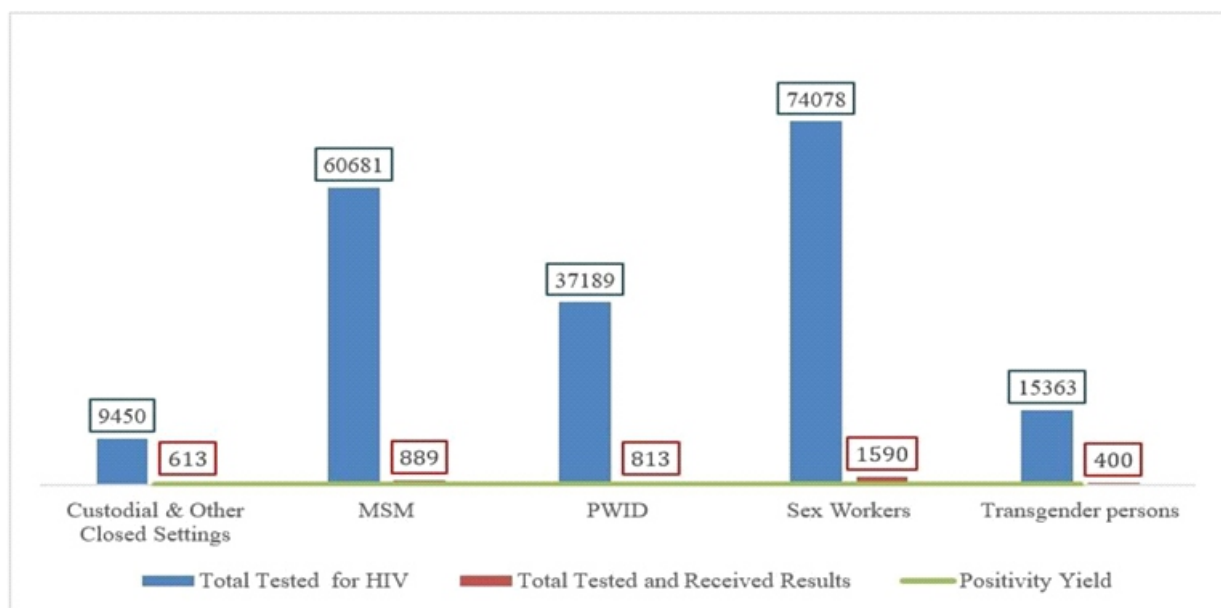


Figure 2.7 Case Finding among Key Population

Among key populations, female sex workers recorded the highest testing volume, with 74,078 individuals tested and 1,590 positive cases identified, yielding 2.1%. Men who have sex with men accounted for 60,681 tests, with 889 positive results and a yield of 1.5%. People who inject drugs underwent 37,189 tests, yielding 813 positive results at 2.2%. Persons in prisons and closed settings recorded the highest yield at 6.5%, with 613 positives from 9,450 tests. Transgender individuals had 15,363 tests, yielding 400 positive results at 2.6%. Overall testing volume among key populations declined by over 50% for both female sex workers and men who have sex with men. This substantial reduction is likely attributable to decreased expanded HIV testing services targeting these sub-populations, potentially reflecting shifting programmatic priorities, funding constraints, or reduced outreach activities. The decline is concerning given the elevated HIV burden and continued transmission risks within these groups, underscoring the need to sustain and prioritize key population testing as a critical component of epidemic control strategies. Maintaining robust testing coverage among key populations remains essential to reach undiagnosed individuals, ensure timely linkage to care, and reduce onward transmission in high-risk networks.

2.3 HIV Testing Strategies

Nigeria implemented a range of innovative HIV testing strategies to improve HIV case identification, strengthen linkage to care, and support timely initiation and retention on antiretroviral therapy (ART). These include index testing among biological children and sexual partners of people living with HIV (PLHIV), couples testing to promote mutual disclosure and treatment uptake, and HIV self-testing to expand access through confidential and convenient testing options. Recency testing was used to identify possible clusters of infection and guide targeted public health interventions, while sexual network testing facilitates case finding within the social and sexual networks of HIV-positive individuals. In addition, targeted community and facility provider-initiated testing and counselling approaches were employed to reach key and priority populations. HTS was targeted at age bands with high positivity rates across the male and female gender ensuring increase in testing coverage across age bands. Collectively, these strategies have enhanced the efficiency of HIV case finding and contribute to Nigeria's progress towards achieving the UNAIDS 95-95-95 targets.

2.3.1 HIV Self-Testing

Nigeria adopted the HIV Self-Testing (HIVST) strategy in 2017 through the development of the National HIV Self-Testing Guidelines and the evaluation of HIVST kits. HIVST enables individuals to collect their own specimen (oral fluid or blood), perform the test, and interpret the results privately, either independently or with support from a trusted person. The approach has demonstrated high acceptability across diverse population groups, including key populations, the general population, pregnant women, and their male partners. By expanding access to confidential and convenient HIV testing, HIVST is expected to accelerate progress towards the UNAIDS 95-95-95 targets. It also increases testing uptake among firsttime testers, individuals with undiagnosed HIV, and those at substantial risk of infection who require regular retesting.

The presented chart above illustrates a quantitative distribution across the various states within Nigeria and the Federal Capital Territory.

The data is depicted using a bar graph format, with each bar representing a specific state and its height corresponding to a numerical value. Anambra State had the highest distribution of the HIVST kits (141,396) and this was followed by Kwara (55,330), Gombe (35,239) and Ebonyi (29,269). The other States had distribution numbers as Abia (537), Adamawa (2,838), Akwa-Ibom (20,444), Bauchi (104), Bayelsa (170), Benue (9,203), Borno (155), Cross-River (21,308), Delta (426), Ebonyi (29,269), Edo (1,782), FCT (2,762), Jigawa (309), Kebbi and Sokoto had no distributions, Zamfara (286), Taraba (5,696), Osun (1,306), Oyo(3,186), Plateau (7,182) just to mention a few.

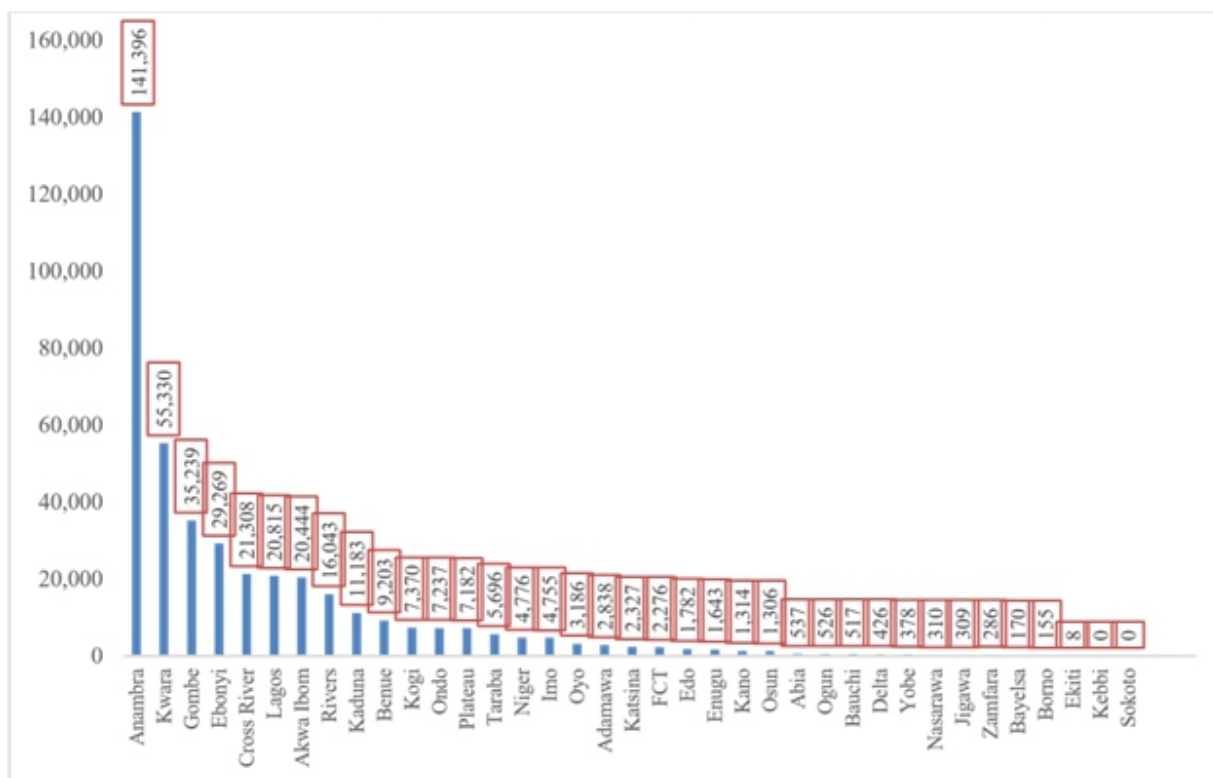


Figure 2.8 HIVST kits distribution in 2025

A total of 417,540 individual HIVST kits were distributed in 2025, representing a 75.8% (180,015) change in comparison to 2024. About 62% (257,350) of which were via the assisted testing approach, and 38% (160,190) via the unassisted testing approach.

The specific indicator represented by these values is not identified in the chart. Based on the magnitude and geographic distribution, they may represent counts, rates, or other quantitative measures related to public health, demographics, programme performance, or socioeconomic

indicators across Nigerian states. However, because the vertical axis is not labelled and the units of measurement are not specified, the exact meaning of the values cannot be determined. Despite this limitation, the chart clearly illustrates substantial variation in the measured indicator across the states, highlighting geographic disparities in the distribution of the underlying metric.

2.3.2 Recency Testing

HIV Recency Testing is a key component of Nigeria's national HIV response, providing laboratory-based evidence to identify individuals who acquired HIV within the previous 12 months. By distinguishing recent from long-standing infections, recency testing generates valuable information on current HIV transmission dynamics, enabling the identification of transmission hotspots and populations at increased risk. These insights support targeted prevention interventions, strengthen surveillance, and improve the strategic allocation of resources. In addition, recency testing informs programme planning by identifying areas with ongoing transmission, thereby enhancing the effectiveness of public health responses aimed at reducing new HIV infections. Recency testing was discontinued across the country following the SWO as the USG funding no longer supports its implementation. During the reporting period, very few sites in the country reported recency testing numbers to the NDARS. These numbers constituted a runoff of existing stock of Asante to prevent expiration. A total of 524 recent cases were identified across the country, and 1,518 were reclassified long-term cases. With the planned introduction of standard Q rapid test kits, recent/acute HIV infection surveillance will continue to be implemented in the country.

2.3.3 Linkage to Treatment

Prompt linkage to care for newly diagnosed people living with HIV (PLHIV) remains a core standard of HIV testing services and a fundamental component of the HIV care continuum. Ensuring that individuals diagnosed with HIV are rapidly linked to treatment and care services is essential for improving health outcomes, reducing HIV-related morbidity and mortality, and preventing further HIV transmission. Delays in linkage to care increase the risk of loss to follow-up, disease progression, and missed opportunities for early initiation of antiretroviral therapy (ART). Evidence consistently demonstrates that early ART initiation improves survival, enhances quality of life, and facilitates viral suppression, thereby benefiting both individual and public health. Effective linkage to care reflects a well-coordinated referral system that enables newly diagnosed individuals to enroll in treatment without unnecessary delays. It also demonstrates strong collaboration among HIV testing sites, treatment facilities, community-based organizations, and case management systems. Achieving high linkage rates requires standardized referral protocols, adequately trained healthcare workers, robust patient tracking systems, and community-based support mechanisms that facilitate treatment initiation and retention. Strengthening linkage to care remains critical for achieving national HIV programme goals and the UNAIDS 95-95-95 targets.

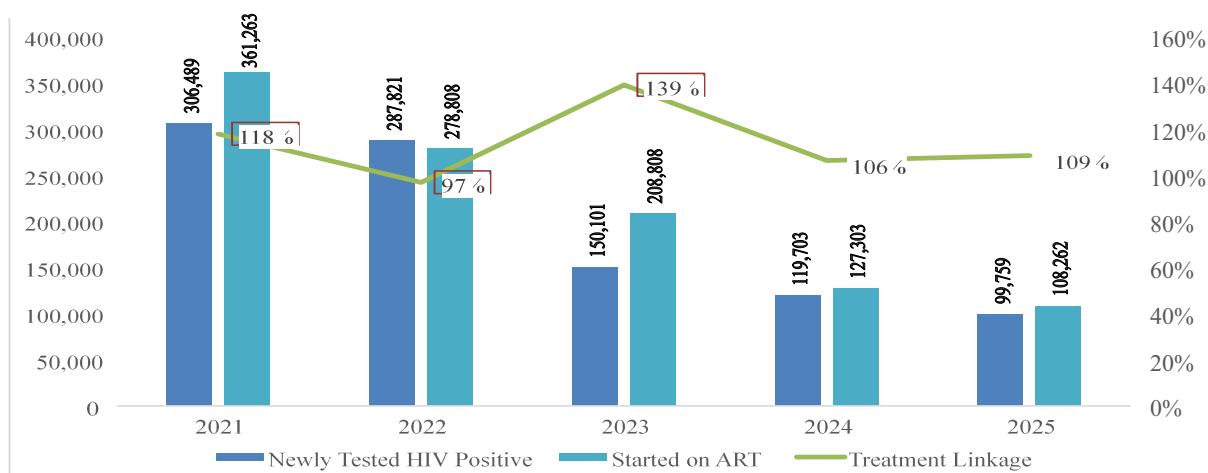


Figure 2.9 Linkage to Treatment

Between 2021 and 2025, Nigeria recorded sustained progress in expanding knowledge of HIV status among PLHIV. The number of PLHIV with known HIV status increased from 1,424,707 in 2021 to 1,576,698 in 2025. These improvements demonstrate the effectiveness of HIV testing services, strengthened surveillance systems, and expanded access to HIV diagnosis. In contrast, the number of newly identified PLHIV declined from 306,489 in 2021 to 99,759 in 2025, while the number of individuals initiating ART (TX_New) decreased from 361,263 to 108,262 over the same period. Both indicators peaked in 2021 before declining in subsequent years. The ratio of TX_New to newly identified PLHIV fluctuated during the review period, exceeding 100% in 2021 (118%), 2021 (118%), and 2023 (139%), declining to 97% in 2022, 98% in 2024 and peaked again in 2025 (109%). Numbers above 100% linkage rate indicate that, there are facilities not reporting to that national platforms such as private hospitals that refer positive clients to Government facilities to access ART, paediatrics diagnosed with EID testing (testing data not reported in the conventional way as adults in the HTS register). This is in addition to treatment programmes successfully initiating ART among previously diagnosed persons who had not yet enrolled in care, reflecting intensified efforts to close treatment gaps. Conversely, ratios close to 100% suggest prompt linkage of newly diagnosed individuals to treatment.

The decline in newly identified PLHIV should be interpreted alongside Nigeria's transition to more targeted, risk-based HIV testing strategies. Rather than reflecting reduced programme performance, fewer new diagnoses likely indicate improved testing efficiency, increased saturation of testing among high-risk populations, and declining HIV incidence resulting from strengthened prevention interventions. Overall, the findings demonstrate substantial progress in HIV diagnosis and linkage to treatment while underscoring the importance of sustaining targeted case-finding strategies, rapid ART initiation, and continuous monitoring to identify undiagnosed individuals and accelerate progress towards HIV epidemic control.

CHAPTER 3

HIV TREATMENT

3.1 Background

The National AIDS, Viral Hepatitis, and STI Control Programme (NASCP), in collaboration with all relevant partners, has led the implementation of a range of strategic interventions aimed at enhancing access to quality HIV services.

In 2025, to sustain and consolidate data quality for effective program planning and implementation, including clinical quality - the country strengthened and scaled several key measures. These included Patient Biometric Services (PBS), triangulation of antiretroviral (ARV) consumption data, and routine Data Quality Assessments (DQAs). Additionally, an AIDS Indicator Survey conducted across two subnational units triggered intensified ART client verification processes. The implementation landscape was further impacted by a temporary Stop Work Order, which paused routine facility activities and prompted an immediate operational focus on thorough data reconciliation and client deduplication. Collectively, these interventions were designed to enhance the reliability of treatment data at the individual client level and verify the actual number of people actively receiving antiretroviral therapy (ART). By the end of 2025, a total of 1,550,000 unique clients on ART had been validated, reflecting the impact of these rigorous verification protocols and marking a marginal decline from the 2024 figure.

Key strategies employed by NASCP and its partners to drive quality HIV service delivery included the implementation of Differentiated Service Delivery (DSD) models across both facility and community settings, strengthened coordination at national and state levels, expanded support for pediatric and adolescent HIV programming, and the nationwide scale-up of the Advanced HIV Disease (AHD) package of care. The National Guidelines for HIV Prevention, Treatment, and Care continue to emphasize interventions that enhance client retention and overall quality of care.

Furthermore, several capacity-building and service-optimization initiatives were carried out, including inter-state learning exchange visits, integration of HIV services, annual programmatic reviews of DSD implementation, and ongoing capacity strengthening for healthcare workers. These efforts were instrumental in improving HIV treatment outcomes and promoting increased ownership and engagement among healthcare providers and PLHIV. Additionally, the fixed-dose combination of ritonavir-boosted darunavir (DRV/r 400/50 mg) was further scaled up and sustained for use in second-line ART, following the availability of its generic formulation, and was distributed across all 36 states and the Federal Capital Territory (FCT).

Nigeria made notable progress towards achieving the UNAIDS global 95-95-95 targets. At the end of 2025, the validated data indicated that 79% of people living with HIV (PLHIV) were aware of their HIV-positive status, with about 98% of PLHIV with known HIV-positive status receiving ART, and 94% of PLHIV on treatment achieved viral suppression.

3.2 Access to ART Services

The National AIDS, Viral Hepatitis, and STIs Control Programme (NASCP), in collaboration with key national and international stakeholders, has sustained and optimized strategic efforts to guarantee uninterrupted access to lifesaving antiretroviral therapy (ART) across all 36 states and the Federal Capital Territory (FCT).

Currently, the national response supports a robust network of 2,027 comprehensive ART sites. This

footprint spans primary, secondary, and tertiary health facilities, as well as decentralized community-based service delivery models strategically mapped nationwide. This multi-tiered delivery architecture is deliberately designed to reduce geographic and structural barriers to care, thereby driving equitable access and improving long-term client retention.

To align with evolving epidemiological priorities and the national drive toward program sustainability, this service network has expanded its operational scope beyond simple treatment expansion to encompass several critical pillars including Differentiated Service Delivery (DSD) optimization and Integrated Care Delivery.

3.3 New Initiation on ART

A total of 108,245 individuals were newly initiated on ART (TX_NEW) nationally in 2025. Of this total, 67,097 (62.0%) were female and 41,148 (38.0%) were male, indicating that female clients accounted for close to two-thirds of all new ART initiations nationwide.

Sex	ART Initiations	% of National Total
Female	67,097	62%
Male	41,148	38%

Female clients represented the highest contribution to ART initiation nationally, accounting for 67,097 initiations (62.0% of the total). This female predominance was consistent across nearly every state and most age bands and is most pronounced in the 15–49 age range — the period covering adolescence, reproductive age, and active sexual life — which is consistent with wider testing coverage among women through antenatal care (PMTCT) touchpoints and broader HIV testing services access for women.

Male clients accounted for the lower share of national ART initiations, at 41,148 (38.0% of the total). This gap suggests men are being tested and linked to treatment at a comparatively lower rate than women, reinforcing the well-documented programmatic challenge of male engagement in HIV testing and treatment services across Nigeria

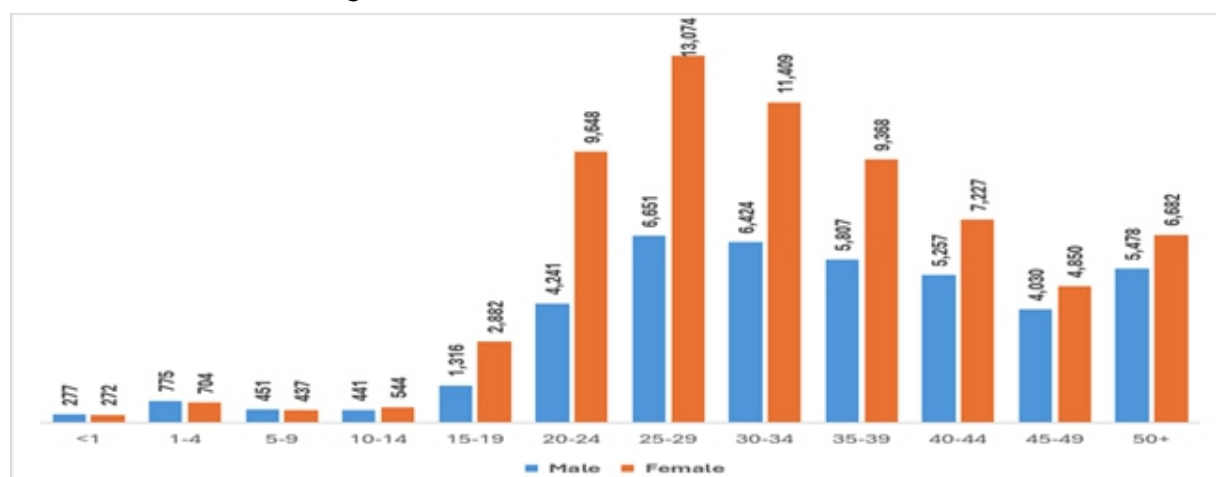


Figure 3.1 Newly Initiated on ART by Age and Sex

The 25–29 age band was the single largest contributor to ART initiation, with 19,725 initiations, representing 18.2% of the national total. This was closely followed by the 30–34 age band (17,833 initiations, 16.5%) and the 20–24 age band (13,889 initiations, 12.8%). Combined, the 20–39 age range accounted for over 60% of all ART initiations, confirming that HIV treatment initiation in Nigeria is

heavily concentrated among young adults of reproductive and economically active age.

The under-1 (<1 year) age band recorded the lowest contribution, with only 549 initiations (0.5% of the total), followed by the 5–9 age band (888 initiations, 0.8%) and the 10–14 age band (985 initiations, 0.9%). The low volume among infants and young children reflects both the smaller at-risk population in this age category and the relatively lower burden of new pediatric HIV diagnoses, aided by progress in prevention of mother-to-child transmission (PMTCT).

Across all 24 age-by-sex combinations, Female clients aged 25–29 formed the single largest contributing group nationally, with 13,074 initiations — 12.1% of the entire national total on their own. This was followed by Female 30–34 (11,409; 10.5%) and Female 20–24 (9,648; 8.9%). At the other end, Female clients under 1 year old formed the smallest group (272; 0.25%), closely followed by Male clients under 1 year (277; 0.26%) and Female clients aged 5–9 (437; 0.40%).

The female share of initiations within each age band also peaks in early adulthood: it is highest in the 20–24 band, where women account for 69.5% of initiations, and lowest in the 1–4 band, where the sexes are nearly balanced (47.6% female — the only band where male initiations marginally outnumber female). This pattern reinforces that the female excess in ART initiation is concentrated in the reproductive and sexually active years, rather than being a constant gap across all ages.

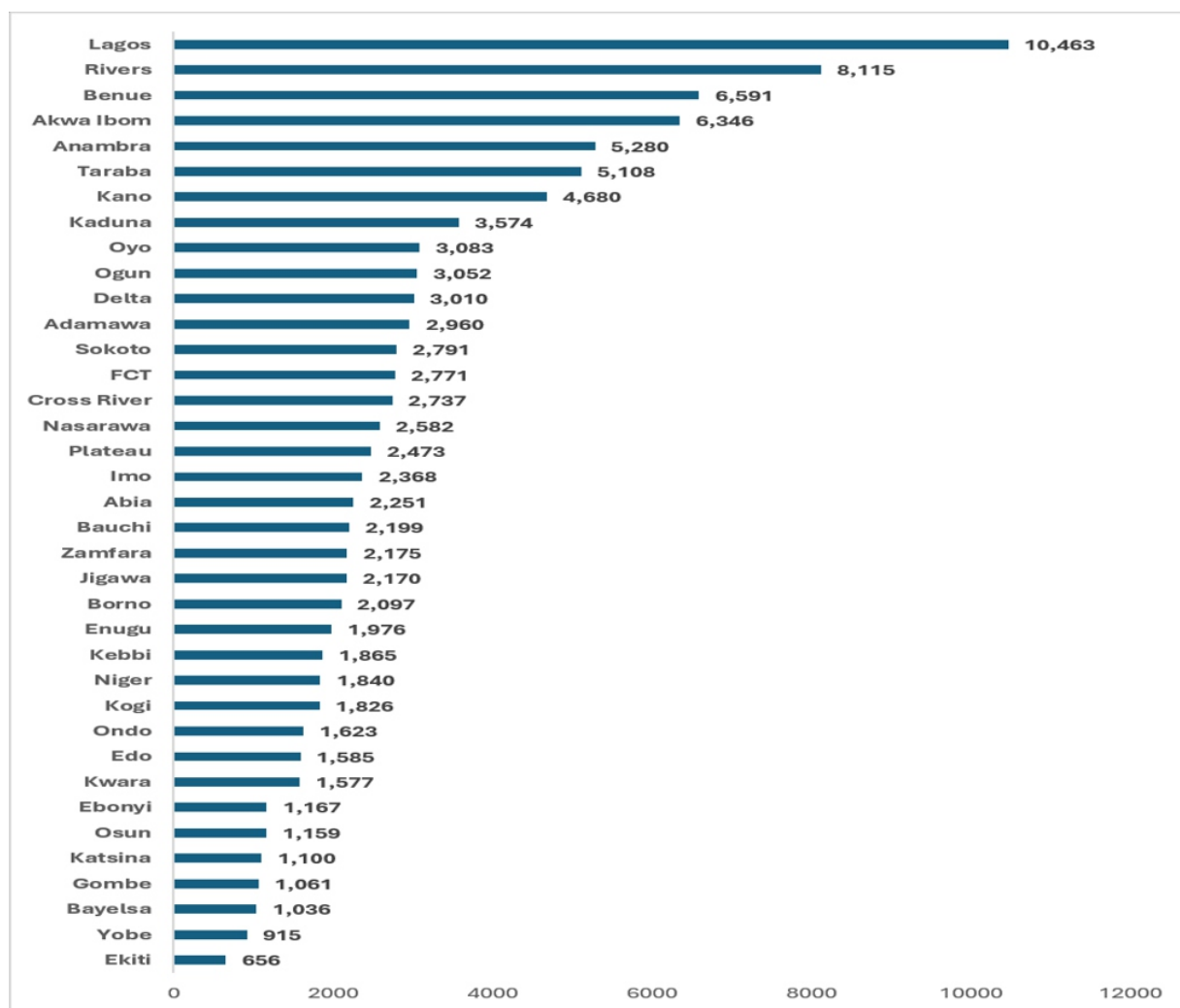


Figure 3.2 Newly Initiated on ART by State

Lagos State recorded the highest number of ART initiations of any state, at 10,463 (9.7% of the national total), driven largely by its large population base and concentration of treatment facilities. Rivers State followed as the second-highest contributor with 8,115 initiations (7.5%), and Benue State ranked third with 6,586 initiations (6.1%). Together, the five highest-contributing states — Lagos, Rivers, Benue, Akwa Ibom, and Anambra — accounted for approximately 34% of all ART initiations nationwide, indicating a marked geographic concentration of the treatment burden in a relatively small number of states.

Ekiti State recorded the lowest number of ART initiations nationally, at 656 (0.6% of the total), followed by Yobe State (915 initiations, 0.8%) and Bayelsa State (1,031 initiations, 1.0%). These lower figures may reflect smaller state populations, lower HIV prevalence, or potential gaps in testing coverage and case-finding that warrant further programmatic review.

Table 3.2 Trend of Newly Initiated on ART disaggregated by Age and Sex.

Age	Sex	2019	2020	2021	2022	2023	2024	2025
0 - 4 years	Male	2,617	2,413	2,161	2,068	1,441	1,210	1,052
	Female	2,533	2,239	2,094	2,111	1,361	1,213	976
5 - 9 years	Male	1,597	1,659	1,654	1,227	994	654	451
	Female	1,598	1,597	1,641	1,372	942	629	437
Adolescent (10-19 years)	Male	3,631	5,905	6,908	5,259	3,560	2,283	1,757
	Female	8,004	10,883	8,557	8,353	6,156	4,303	3,426
Adult (20+ years)	Male	73,051	143,049	150,342	93,726	73,687	42,005	37,888
	Female	135,548	217,082	203,473	146,463	116,875	71,951	62,258
0 - 14 years	Male	5,515	5,498	5,781	4,746	3,645	2,547	1,944
	Female	5,722	5,514	5,843	5,299	3,733	2,675	1,957
>15 years	Male	75,381	147,528	155,284	97,534	76,037	43,605	39,204
	Female	141,961	226,287	209,922	153,000	121,601	75,241	65,140

National New Treatment Initiation (TX_NEW) volume rose sharply between 2019 and 2020/2021 before entering a sustained decline through 2025. Total new initiations peaked at 384,827 in 2020, then fell for four consecutive years to 108,245 in 2025 — a decline of 52.6% from the 2019 baseline (228,579) and 71.9% from the 2020 peak.

The rate of decline was moderated in 2025 (-12.9%) relative to the steep -39.4% drop recorded in 2024, suggesting the year-on-year contraction in new initiations may be stabilizing, though volumes remain well below pre-2022 levels.

New Treatment Initiation fell from 124,248 in 2024 to 108,245 in 2025 — a decrease of 16,003 (12.9%). Both sexes declined, but at different rates: female initiations fell by 10,999 (-14.1%, from 78,096 to 67,097), while male initiations fell by 5,004 (-10.8%, from 46,152 to 41,148). The slightly steeper female decline narrowed the female share of total initiations marginally, from 62.9% in 2024 to 62.0% in 2025. Adult females (20+) recorded the largest absolute decline of any age-sex group between 2024 and 2025, dropping by 9,693 initiations (-13.5%). In relative terms, however, the steepest percentage declines occurred in the pediatric 5–9 band, where both males (-31.0%) and females (-30.5%) fell by roughly a third year-on-year — the sharpest contraction of any group in the dataset.

Adult males (20+) recorded the smallest relative decline of any group, falling by 9.8% (from 42,005 to 37,888) — the most stable segment year-on-year, and the only age-sex group to fall by less than 10%. The Adult (20+) age band overwhelmingly dominates new treatment initiation, accounting for 100,146 of the 108,245 total initiations in 2025 — 92.5% of the national total, consistent with its 91– 94% share held every year since 2019.

The 5–9 year age band was the smallest contributor in 2025, with 888 initiations (0.8% of the total), and has also seen the steepest long-run decline of any band — down 72.2% since 2019, the largest proportional drop across all age groups.

3.4 HIV Treatment Cascade

The HIV treatment cascade is a critical framework for tracking progress along the continuum of HIV care. It monitors the proportion of people living with HIV (PLHIV) who are aware of their HIV-positive status, those who have initiated antiretroviral therapy (ART), and those who have achieved viral suppression. For the first and second 95 indicators, the cascade uses a fixed denominator based on the estimated total number of PLHIV. In alignment with the 2025 Global AIDS Monitoring (GAM) guidance, countries with viral load testing coverage of at least 50% among PLHIV on ART are advised to calculate the third 95 by multiplying the proportion of virally suppressed individuals among those tested by the total number of PLHIV receiving treatment. This assumes that levels of suppression in the untested population are the same as those in the tested population.

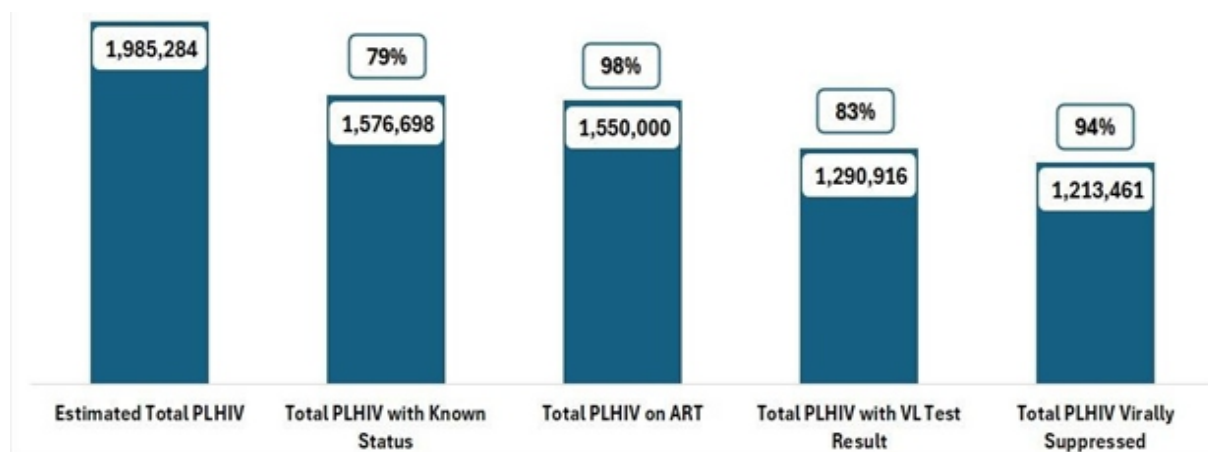


Figure 3.3 HIV Treatment Cascade among Total PLHIV

The HIV treatment cascade in Figure 3.3 illustrates Nigeria's progress in identifying, treating, and achieving viral suppression among total people living with HIV (PLHIV). As of 2025, the estimated number of PLHIV was 1,985,284. Of this population, 79% (1,576,698 individuals) were diagnosed and became aware of their HIV-positive status, furthermore 98% of PLHIV with known HIV-positive status (1,550,00 individuals) were on antiretroviral therapy (ART) as at the end of 2025, indicating a considerably strong linkage to treatment despite significant case finding gaps.

Viral suppression, a key marker of treatment effectiveness and reduced transmission risk, was achieved in 94% of the total PLHIV population on ART (1,213,461 individuals). This highlights a gap in achieving the third '95' target, likely influenced by limitations of the viral load testing coverage and follow-up, and suboptimal reporting of viral load testing and suppression.

Overall, the data highlights strong performance in ART uptake, while underscoring the need to intensify efforts in scaling up HIV diagnosis/case finding, viral load testing, strengthening adherence support, and ensuring

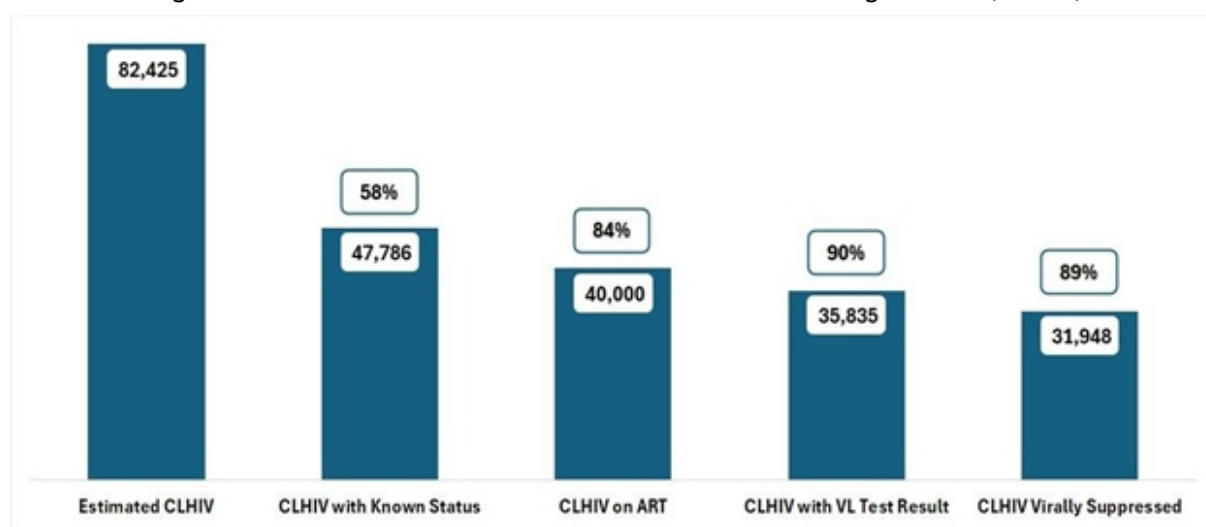


Figure 3.4 HIV Treatment Cascade among CLHIV

58% of the estimated CLHIV know their HIV-positive status (47,786 children), and 49% of CLHIV with known HIV-positive status have been placed on ART (40,000 children). According to the GAM recommendation highlighted above, the number of CLHIV with viral load suppression reached is 31,948 resulting in a viral load suppression coverage of 89% among the CLHIV population on ART.

Case finding among children remains the most significant challenge for the National HIV program. To mitigate this, the country is scaling up facility and community PMTCT services, prioritizing family index testing and optimizing the utilization of Point of Care (PoC) diagnostics for children, amongst other interventions. g sustained viral suppression.

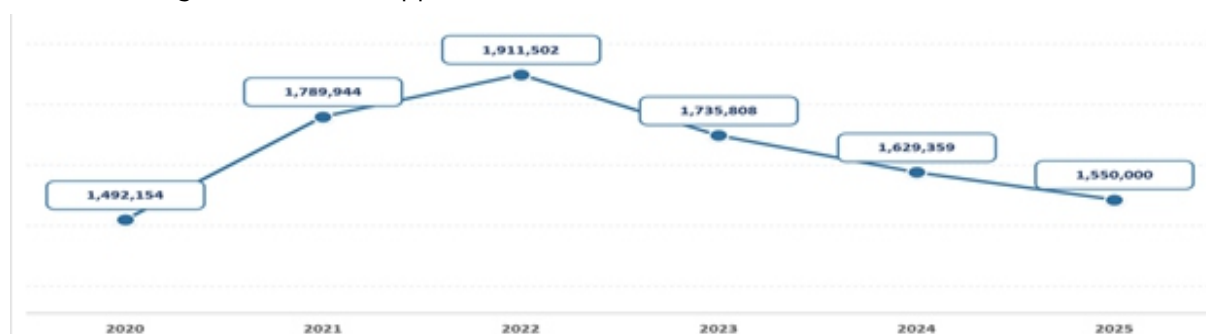


Figure 3.5 Trend of Total PLHIV on ART

The number of verified individuals currently on antiretroviral therapy (ART) (TX_CURR) in Nigeria has demonstrated fluctuations over the past five years, from 2020 to 2025. In 2020, a total of 1,492,154 clients were on ART. This figure steadily increased in subsequent years, reaching 1,789,944 in 2021 and peaking at 1,911,502 in 2022. However, from 2023 to 2025, the verified ART population began to decline, with reported figures dropping to 1,735,808 in 2023, reducing further to 1,629,359 in 2024 and deep to 1,510,000 in 2025.

This downward trend is largely due to the Getting the Data Right (GTDR), which is a data quality and systems strengthening initiative implemented in 2023. It was a collaborative effort led by the Nigerian government through the National Agency for the Control of AIDS (NACA), National AIDS, Viral Hepatitis and STIs Control Programme (NASCP), with critical support from key partners like PEPFAR (The U.S. President's Emergency Plan for AIDS Relief), The Global Fund, and the U.S. Centers for Disease Control and Prevention (CDC).

The GTDR initiative involved enhanced data quality assurance measures such as biometric registrations among PLHIV, client verification/ identification that was targeted at achieving the accurate and verified number of PLHIV on treatment. National Data Quality Assessment (DQA), and other rigorous validation processes, also helped to eliminate over-reporting and ensured greater accuracy in the fragmented data systems in the program.



Figure 3.6 Trend of CLHIV on ART

The number of children (0-14 years) receiving antiretroviral therapy (ART) in Nigeria has experienced a gradual decline over the five-year period from 2020 to 2025. In 2020, 57,445 children were reported to be on ART. This figure slightly increased in 2021 to 59,423, reflecting intensified efforts to scale up pediatric HIV services and improve case identification.

However, subsequent years witnessed a downward trend. By 2022, the number of children on ART dropped to 50,676, and further declined to 45,517 in 2023. This reduction could also be attributed to the client verification exercise that was embarked on in 2023 such as biometric recapture, client de-duplication, and more rigorous validation processes which eliminated overreporting of children on ART.

In 2024, a slight improvement was recorded, with 49,820 children. The paediatric HIV programme has recorded a marked and troubling decline in treatment coverage over the reporting period. The number of children currently receiving antiretroviral therapy (ART) fell to 40,000 in 2025, reflecting a steep drop from earlier levels. Correspondingly, paediatric ART coverage declined sharply — from 70% to 49%, a fall of 21 percentage points that stands out as one of the most alarming trends within the programme, and points to a widening gap between the estimated number of children living with HIV (CLHIV) and those who are actually identified, linked to care, and retained on treatment. This decline reflects persistent and worsening weaknesses in pediatric case finding: CLHIV are not being identified early

enough, or in sufficient numbers, to sustain previous gains. Left unaddressed, the trend threatens to reverse progress toward pediatric treatment and viral suppression targets and raises the risk of preventable morbidity and mortality among affected children.

Reversing this trajectory will require immediate, deliberate intensification across three interlinked fronts:

1. Scale-up of family-centered testing approaches — including index-case testing, provider-initiated testing at paediatric and outpatient entry points, and household-based testing for children of PLHIV — to close the case-finding gap.
2. Accelerated treatment initiation for every child newly identified as HIV-positive, with same-day ART initiation wherever clinically appropriate.
3. Strengthened PMTCT programming to prevent new paediatric infections at the source and sustain long-term reductions in the paediatric caseload.

Without urgent action on all three fronts, the paediatric ART coverage gap is likely to widen further — compounding the losses already visible across the cascade, from an estimated 82,425 CLHIV, to 47,786 with known status, to just 40,000 currently on treatment with urgent need for focused interventions targeting pediatric HIV, including improved diagnostic capacity, decentralization of services, and sustained capacity building for healthcare providers managing pediatric ART.

3.5 UNAIDS 95-95-95 Cascade

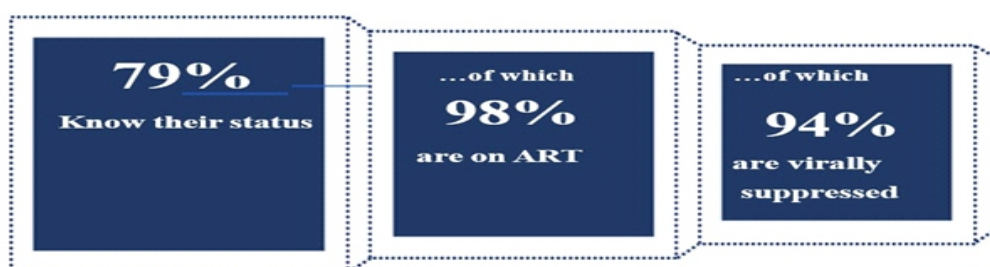


Figure 3.7 PLHIV 95-95-95 Cascade

Figure 3.7 illustrates Nigeria's current standing in relation to the global 95-95-95 HIV targets. The country has successfully achieved the second 95 and third 95 targets, with 98% of PLHIV who know their HIV status on antiretroviral therapy (ART), and 94% of those on treatment attaining viral suppression.

Despite this commendable progress, a significant gap remains in the first 95 target: only 79% of the estimated number of PLHIV know their HIV status. This indicates that a substantial proportion of PLHIV remain unaware of their status. To bridge this gap, intensified efforts are required to strengthen HIV case-finding strategies, especially among key populations, underserved communities, and hard-to-reach groups. Prioritizing innovative, targeted, and community-based testing approaches will be essential to ensuring that all PLHIV are identified and linked to care.

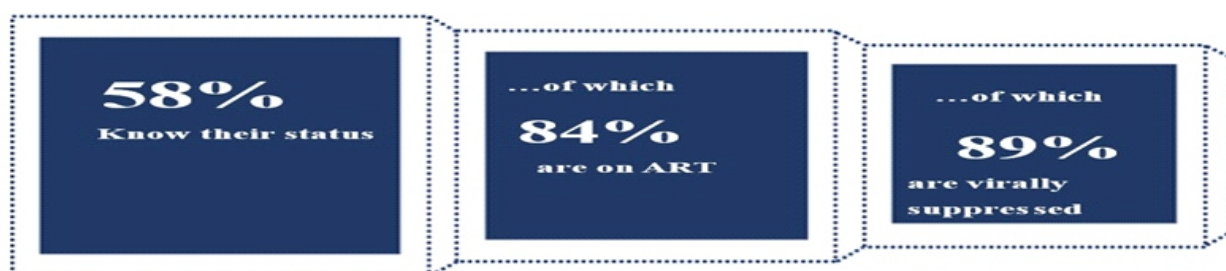


Figure 3.8 95-95-95 CLHIV Cascade

Figure 3.8 presents the 95-95-95 cascade for children living with HIV (CLHIV). In 2025, Nigeria had a decline towards the UNAIDS 95-95-95 targets for children living with HIV, achieving 58-84-89, respectively. This marks a drop in HIV diagnosis among children compared to 2024, while treatment coverage and viral load suppression have remained steady. To address the substantial deficit in pediatric case finding, the country intensified the implementation of child-focused strategies. These included the scale-up of the Prevention of Mother-to-Child Transmission (PMTCT) program, implementation of family index testing, and the deployment of point-of-care (PoC) testing for Early Infant Diagnosis (EID). These targeted interventions have contributed to the observed progress by enhancing early identification of HIV-positive infants and children, facilitating timely treatment initiation, and ultimately improving retention in care and viral suppression outcomes in this vulnerable population.

3.6 ART Coverage

The National antiretroviral therapy (ART) coverage declined from 87% in 2024 to 78% in 2025 based on the Treatment number recalibrations conducted. The regional variations in ART coverage persisted across the country; however, the pattern was not uniformly concentrated in one geopolitical zone. Based on the PLHIV and on-ART estimates, higher ART coverage was observed in selected states across different regions, including Benue, Gombe, Kebbi, Taraba, Lagos, Delta, Plateau and Imo. This suggests that stronger ART coverage is state-specific rather than clearly attributable to the North-Central geopolitical zone as a whole.

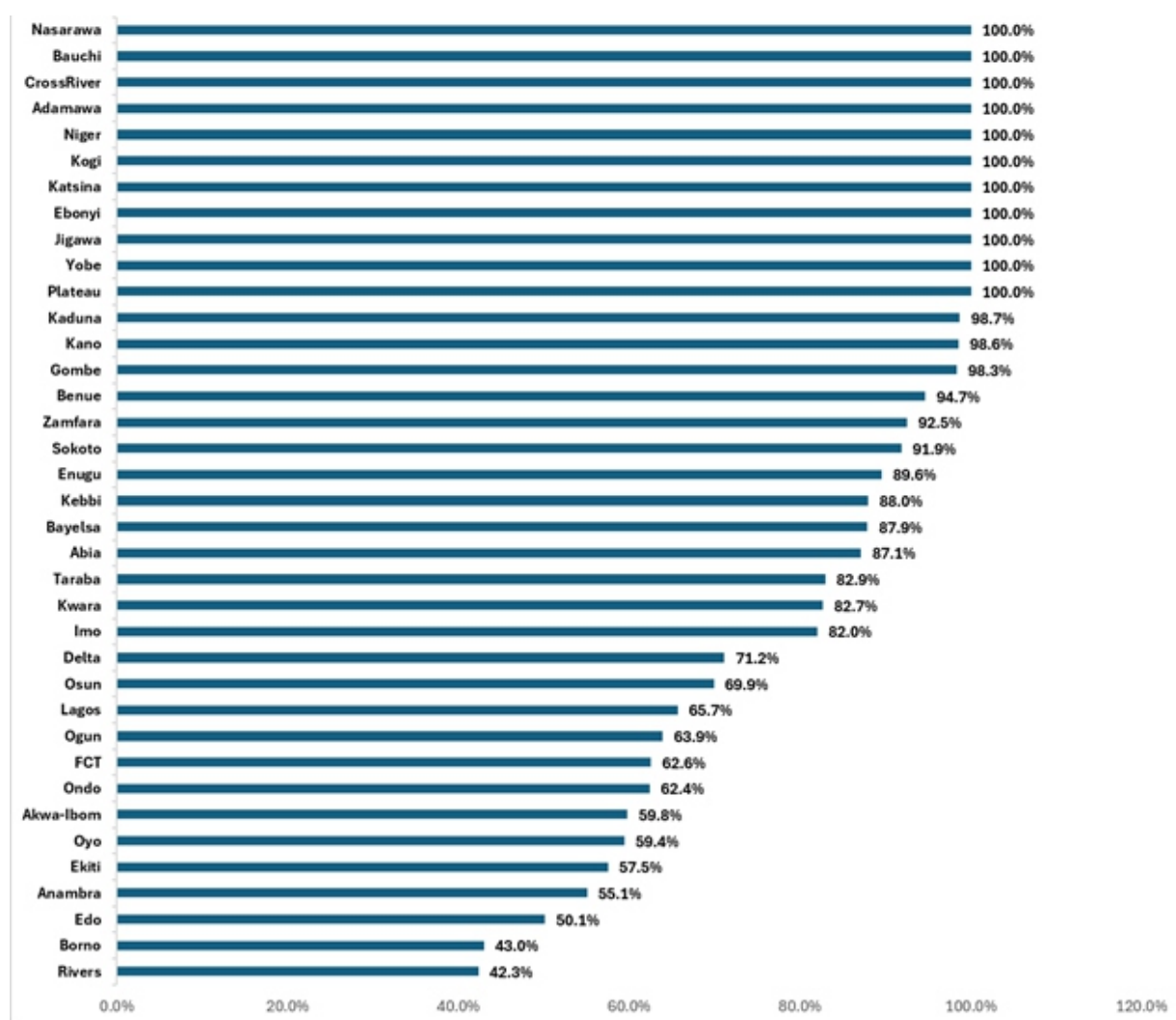


Figure 3.9 ART Coverage by State

As shown in Figure 3.9, In 2025, eleven states (Adamawa, Bauchi, Cross River, Ebonyi, Jigawa, Katsina, Kogi, Nasarawa, Niger, Plateau, and Yobe) exceeded their treatment coverage targets (>100%); indicating high levels of treatment coverage among people living with HIV (PLHIV). In contrast, six states (Oyo, Ekiti, Anambra, Edo, Borno, and Rivers) reported low ART coverage below 60%, highlighting significant gaps in service uptake. To close these disparities, there is a critical need for the national programme to strengthen HIV service delivery systems in underperforming states. Targeted technical support, improved resource allocation, and tailored interventions will be essential to improving ART. The chart below further highlights ART coverage across the 36 states and FCT

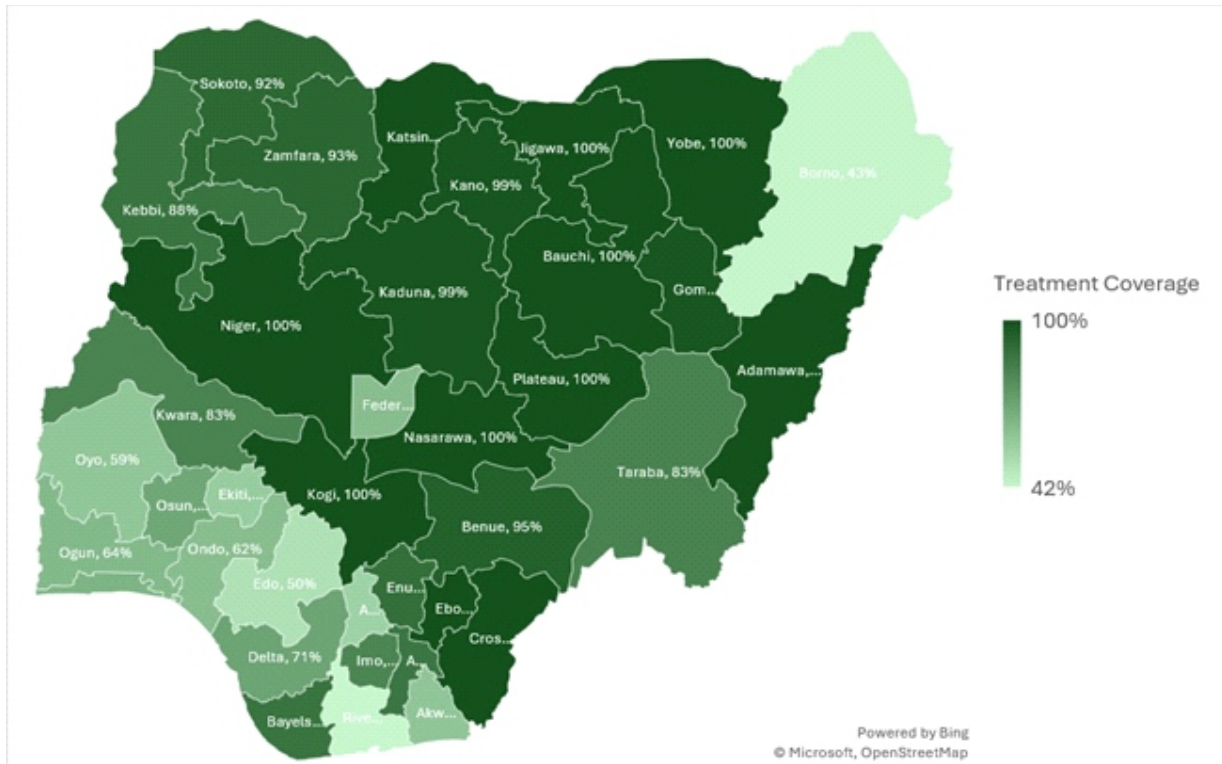


Figure 3.10 State-level ART coverage in Nigeria.

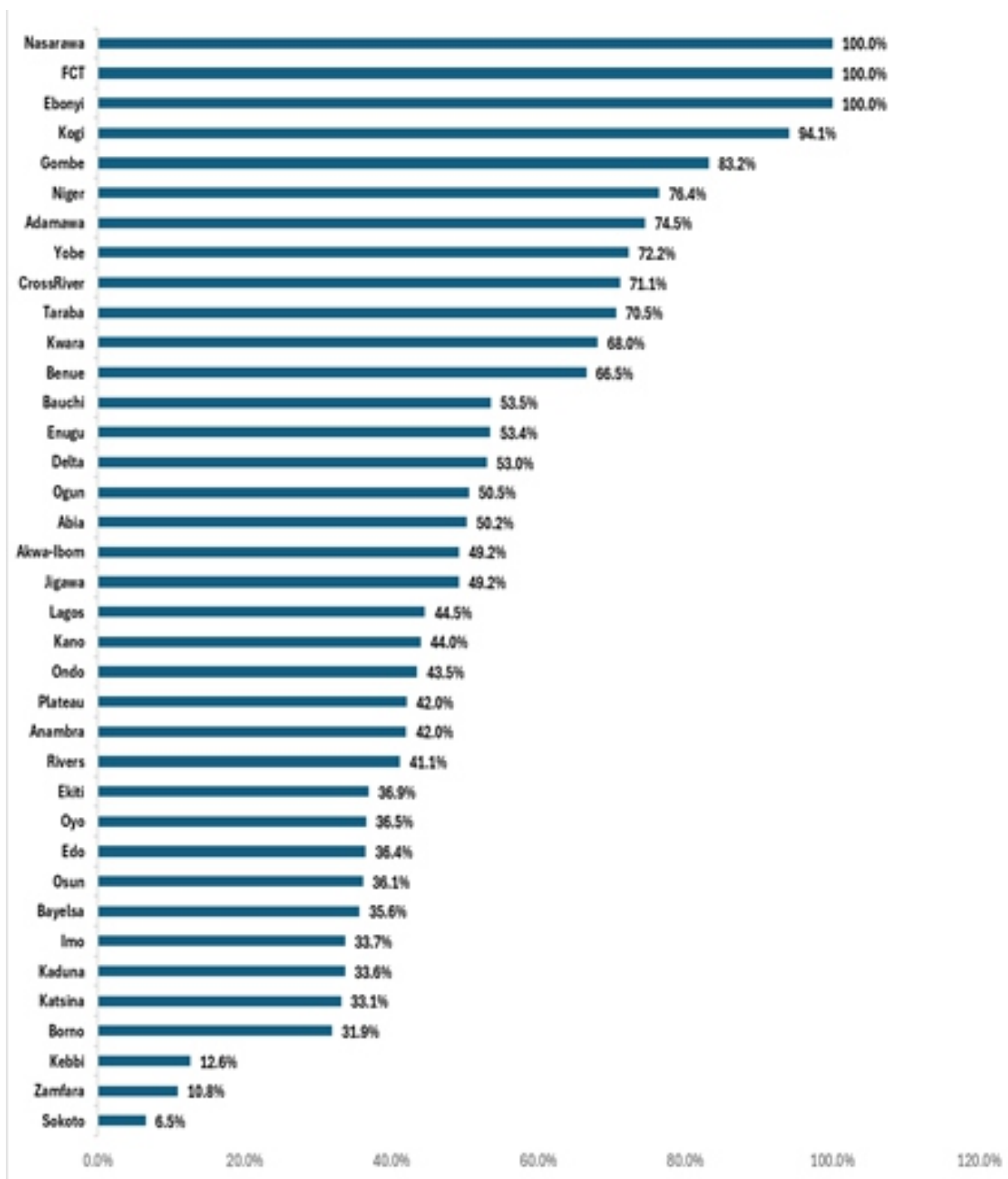


Figure 3.11 ART Coverage among CLHIV by State

The national antiretroviral therapy (ART) coverage for children living with HIV (CLHIV) dramatically declined from 74% in 2024 to 49% in 2025 based on the Treatment number recalibrations conducted. Three states (Nasarawa, FCT, and Ebonyi) have achieved saturation in pediatric ART coverage. Out of the remaining 34 states, only Kogi achieved pediatric ART coverage above 90%, with 25 states having low pediatric ART coverage below 60%, highlighting significant gaps in service uptake. The data also shows disparities in pediatric ART coverage between states. The findings point to the need for targeted interventions in underperforming states to strengthen linkage to treatment, retention, and equitable access to HIV services.

Furthermore, to close existing gaps, there is an urgent need to re-evaluate the national pediatric HIV program. The national pediatric case finding and treatment efforts require immediate intensification. This includes identifying persistent challenges and implementing innovative, evidence-based strategies that align with global best practices to enhance effective service delivery, case identification, and treatment outcomes for this vulnerable population.

3.7 Viral Load (VL) Testing Coverage

Monitoring the effectiveness of antiretroviral therapy (ART) relies primarily on viral load testing, which serves as the gold standard for assessing treatment success. National HIV treatment guidelines recommend that all individuals on ART undergo this test at least annually to evaluate their treatment response. A suppressed viral load is considered as a positive treatment outcome and, within Nigeria's national HIV program, is defined as having a viral load of $\leq 1,000$ copies of HIV RNA per milliliter of blood.

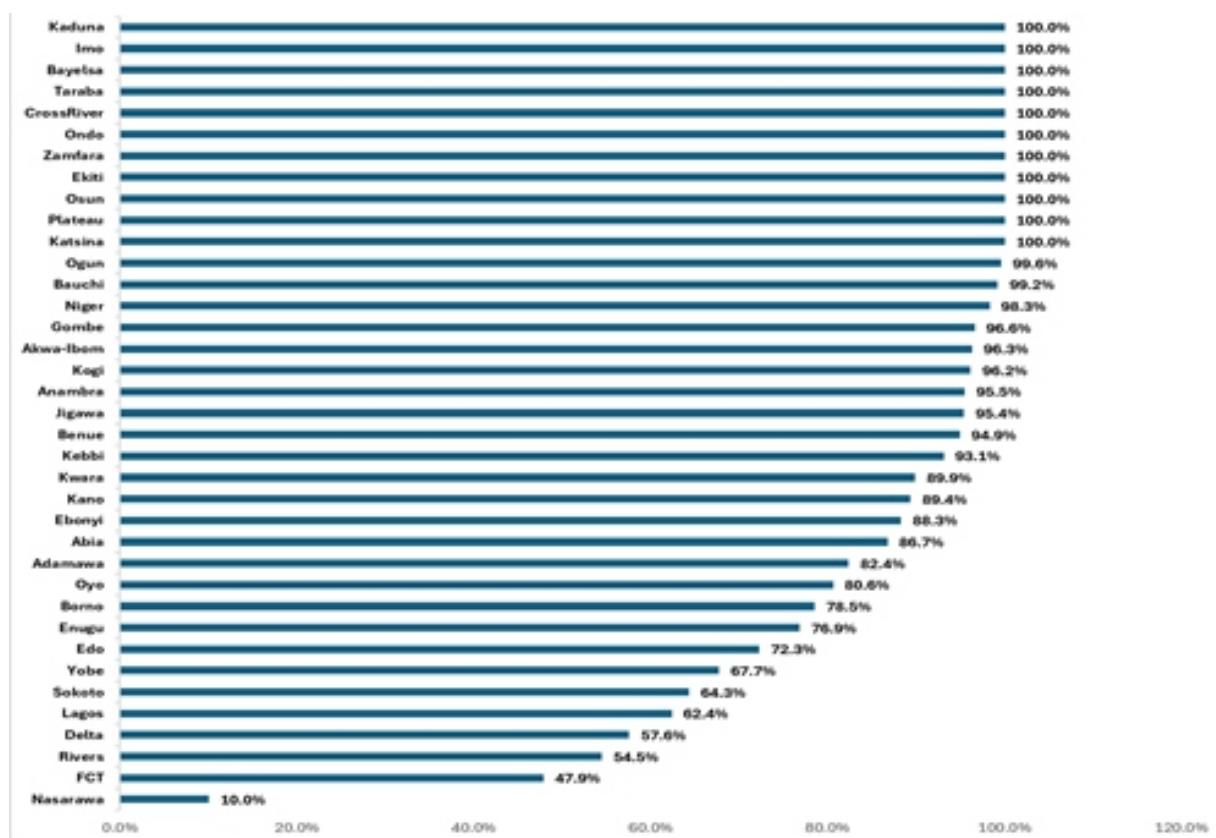


Figure 3.12 Viral Load Testing Coverage by state

Figure 3.12 presents state-level variations in viral load testing (VLT) coverage across the 36 states and the FCT in 2025, highlighting significant disparities in program performance. Eleven states (Ogun, Kaduna, Imo, Bayelsa, Taraba, Cross River, Ondo, Zamfara, Ekiti, Osun, Plateau, and Katsina) and reported 100% VLT coverage, and ten additional states (Kwara, Kebbi, Benue, Jigawa, Anambra, Kogi, Akwa-Ibom, Gombe, Niger, and Bauchi) reported VLT coverage between 90-95%. These states have demonstrated strong capacity in providing VLT services in line with national guidelines. Conversely, four states (Delta, Rivers, FCT, and Nasarawa) reported notably low VLT coverage below 60%, indicating critical gaps in testing access, sample collection, or result turnaround. Addressing these gaps will require targeted technical support in underperforming states, including technical assistance, improved supply chain, strengthened laboratory systems, and community engagement, particularly in underperforming states, and more accurate and correct reporting of viral load test results.

3.8 Viral Load (VL) Suppression

In 2025, 1,294,051 viral load test results were recorded against 1,213,461 documented as virologically suppressed, yielding a national Viral Load Suppression (VLS) rate of 93.8%; which is below the 95% target.

Table 3.3 National VLT and VLS

Indicator	As Reported
Total Viral Load Test Results (VLT)	1,294,051
Total Virologic Suppression (VLS)	1,213,461
National VLS Rate	93.8%
Target	≥ 95.0%

Of the 37 states, 13 (35.1%) met or exceeded the 95% VLS rate target, while 24 (64.9%) fell below it. Bayelsa recorded the highest suppression rate at 98.9%, and Oyo State had the lowest suppression rate at 78.5%.

Table 3.4 States Meeting or Exceeding the 95% VLS Rate Target (13 States)

State	VLT	VLS	VLS Rate
Bayelsa	12,697	12,563	98.9%
Kogi	30,600	29,995	98.0%
Delta	6,403	6,166	96.3%
Ekiti	11,034	10,621	96.3%
Cross River	54,067	51,802	95.8%
Abia	39,545	37,825	95.7%
Katsina	18,758	17,925	95.6%
Imo	46,656	44,577	95.5%
Akwa Ibom	126,383	120,659	95.5%
Bauchi	28,927	27,591	95.4%
Gombe	20,236	19,301	95.4%
Osun	23,464	22,330	95.2%
Nasarawa	616	586	95.1%

Of the 37 states, 13 (35.1%) met or exceeded the 95% VLS rate target, while 24 (64.9%) fell below it. Bayelsa recorded the highest suppression rate at 98.9%, and Oyo State had the lowest suppression rate at 78.5%.

Table 3.4 States Meeting or Exceeding the 95% VLS Rate Target (13 States)

State	VLT	VLS	VLS Rate
Kaduna	52,441	49,753	94.9%
Niger	30,394	28,824	94.8%
Lagos	81,025	76,720	94.7%
FCT	20,627	19,423	94.2%
Ondo	17,185	16,162	94.0%
Kano	36,064	33,882	93.9%
Kwara	10,890	10,219	93.8%
Yobe	5,865	5,503	93.8%
Anambra	47,594	44,632	93.8%
Jigawa	11,895	11,121	93.5%
Benue	168,992	157,882	93.4%
Taraba	47,020	43,859	93.3%
Kebbi	14,548	13,515	92.9%
Adamawa	23,968	22,215	92.7%
Ebonyi	13,840	12,814	92.6%
Ogun	23,459	21,627	92.2%
Plateau	44,760	41,244	92.1%
Edo	17,915	16,498	92.1%
Rivers	49,423	44,480	90.0%
Enugu	37,734	33,281	88.2%
Borno	16,683	14,462	86.7%
Zamfara	12,096	10,192	84.3%
Sokoto	9,844	8,061	81.9%
Oyo	23,425	18,395	78.5%

Oyo State recorded the lowest suppression rate nationally at 78.5%, followed by Sokoto (81.9%) and Zamfara (84.3%).

Table 3.5 States Performing Below the 95% VLS Rate Target (24 States)

State	VLT	VLS	VLS Rate
Kaduna	52,441	49,753	94.9%
Niger	30,394	28,824	94.8%
Lagos	81,025	76,720	94.7%
FCT	20,627	19,423	94.2%
Ondo	17,185	16,162	94.0%
Kano	36,064	33,882	93.9%
Kwara	10,890	10,219	93.8%
Yobe	5,865	5,503	93.8%
Anambra	47,594	44,632	93.8%
Jigawa	11,895	11,121	93.5%
Benue	168,992	157,882	93.4%
Taraba	47,020	43,859	93.3%
Kebbi	14,548	13,515	92.9%
Adamawa	23,968	22,215	92.7%
Ebonyi	13,840	12,814	92.6%
Ogun	23,459	21,627	92.2%
Plateau	44,760	41,244	92.1%
Edo	17,915	16,498	92.1%
Rivers	49,423	44,480	90.0%
Enugu	37,734	33,281	88.2%
Borno	16,683	14,462	86.7%
Zamfara	12,096	10,192	84.3%
Sokoto	9,844	8,061	81.9%
Oyo	23,425	18,395	78.5%

Despite the generally positive performance nationwide, the disparities between the highest and lowest-performing states underscore the need for targeted support and differentiated interventions to ensure uniform treatment outcomes. Strengthening adherence support, improving access to viral load testing, and addressing health system challenges in lagging states will be essential to achieving equitable viral suppression outcomes across the country.

VLS rate rose with age from a lower base among infants and young children to a plateau of approximately 93–94% from the mid-20s age bands onward. The 30–34 age band recorded the national VLS rate at 94.3%, closely followed by 25–29 years (94.2%).

It was also observed that the 1–4 year band was the lowest-performing age group with a VLS rate of 79.8% (4,528 tested), nearly 14% points below the national average, which is consistent with global viral suppression trends for pediatric and adolescent clients which typically shows lower variable suppression due to adherence challenges (caregiver-dependent dosing, disclosure issues, formulation palatability), while suppression improves and stabilizes among adults on long-term, well established regimens.

Age Band	VLT	VLS	VLS Rate
<1 year	284	205	72.2%
1–4 years	4,528	3,614	79.8%
5–9 years	11,502	10,321	89.7%
10–14 years	18,259	16,120	88.3%
15–19 years	25,423	22,933	90.2%
20–24 years	53,289	48,682	91.4%
25–29 years	112,078	105,632	94.2%
30–34 years	174,827	164,874	94.3%
35–39 years	191,619	179,978	93.9%
40–44 years	203,636	191,178	93.9%
45–49 years	157,006	146,584	93.4%
50+ years	284,622	266,584	93.7%

Nationally, male clients recorded a higher VLS rate (95.4%) when compared with female clients, with a suppression rate of 93.3%.

Table 3.7 VLS Rate by Sex

Sex	VLT	VLS (est.)	VLS Rate
Male	440,555	420,481	95.4%
Female	850,361	792,980	93.3%

When comparing State-level VLS rate, with combination with different age band, it was observed that Akwa Ibom's 1–4 year age band recorded the weakest combined VLS rate at 48.5%, while the age band of 25–29 (Delta state), 30–34 and 35–39 for Bayelsa State recorded the highest VLS rates of 99.9%, 99.6% and 99.7% respectively.

Table 3.8 State level VLS rate by age band

State	Age Band	VLT	VLS	VLS Rate
Delta	25–29	3,778	3,775	99.9%
Bayelsa	35–39	3,059	3,049	99.7%
Bayelsa	30–34	4,594	4,577	99.6%
Enugu	50+	13,139	9,703	73.8%
Oyo	20–24	651	478	73.4%
Oyo	15–19	559	408	73.0%
Sokoto	50+	1,467	1,041	70.9%
Sokoto	45–49	918	643	70.0%
Sokoto	5–9	96	63	65.6%
Oyo	45–49	4,540	2,945	64.9%
Akwa Ibom	1–4	813	394	48.5%

Combining Age Band and Sex at the national level, male clients aged 30–34 recorded the highest VLS rate of any age-sex combination (97.7%), while female clients aged 10–14 recorded the lowest among bands with a robust sample size (86.2%).

Table 3.9 VLS by age band and sex

Age Band	Sex	VLT	VLS Rate
30–34	Male	53,872	97.7%
25–29	Male	41,231	97.4%
45–49	Female	113,153	94.2%
10–14	Female	9,735	86.2%
5–9	Male	5,756	88.3%

3.9 Advanced HIV Disease

The World Health Organization (WHO) defines Advanced HIV Disease (AHD) as a CD4 cell count below 200 cells/mm³ or WHO clinical stage 3 or 4 in adults, adolescents, and children aged 5 years and older, while all children under 5 years old living with HIV are considered to have AHD. Advanced HIV Disease (AHD) is associated with increased morbidity and mortality among people living with HIV (PLHIV). To address this, the national program has implemented a comprehensive AHD care package aimed at early identification and effective management of affected individuals. Additionally, the national program is currently rolling out the paediatric AHD package of care (STOP AIDS package) across selected sites in 6 states. Nationwide rollout will be informed by the learnings from this first phase of the rollout. This package includes WHO clinical staging, and CD4+ cell count testing for AHD identification for adults and children/adolescent 5 years of age and older, systematic screening diagnostics for opportunistic infections, timely initiation of treatment, and prophylaxis, particularly for tuberculosis, Cryptococcal Meningitis, Severe Bacterial Infection (SBI). Treatment of malnutrition and improving access to vaccine preventable diseases for children under 5 and HPV vaccine for adolescent girls is also a core component of the package of care for children. It also prioritizes prompt initiation of antiretroviral therapy (ART) and reinforces adherence support to improve treatment outcomes.

The integration of the AHD care package into the National Program has reignited our commitment to optimizing CD4 testing. CD4 tests are a critical component of patient care, specifically recommended for identifying Advanced HIV Disease (AHD) in People Living with HIV (PLHIV) who are newly enrolled, those who have re-entered care after being lost to follow-up, or individuals who are experiencing treatment failure. It is however, important to note that the major focus for reporting has been on CD4 testing among PLHIV newly enrolled to treatment. All children less than five years are considered as AHD and do not require CD4 test to receive the package of care. However, children younger than five years who have been receiving antiretroviral therapy for more than one year and are clinically stable should not be considered to have AHD.

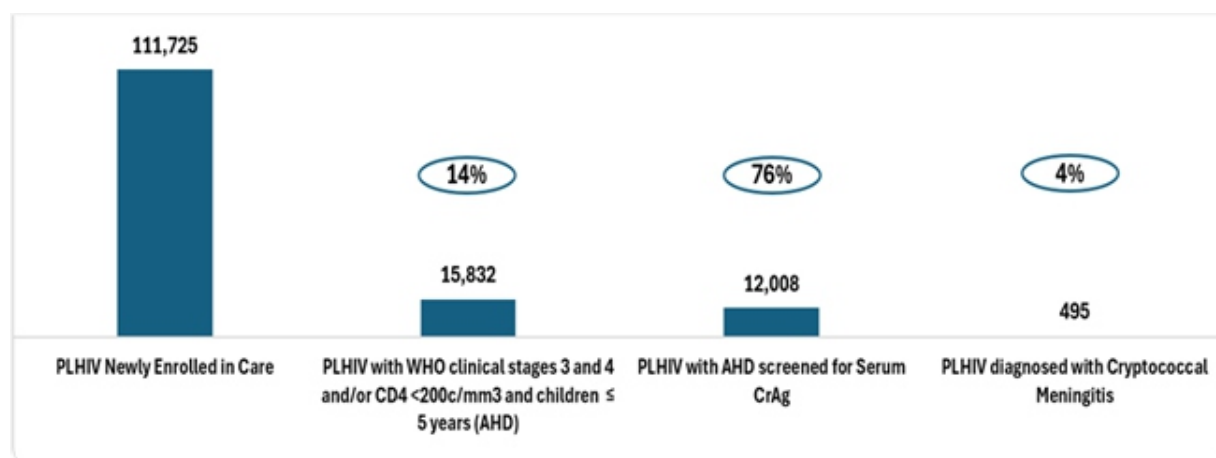


Figure 3.13 AHD Screening Cascade for newly enrolled clients

The chart above provides an AHD Screening and Diagnostic Cascade for newly enrolled PLHIV in 2025. Out of 111,725 newly enrolled PLHIV, 15,832 (14%) were identified as presenting with AHD. Among these eligible AHD clients, 12,008 (76%) received Serum Cryptococcal Antigen (CrAg) screening, resulting in 495 diagnosed cases of Cryptococcal Meningitis (4% positivity rate). Approximately 1 in 7 newly enrolled clients presents with AHD, and 1 in 24 screened AHD clients tests positive for Serum CrAg / Cryptococcal Meningitis. While the program demonstrates solid diagnostic yield, a significant 24% screening gap (3,824 unscreened AHD clients) represents missed opportunities where an estimated 158 additional cryptococcal cases may have gone undetected.

To close the screening gap, increase diagnostic capture, and achieve ≥95% Serum CrAg screening

coverage among AHD clients, the following strategies are recommended:

1. Strengthen commodity management and supply chain security for rapid CrAg LFA test kits and LP/antifungal supplies (Fluconazole, Amphotericin B, Flucytosine) to prevent facility-level stockouts.
2. Conduct continuous clinical mentoring focused on AHD package implementation, immediate CrAg screening protocols, and prompt preemptive antifungal management.
3. Establish monthly cascade review meetings where facilities track their Identified vs. Screened gaps and test rapid-cycle improvement interventions (PDSA cycles).

3.10 HIV/TB Cascade

Tuberculosis (TB) remains one of the most prevalent and severe opportunistic infections affecting people living with HIV (PLHIV). In recognition of the dual burden posed by TB and HIV, the World Health Organization (WHO) continues to advocate for the integration of collaborative TB/HIV activities within both TB and HIV service delivery platforms. The effective implementation of these interventions hinges on strong coordination between the Federal Ministry of Health and Social Welfare (FMoHSW) and key stakeholders. A cornerstone of this collaborative approach is the routine clinical screening for TB at every clinical encounter for PLHIV. This strategy is vital for the early detection and prompt management of TB cases within this high-risk population, thereby improving health outcomes and reducing TB-related morbidity and mortality among PLHIV.

3.11 Mortality Among PLHIV

Mortality Surveillance focuses on systematically capturing deaths among people living with HIV, this is critical for understanding the epidemic's impact even amid expanding access to antiretroviral therapy (ART). In 2025, 17,830 deaths occurred among PLHIV. Compared with 2024 numbers, 21,682. This is a significant decrease. Continued mortality surveillance is essential for uncovering disparities (e.g., by region, demographic group, or stage of disease) and for guiding strategies to reduce HIV-related fatalities.

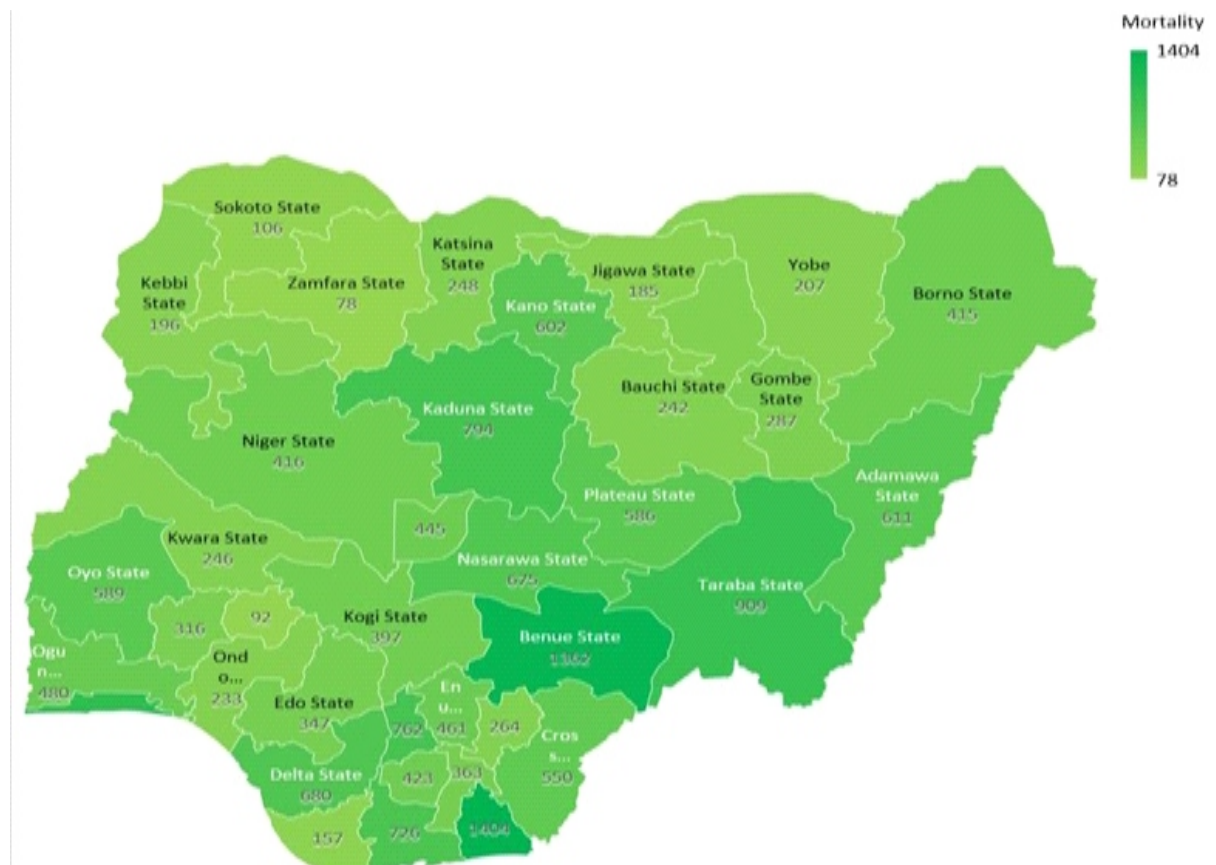
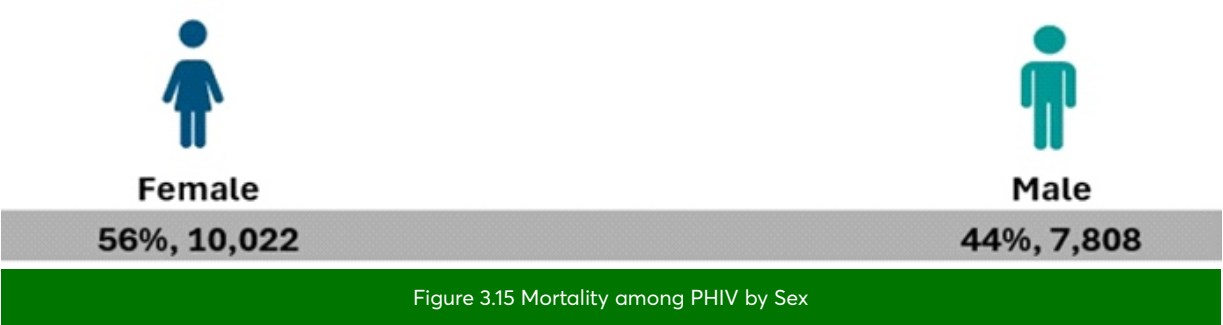


Figure 3.14 Mortality among PHIV by States

Figure 3.14 illustrates mortality surveillance coverage across states, with shading intensity corresponding to the number of reported deaths. Akwa Ibom recorded the highest mortality (1,404 deaths), followed by Benue (1,362), Lagos (976), and Taraba (909). States such as Zamfara (78), Ekiti (92), and Sokoto (106) reported the lowest mortality counts. Overall, the map highlights substantial state-level variations in mortality surveillance, with higher reporting in parts of the North-Central and South-South regions compared to the North-West and some South-West states.

The chart below shows the gender distribution of mortality among People Living with HIV (PLHIV) in Nigeria. It highlights a notable disparity between female and male mortality figures:

Females account for 56% of the total deaths while Males make up 44% of deaths. This indicates that women constitute a larger proportion of HIV-related mortality in Nigeria, which may reflect differences in access to care, social determinants of health, or biological vulnerability. This gender-disaggregated data is crucial for tailoring public health interventions, improving equity in treatment access, and informing national HIV response strategies.



CHAPTER 4

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) AND PROGRESS TOWARDS THE ELIMINATION OF MOTHER TO CHILD TRANSMISSION (EMTCT) OF HIV, SYPHILIS AND HEPATITIS B

Prevention of mother-to-child transmission (PMTCT) of HIV, syphilis and hepatitis B comprises a comprehensive, integrated and client-centered package of preventive, testing, treatment and follow-up interventions delivered across the continuum of maternal, newborn and child healthcare. These services are provided to pregnant and breastfeeding women, their infants and partners from pregnancy through childbirth and the breastfeeding period to prevent vertical transmission, improve maternal and child health outcomes, and ensure timely linkage to lifelong care where required.

The ultimate objective of these interventions is the elimination of mother-to-child transmission (EMTCT) of HIV, syphilis and hepatitis B as a public health problem. In line with the World Health Organization's Triple Elimination Initiative, Nigeria continues to strengthen the integration of PMTCT services within routine antenatal, delivery, postnatal and child health platforms to expand equitable access to high-quality screening, prevention, treatment and follow-up services.

In addition, maternal viral hepatitis services, including hepatitis C screening where implemented, are increasingly being integrated into routine antenatal care to enhance early diagnosis, linkage to care, and comprehensive maternal and infant health outcomes.

According to recent UNAIDS estimates, approximately 1.9 million people are living with HIV in Nigeria, including about 140,000 children (0–14 years). An estimated 22,000 children are infected with HIV annually, with the majority of these infections resulting from vertical transmission during pregnancy, labour, delivery, or breastfeeding (UNAIDS, 2025). Although the annual number of new paediatric HIV infections has declined considerably over the past decade, Nigeria still accounts for a substantial proportion of new paediatric HIV infections globally, underscoring the need to accelerate PMTCT interventions and close persistent gaps in antenatal HIV testing, treatment coverage, early infant diagnosis, and retention of mothers and infants in care.

Despite significant global progress, the elimination of vertical transmission remains a public health priority due to the persistent burden of preventable paediatric HIV, congenital syphilis, and perinatal hepatitis B infections. Strengthening PMTCT services is therefore central to achieving Universal Health Coverage (UHC), improving maternal and child survival, and attaining the Sustainable Development Goals (SDGs).

Nigeria has, however, recorded important gains in strengthening PMTCT services. In 2024, national PMTCT coverage increased to approximately 66%, Early Infant Diagnosis (EID) coverage reached 57%, while paediatric antiretroviral therapy (ART) coverage improved markedly from 29% to 74% following intensified national interventions. Despite these achievements, the country remains below the global EMTCT targets, which call for 95% HIV testing among pregnant women, 95% ART coverage among pregnant women living with HIV, 95% viral suppression among women receiving treatment, and 90% EID coverage for HIV-exposed infants by two months of age. Sustained investments in integrated HIV, syphilis, and HBV services will therefore be essential to eliminate mother-to-child transmission and achieve EMTCT validation (Federal Ministry of Health and Social Welfare, 2025).

The Triple Elimination Initiative aims to eliminate mother-to-child transmission (EMTCT) of HIV, hepatitis B, and syphilis by leveraging existing service delivery platforms to achieve elimination targets.

The convergence of essential interventions required to prevent mother-to-child transmission of the three infections underscores the feasibility and effectiveness of an integrated approach.

The core pillars of this integrated approach include prevention of primary infections through prophylaxis and promotion of safe sexual practices. Family planning services are incorporated to assess fertility intentions, support pregnancy planning, and prevent unintended pregnancies. Routine clinical screening during antenatal care (ANC) ensures early identification of infections, followed by prompt and effective treatment for women who test positive, and linkage to care to prevent transmission to the child in accordance with the national, UNAIDS and WHO guidelines.

The initiative further includes counselling for women and their partners on transmission risk reduction and adherence to prophylaxis and treatment protocols, and testing for these diseases.

It promotes safe childbirth with skilled birth attendants, postnatal follow-up of exposed infants, and administration of the HBV birth dose vaccine. Additional elements include optimal infant feeding practices, lifelong antiretroviral therapy for mothers and/or partners living with HIV, and appropriate treatment for women and/or their partners diagnosed with HBV or syphilis.

4.1 PMTCT services are delivered on 4 pillars:

Pillar 1	Primary Prevention of Infection and mother-to-child transmission: Testing, case finding, treatment, and primary prevention for HIV, syphilis, and HBV infection in non-pregnant, pregnant, and breastfeeding women and girls of childbearing age.
Pillar 2	SRH Linkages and Integration: Appropriate counselling, care, and support, and for SRH services for women and girls living with HIV or HBV or Sero-positive for syphilis to (i) assess fertility intentions and support pregnancy planning and prevention, and (ii) prevent, diagnose, and treat STIs.
Pillar 3	Essential Maternal EMTCT Services: Appropriate maternal testing, prophylaxis and treatment for pregnant and breastfeeding women and girls living with HIV or HBV or sero-positive for syphilis for prevention of transmission to infants
Pillar 4	Infant, Child, and Partner Services: Timely testing, prevention, treatment, care, and support for exposed infants, infected children, household contacts, and partners of women and girls living with HIV or HBV or sero-positive for syphilis.

mother-to-child transmission of HIV still remains a leading transmission route of HIV infection in Nigeria. Nigeria is the leading global contributor to mother-to-child transmission (MTCT) of HIV, with an estimated MTCT rate of 10.6% at 6 weeks and 20.4% after the cessation of breastfeeding (Nigeria Spectrum Estimates, 2025). Some barriers identified as limiting the attainment of elimination of mother-to-child transmission include inadequate access to ANC services, as well as access to HTS during pregnancy and postpartum; drop-offs during pregnancy and breastfeeding; incident HIV infections during pregnancy and breastfeeding; and unsuppressed viral load during pregnancy or breastfeeding.

Other risk factors associated with mother-to-child transmission (MTCT) of HIV are highlighted in Table 4.1 below:

Table 4.1 Risk Factors for MTCT

Pregnancy	Labour and Delivery	Breastfeeding
• High maternal viral load • Late initiation to ART • Poor adherence to ART • Opportunistic Infection • STIs • Malnutrition • Pre-Partum hemorrhage	• High maternal viral load • Prolonged rupture of membranes • Chorioamnionitis • Prolonged labour • Invasive delivery procedures • Instrumental delivery • Episiotomy & genital lacerations • First infant in multiple birth • Preterm birth • Fetal genetic characteristics • Peri-Partum hemorrhage	• High maternal viral load • Early mixed feeding • Breast fissures, infections • Poor maternal nutrition • Oral disease in an infant • PostPartum hemorrhage

4.2 Analysis of PMTCT Cascade

The Elimination of Mother-to-Child Transmission (PMTCT) cascade outlines the sequence of services designed to prevent mother-to-child transmission of HIV, Syphilis and Viral Hepatitis from mother to child. It captures the essential steps pregnant women who are diagnosed with any of these infections must take to access and receive treatment and care for themselves and their infants.

The cascade begins with HIV testing for all pregnant women and ends with the determination of the final HIV status of HIV-exposed infants (HEIs). It ensures that women who test positive are promptly linked to antiretroviral therapy (ART) and retained in care throughout pregnancy, labour & delivery, and breastfeeding, while their infants receive appropriate follow-up, including early infant diagnosis (EID). The PMTCT cascade is commonly disaggregated into the following sub-cascades for programmatic monitoring:

- ANC Cascade: Covers HIV, Syphilis, and Hepatitis B testing and treatment initiation during antenatal care.
- Maternal Cascade: Encompasses maternal ART retention during pregnancy, labour & delivery, and postpartum.
- EID Cascade: Includes virological testing and final HIV status determination of HEIs. The illustrations below present 2025 program data and performance across the PMTCT cascade.

4.3 PMTCT Program Performance

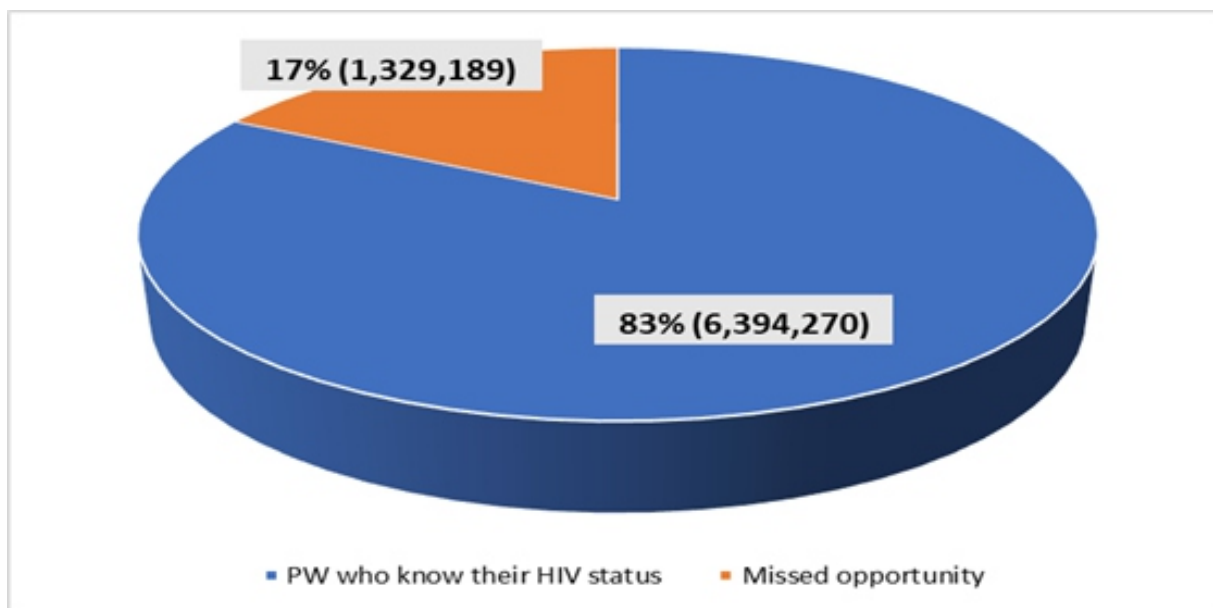


Figure 4.1 HIV testing at ANC

Figure 4.1 illustrates that 6,394,270 (83%) of the total 7,723,459 pregnant women knew their HIV status during antenatal care (ANC) visits. This includes 8,404 newly tested positive women and 20,590 who were already known to be HIV-positive. However, 1,306,700 of the pregnant women were not tested for HIV.

The 17% testing gap represents a missed opportunity for the Elimination of mother-to-child transmission (EMTCT) of HIV. This gap may be attributed to a variety of factors, including disruptions in service delivery following the United States Government (USG) stop work order, stockouts of HIV test kits or instances where pregnant women opted out of testing at the facility level. The failure to determine the HIV status of these women elevates the risk of mother-to-child transmission, as undiagnosed HIV-positive pregnant women may not receive the necessary interventions required to prevent mother-to-child transmission to their unborn children.

4.3.1 Trend of HIV Testing Among Pregnant Women

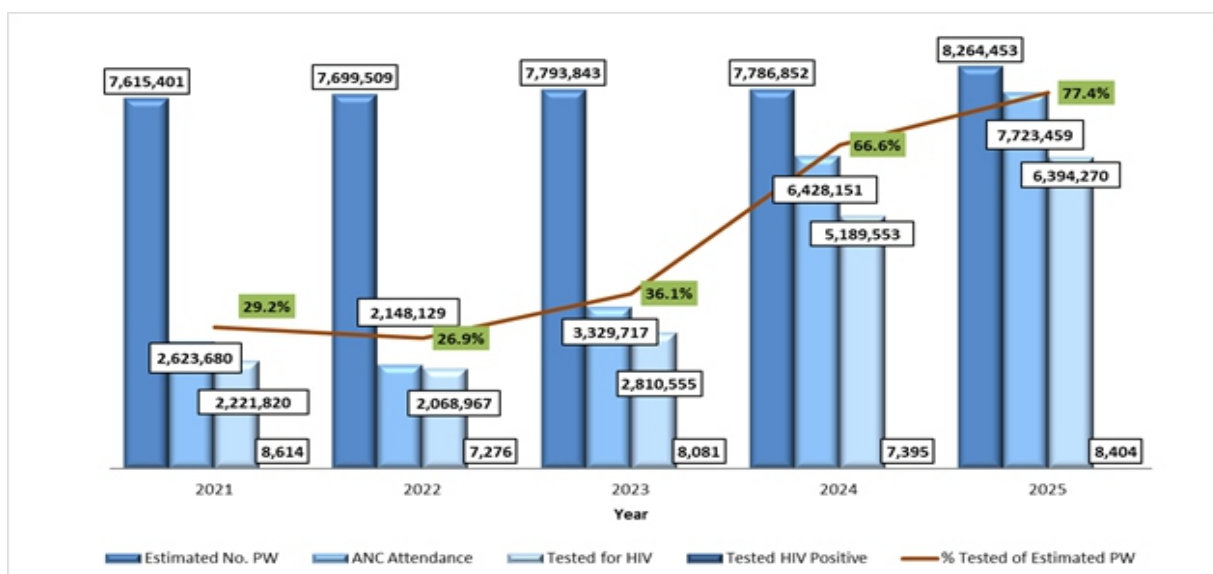


Figure 4.2 Trend in HIV testing at ANC

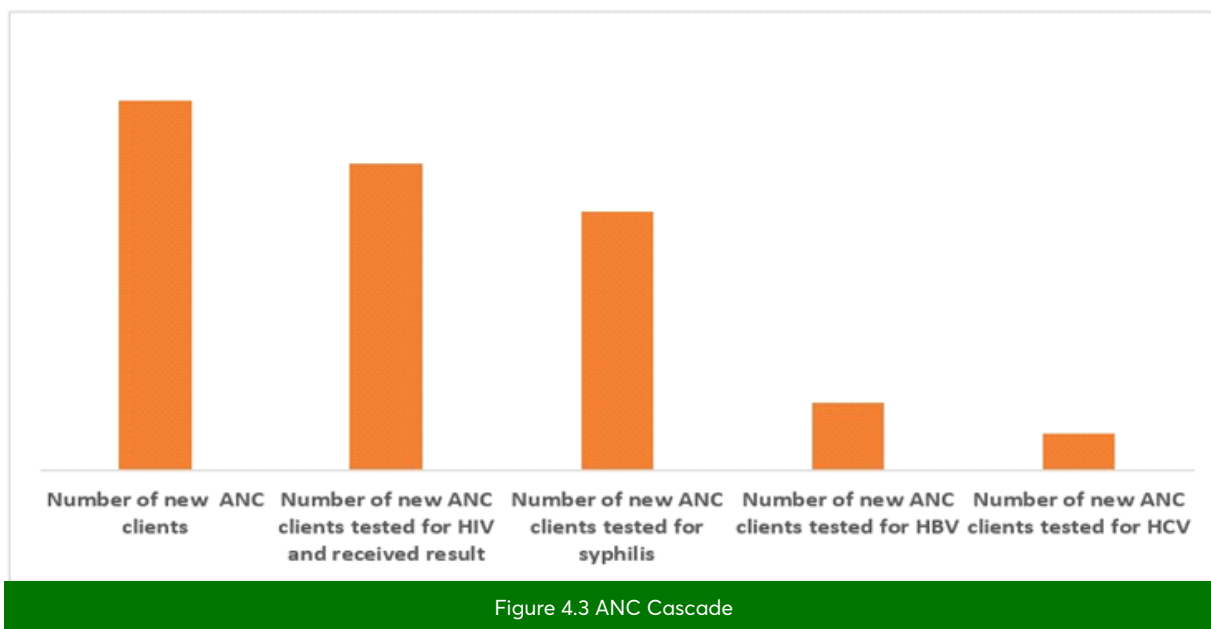
The chart presents a five-year trend analysis (2021-2025) of HIV testing among pregnant women in Nigeria. The indicators reviewed include the estimated number of pregnant women, antenatal care (ANC) attendance, HIV testing uptake, number of women testing HIV positive, and the proportion of pregnant women tested for HIV.

The estimated number of pregnant women remained relatively stable throughout the period, ranging from 7,615,401 in 2021 to 8,264,453 in 2025. ANC attendance declined from 2,623,680 in 2021 to 2,148,129 in 2022 (representing a decrease from 34.5% to 27.8% of the estimated pregnant women in 2021 and 2022 respectively). However, there was a significant increase in ANC attendance to 6,428,151 (82.5%) in 2024 and further to 7,723,459 (93.7%) in 2025, reflecting substantial improvements in service utilization.

A similar trend was observed in the number of pregnant women tested for HIV. Testing coverage significantly maintained an upward trajectory from 2,068,967 in 2022 (26.9%), to 5,189,553 in 2024 (66.6%) and then to 6,394,270 (77.4%) in 2025. The increased access to PMTCT HTS uptake is suggestive of strong PMTCT effectiveness of HIV testing among pregnant women, with 8,614 pregnant women testing positive to HIV in 2021, 8,081 in 2023, and 8,404 in 2025.

The proportion of pregnant women who tested for HIV showed a downward trend from 2021 (29.2%) to 2022 (26.9%), followed by a sharp increase in 2023 (36.1%) and a substantial rise in 2025 to 77.4%. This indicates significant progress in HIV testing coverage during the reporting period.

In conclusion, the year 2025 recorded major improvements in both ANC attendance and HIV testing among pregnant women, with ANC coverage reaching 93.7% and HIV testing coverage increasing to 77.4%. These gains are indicative of strengthened maternal health interventions and expanded HIV services. Despite this progress, approximately 23% of pregnant women remained untested in 2025, underscoring the need for targeted interventions to improve coverage. It is imperative to sustain this momentum through continued investment in maternal and child health programs, intensified outreach to underserved populations, and linkage to care and close monitoring of service quality for those who test positive. EMTCT Cascade



The elimination of mother-to-child transmission (EMTCT) of HIV, syphilis, and hepatitis B (HBV) relies on universal access to integrated antenatal care (ANC) services that include routine screening for all three diseases. The data highlights the number of new ANC (Antenatal Care) clients and the proportion of these clients tested for each of the three diseases.

Number of New ANC Clients (7,723,459): This figure represents the total pool of pregnant women initiating antenatal care during the reporting period. This is a crucial number as ANC visits are a primary entry point for implementing EMTCT interventions. Further questions arise: Is this number increasing or decreasing over time? How does it compare to the estimated total number of pregnant women in the region/country, to gauge ANC coverage?

4.3.2 HIV Testing and Results Received

The fact that 83% of new ANC clients (6,394,270) were tested for HIV and received their results is a positive indicator, and this suggests strong program implementation for HIV testing within ANC settings. While 83% is good, it also means nearly 17% (or roughly 1.31 million) of new ANC clients either weren't tested for HIV or didn't receive their results, and challenges remain in the 17%. Reasons for Not Testing could be due to late ANC entry, multiple ANC visits with no test done, stock-outs of test kits, lack of trained personnel, or client refusal. Reasons for not receiving results could include: clients not returning for results, lost records, or inefficient result delivery systems. This is equally critical, as a test without a result is clinically meaningless. Without timely return of results, HIV infected pregnant women cannot be identified and initiated on treatment, thereby increasing the risk of mother-to-child transmission.

Implications for EMTCT-HIV: High testing coverage is essential for identifying HIV-positive pregnant women who can then be enrolled in prevention of mother-to-child transmission (PMTCT) programs. The remaining gap represents a missed opportunity for intervention.

Syphilis Testing (5,400,682): Syphilis testing coverage of 69.93% is significantly lower than HIV testing. This disparity highlights a significant gap in the integration of triple elimination strategies into ANC services, hence representing a missed opportunity to detect and treat syphilis during pregnancy for a preventable cause of adverse pregnancy outcomes (e.g., stillbirth, neonatal death, preterm birth, low birth weight, congenital syphilis). The relatively lower uptake of syphilis testing could be attributed to Policy & Prioritization where HIV elimination programs might have historically received more funding and programmatic emphasis; Test Kit unavailability arising from issues with the supply chain for syphilis test kits (e.g., RPR/TPHA or rapid tests); Healthcare workers being less consistently trained or aware of the importance of universal syphilis screening; Clients not being aware of the risks of syphilis to their pregnancy as they are aware of HIV.

Implications for EMTCT-Syphilis: The lower coverage means a higher likelihood of missed syphilis cases in pregnant women, leading to preventable congenital syphilis, which has severe long-term health consequences for the child.

HBV Testing (1,422,226): HBV testing has strikingly low coverage, at 22.16%. This is a major concern for the "Triple Elimination" goal. Reasons for Extremely Low Coverage could be that Elimination of mother-to-child transmission of HBV might be a newer or less established program compared to HIV and syphilis; HBV testing (e.g., HBsAg) can be more expensive or require more laboratory infrastructure than rapid HIV or syphilis tests; HBV testing might not be fully integrated into routine ANC services.

Vaccination Strategy: While testing is important for identifying mothers who need antivirals, the primary intervention for preventing HBV MTCT is timely birth dose vaccination for the infants, which relies on identifying mothers at risk, or universal vaccination. However, testing helps identify mothers who need further management or counselling.

Implications for EMTCT-HBV: The extremely low testing rate means that a vast majority of pregnant women are not being screened for HBV, missing opportunities to identify at-risk pregnancies and ensure their infants receive the HBV birth dose vaccine (ideally within 24 hours of birth) and/or other preventive measures.

HCV Testing (765,890): Hepatitis C virus (HCV) screening among pregnant women remains suboptimal, with only 765,890 pregnant women screened, representing a relatively low proportion of new ANC attendees. This limited coverage presents a significant challenge to Nigeria's efforts to strengthen the integrated Triple Elimination agenda and address viral hepatitis within maternal and child health services.

Several factors may contribute to the low uptake of HCV testing. Compared with HIV, syphilis, and routine HCV screening has not yet been fully institutionalized within antenatal care services and is often constrained by limited availability of quality-assured diagnostic commodities, higher testing costs, inadequate laboratory capacity, and inconsistent integration into routine ANC workflows. In addition, insufficient financing for viral hepatitis services continues to impede widespread implementation.

4.3.3 Trend in ANC Attendance

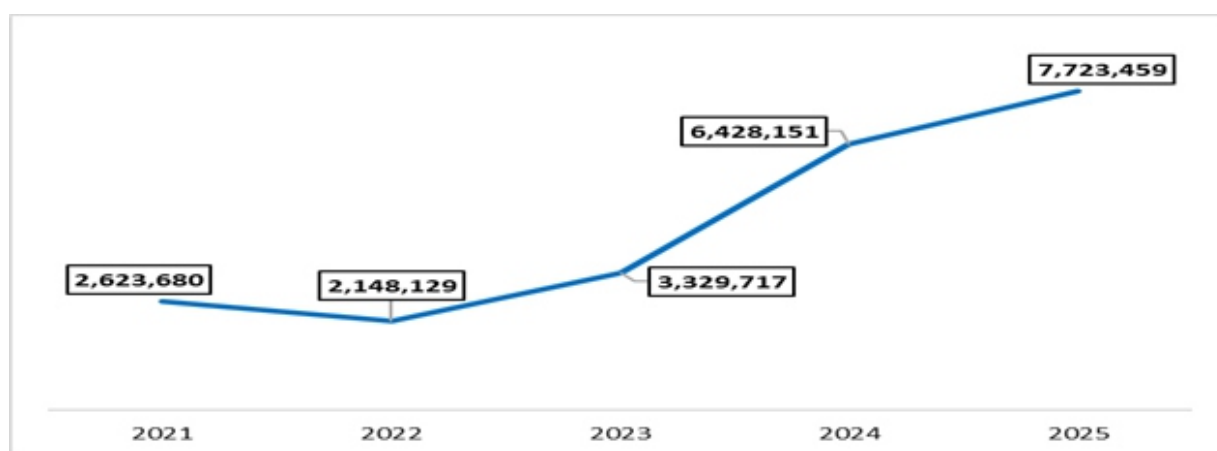


Figure 4.4 Trend in ANC Attendance

In 2021, the value was 2,623,680. This figure saw a significant decrease in 2022, dropping to 2,148,129, which represents a 18.1% decrease from 2021. However, a substantial increase was observed in 2023, as the value rose to 3,329,725, a remarkable 55.06% increase from 2022. The most dramatic growth took place between 2023 and 2025, with the value sharply increasing to 7,723,459, representing a substantial 132% increase from 2023.

The overall trend indicates an initial decline from 2021 to 2022, followed by a strong upward trajectory from 2023 to 2025, demonstrating a rapid acceleration in the observed quantity.

4.3.4 Trend in HIV Testing at PMTCT Setting

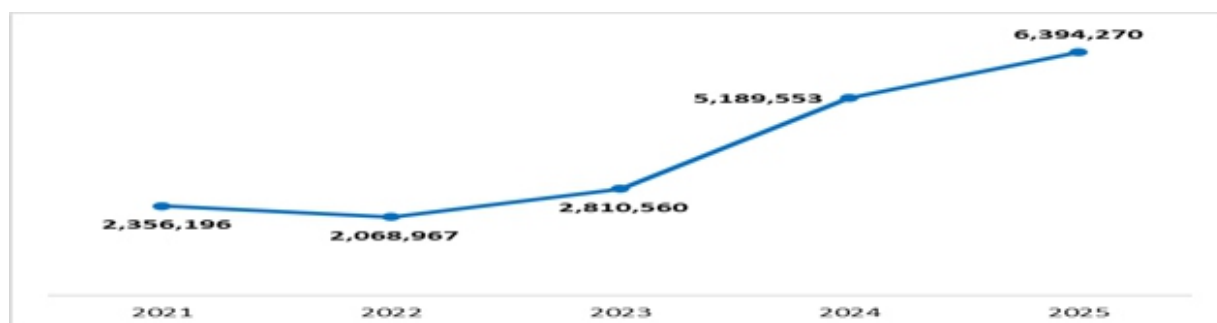


Figure 4.5 Trend in HIV Testing among Pregnant Women

The sustained increase in HIV testing coverage underscores Nigeria's continued commitment to strengthening PMTCT services as a cornerstone of the broader Elimination of Mother-to-Child Transmission (EMTCT) agenda. Continued investments in universal ANC attendance, uninterrupted commodity security, quality service delivery, robust health information systems, and data-driven programme management will be essential to achieving universal HIV testing among pregnant. Consistent with the trend observed in antenatal care (ANC) attendance, HIV testing among pregnant women demonstrated an initial decline followed by a substantial and sustained increase over the reporting period. In 2021, a total of 2,356,196 pregnant women were tested for HIV during ANC services. This declined to 2,068,967 in 2022, representing a 12.19% decrease, likely reflecting residual health system and service delivery disruptions experienced during the preceding years.

The declining trend was reversed in 2023, with 2,810,560 pregnant women receiving HIV testing, representing a 35.84% increase compared with 2022. Programme performance improved significantly in 2024, when the number of pregnant women tested rose to 5,189,553, an increase of 84.64% over the 2023 figure. This positive trajectory was sustained in 2025, with 6,394,270 pregnant women tested for HIV, representing a further 23.21% increase compared with 2024 and an overall 171.38% increase from the 2021 baseline.

Overall, the trend reflects substantial progress in expanding access to HIV testing services within PMTCT programmes and strengthening the integration of provider-initiated HIV testing and counselling into routine antenatal care. The remarkable increase recorded from 2023 onwards demonstrates the impact of intensified programme implementation, increased availability of dual and triple HIV test kits at these sites, and enhanced service delivery.

Additionally, healthcare providers at the unconventional service points received training on HIV testing procedures, documentation, reporting, and referral processes for HIV-positive pregnant women. These efforts improved access to HIV testing services, especially for pregnant women who do not utilize formal health facilities or prefer to remain at home during pregnancy.

4.3.5 PMTCT HIV Testing Outcomes ?

The figure above shows that in 2025, the HIV positivity rate among newly tested pregnant women was 0.13%, with 8,404 out of a total of 6,394,270 pregnant women testing positive and receiving their results.

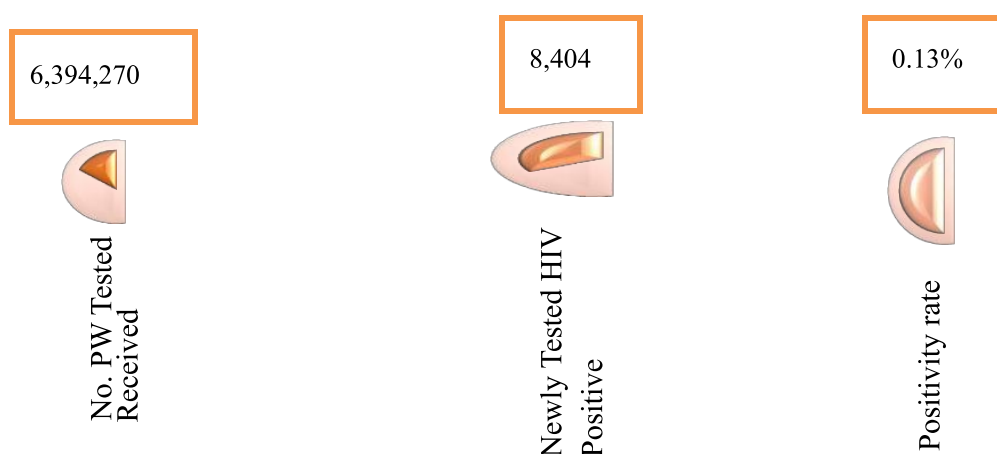


Figure 4.5 Trend in HIV Testing among Pregnant Women

4.3.6 Proportion of Prev. Known Positives & Newly Identified Positives

Figure 4.7 Proportion of Prev. Known Positives & Newly Identified Positives Among HIV Positive Pregnant Women (PPW)

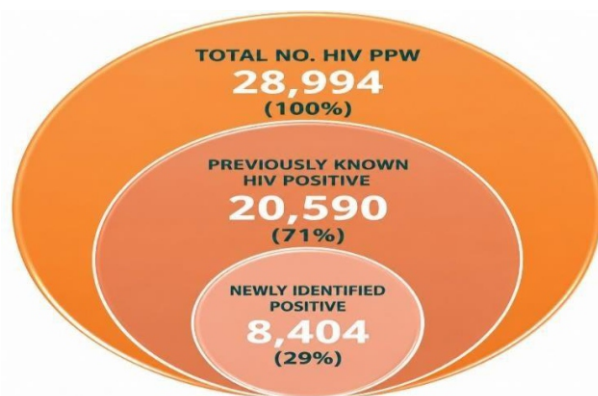


Figure 4.7 Proportion of Prev. Known Positives & Newly Identified Positives Among HIV Positive Pregnant Women (PPW)

The above infographic shows that out of a total of 28,994 HIV-positive pregnant women identified in 2025, 71% were previously known positive, while 29% were newly identified through routine antenatal HIV testing.

This distribution highlights the importance of sustained follow-up and retention in care for known HIV-positive women of reproductive age. It also reflects the effectiveness of antenatal HIV testing services in identifying new infections, which is essential for the timely initiation of PMTCT interventions

4.3.7 HTS Coverage among Pregnant Women

The HTS testing coverage among pregnant women ranges from 65% to 110%. The states are sorted in descending order. 29 states have more than 80% HTS coverage with Anambra being the highest at 110%. The remaining 7+1 states have coverage below 80%, with the least being Kogi at 65%.

In light of the renewed efforts to improve PMTCT testing coverage, ensuring that all pregnant women know their HIV status remains a critical entry point to care. The program must prioritize the routine screening of all newly enrolled pregnant women at antenatal care (ANC) clinics for HIV. To achieve this, it is essential to ensure the continuous availability of HIV test kits and adequately trained human resources for health across all service delivery points including both conventional health facilities and unconventional settings. Furthermore, specific modalities should be instituted to support HIV testing at ANC as a standard practice. These measures are pivotal to closing the gap in HIV case identification among pregnant women and improving overall maternal and child health outcomes

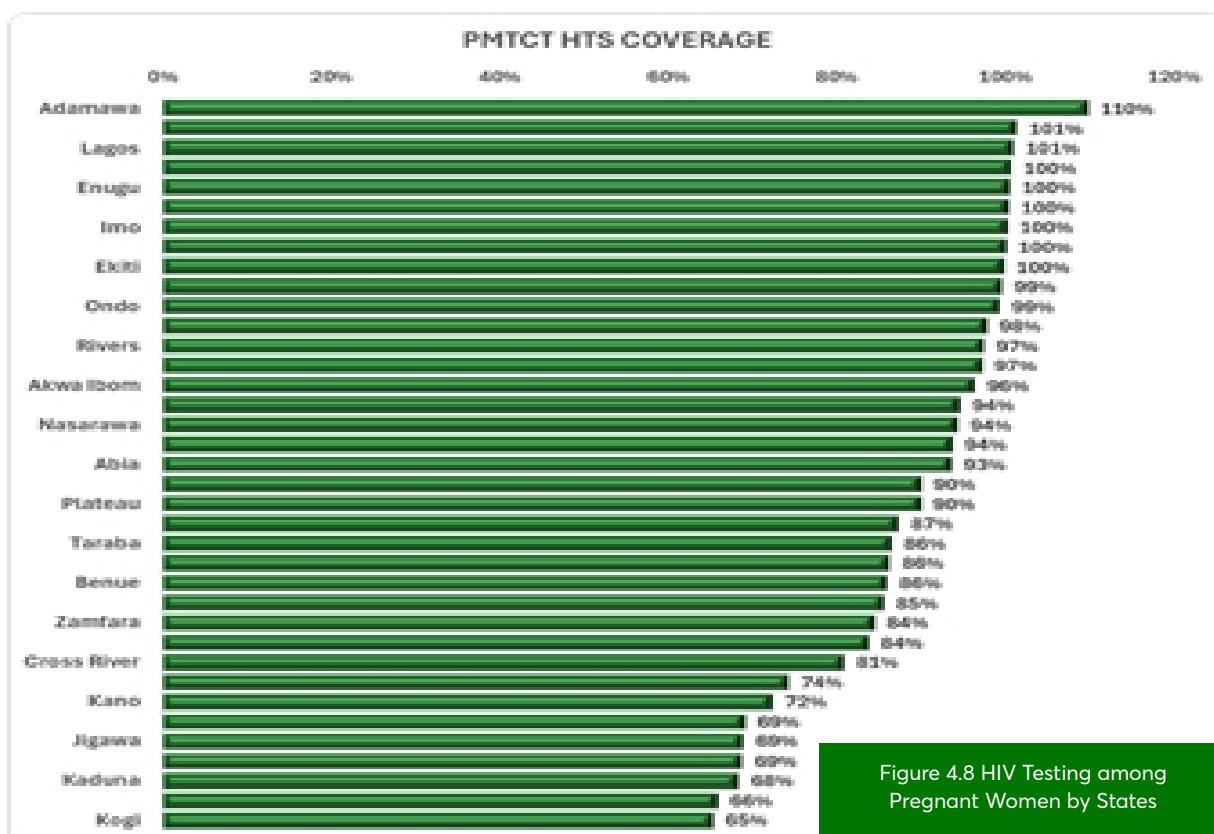


Figure 4.8 HIV Testing among Pregnant Women by States

4.3.8 HIV Positivity Rate at PMTCT setting by State

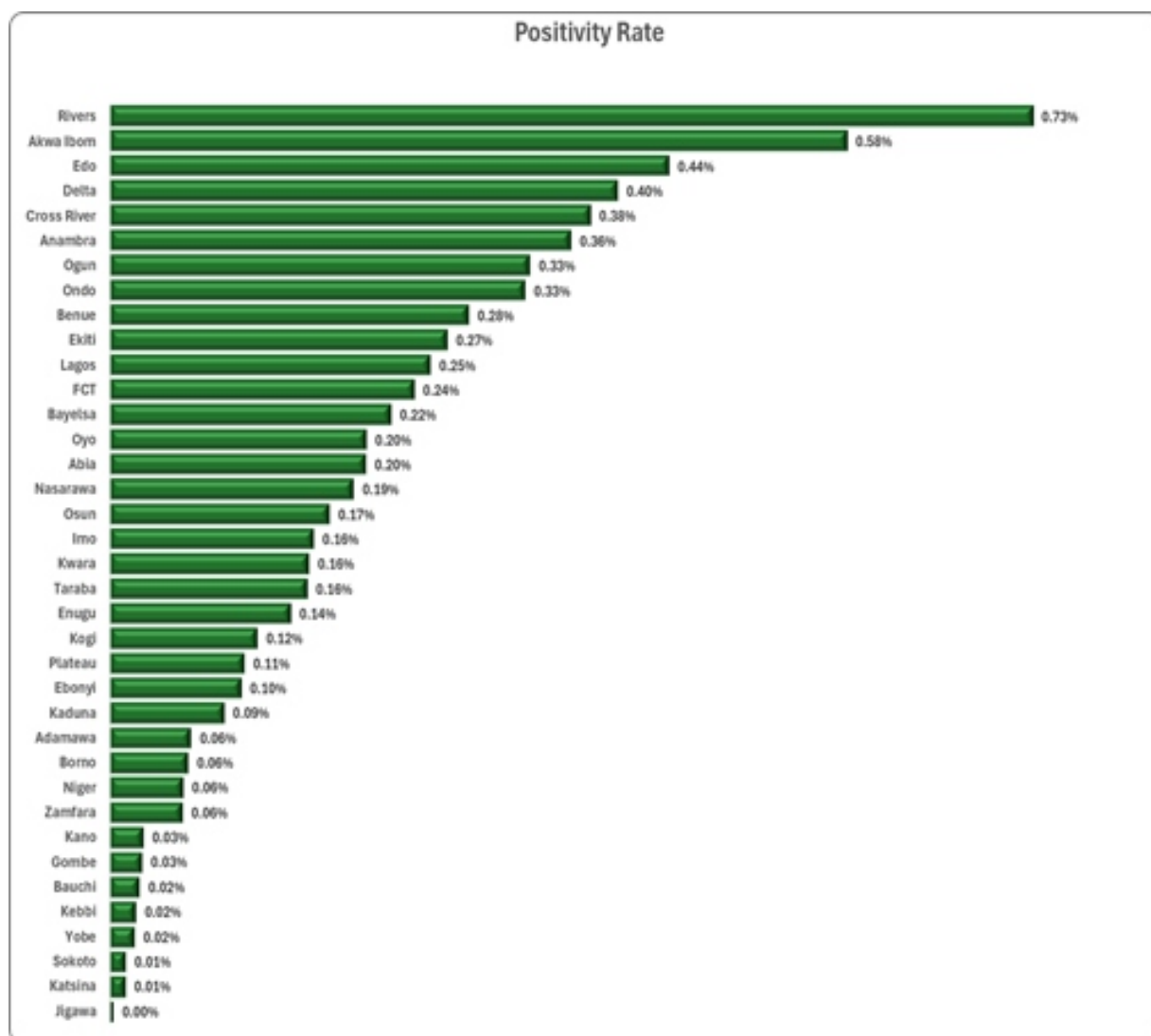


Figure 4.9 HIV Positivity Rate among Newly Tested Pregnant Women

The above chart presents the distribution of a specific indicator across the 36 states and the Federal Capital Territory (FCT) of Nigeria. The values range from 0.00% to 0.73%, with the states arranged in descending order based on performance.

Rivers State recorded the highest value at 0.73%, followed by Akwa Ibom (0.58%) and Edo with 0.44%. These three states are located in the South-South geopolitical zone.

States such as Delta, Cross River, Anambra, Ogun, and Ondo reported moderate values ranging between 0.4 and 0.3. These states span the South-South, South-East, and South-West zones.

Lower values were observed in Benue, Ekiti, Lagos, FCT, Bayelsa, Oyo, Abia, Nasarawa, Osun, Imo, Kwara, Taraba, Enugu, Kogi, Plateau, and Ebonyi with values ranging from 0.2 to 0.1.

Kaduna, Adamawa, Borno, Niger, Zamfara, Kano, Gombe, Bauchi, Kebbi, Yobe, Sokoto, Katsina and Jigawa reported a value of 0.0. These states are predominantly located in the North-West and North-East geopolitical zones.

4.3.9 PMTCT Maternal Cascade

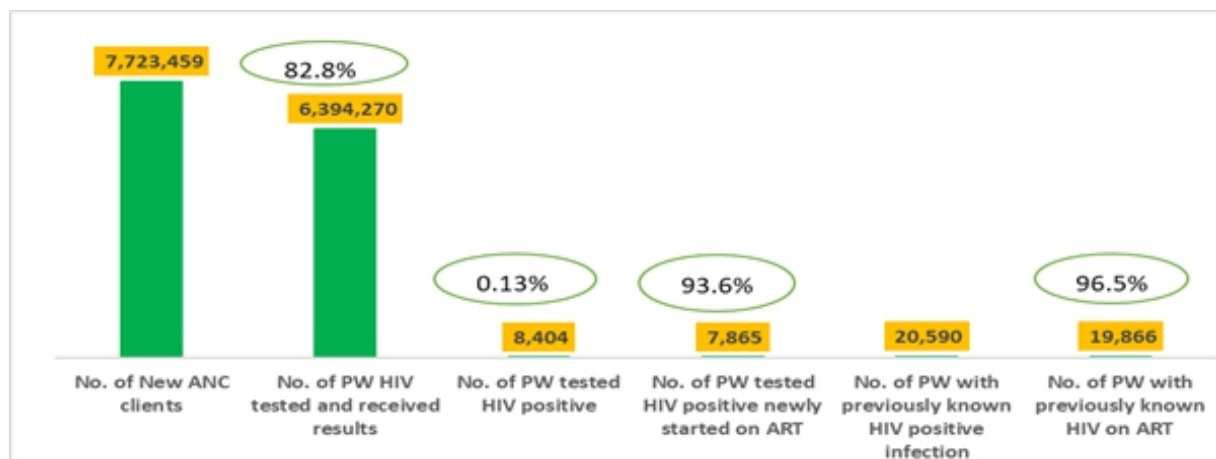


Figure 4.10 Maternal Cascade

The chart presents 2025 programmatic data on HIV testing and treatment among pregnant women attending antenatal care (ANC). A total of 7,723,459 new ANC clients were recorded. Of these, 82.8% (6,394,270) were tested for HIV and received their results. Among those tested, 0.13% (8,404) were newly identified as HIV positive. The total number of HIV-positive pregnant women, including both newly identified and previously known positives, was 28,994. Of this number, 96% (27,731) received antiretroviral therapy (ART) for the prevention of mother-to-child transmission (PMTCT).

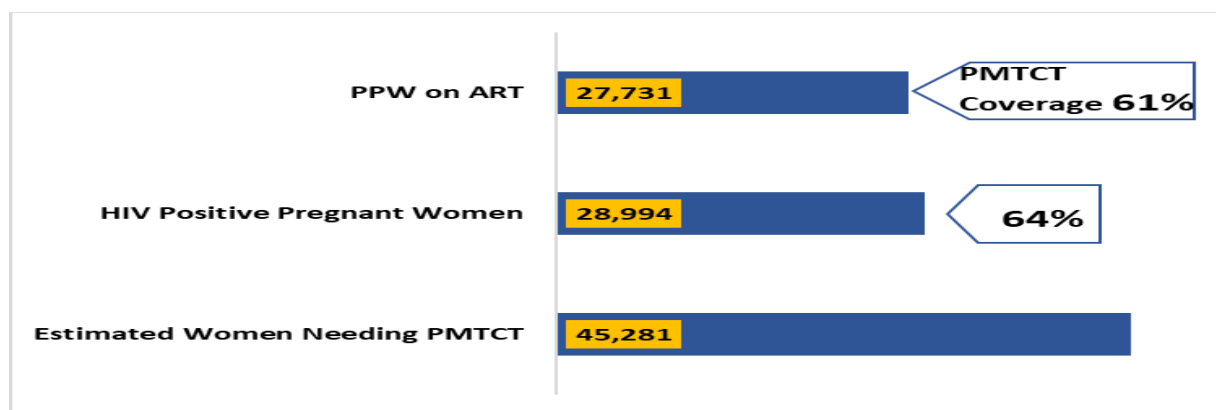


Figure 4.11 PMTCT Coverage by populations

In 2025, Nigeria estimated that 45,281 pregnant women would require PMTCT services. Of this number, 64% (28,994) were identified as HIV positive, and 96% (27,731) were initiated on antiretroviral therapy (ART). This reflects the population PMTCT coverage attained by the country for the reporting period.

Over the years, case identification has remained a major challenge in the EMTCT programme. The 2025 performance underscores the need for intensified efforts in case finding for HIV, Syphilis and HBV, and the adoption of strategic approaches to ensure that all pregnant women across the country are tested for the three diseases. This will help identify those who require EMTCT services and ensure their prompt initiation into treatment and care to prevent mother-to-child transmission of these diseases.

Despite achieving 90% treatment coverage among the general population, PMTCT coverage remains low at 61%. The wide gap in PMTCT coverage continues to drive the burden of HIV among children. As the country progresses towards the 95-95-95 targets, it is imperative to implement targeted interventions to close existing gaps and strengthen areas of weakness within the PMTCT programme.

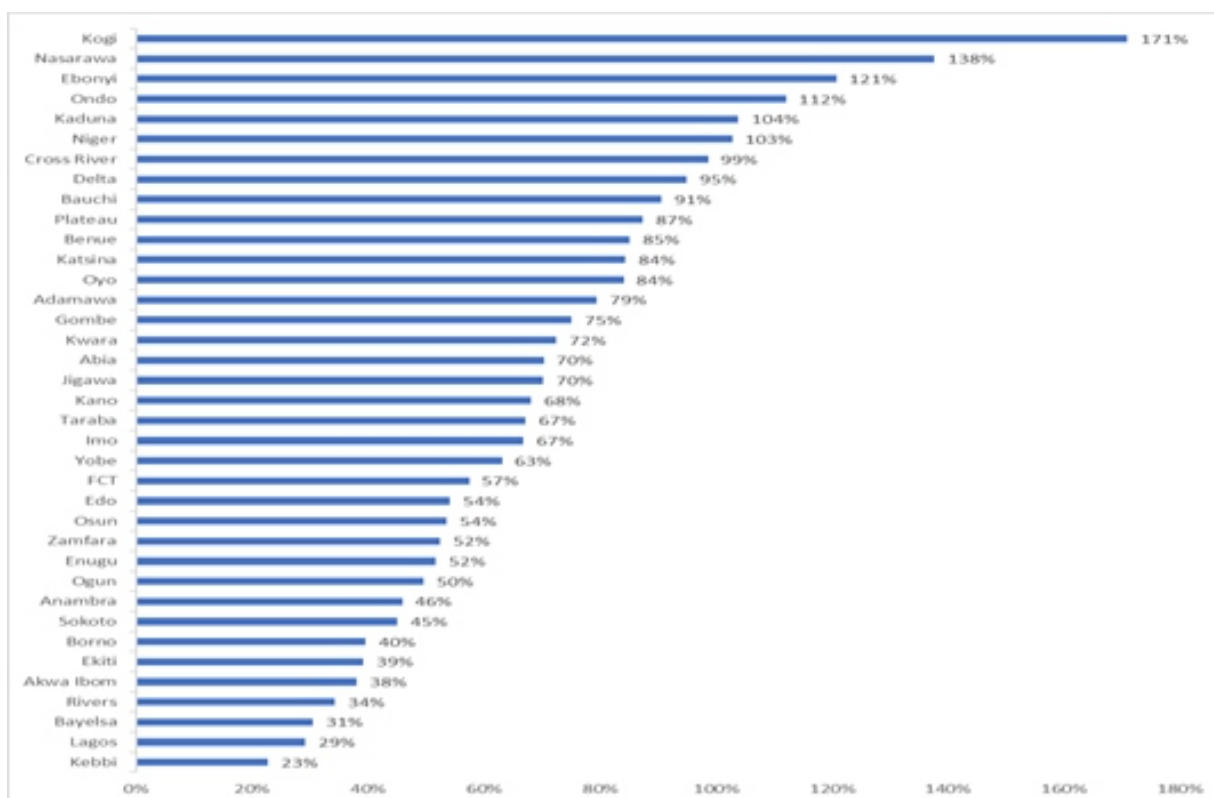


Figure 4.12 PMTCT coverage by population across states

Overall Trend: A substantial disparity in ARV coverage rates are observed among the listed regions, ranging from a descending order of 171% in Kogi to 23% in Kebbi State. This indicates significant variance in the effectiveness of PMTCT initiatives across Nigeria.

Highest Coverage: Kogi state records the highest estimated maternal ARV coverage at 171%, followed closely by Nasarawa at 138%, Ebonyi (121%), Ondo (112%), Kaduna (104%) and Niger (103%) demonstrating comparatively high coverage rates of 100% and above. Cross River (99%) and Delta (95%) and Bauchi 91% also recorded high coverage rates indicating strong uptake and effectiveness in EMTCT services in these states.

Mid-Range Coverage: A majority of states exhibit coverage rates typically ranging between 90% and 50%, indicating good uptake and effectiveness of PMTCT services in these states.

Notable examples of states in the upper mid-range include, Plateau (87%), Benue (85%), Katsina (84%), Oyo (84%), Adamawa (79%), Gombe (75%), Kwara (72%), Abia (70%), Jigawa (70%), Kano (68%), Taraba (67%), Imo (67%), and Yobe (63%).

States in the lower mid-range include the FCT (57%), Edo (54%), Osun (54%), Zamfara (52%), Enugu (52%), Ogun (50%), Anambra (46%), Sokoto (45%), Borno (40%), Ekiti (39%), Akwa Ibom (38%), Rivers (34%), Bayelsa (31%), Lagos (29%), and Kebbi (23%).

Lowest Coverage: Kebbi records the lowest PMTCT coverage at 23% closely followed by Lagos at 29%. Other states with similarly low coverage are Bayelsa (31%), Rivers (34%), Akwa Ibom (38%), Ekiti (39%), Borno 40%) and Sokoto (45%), and Anambra (46%). It is advisable to institutionalize a timely tracking and follow-up system across the underperforming states to ensure that identified pregnant women are placed and retained on ART. National EID Cascade

4.3.10 National EID Cascade

From figure 4.12, the number of booked and un-booked facility deliveries stood at 10,853. The cascade demonstrates strong performance in the uptake of immediate postnatal interventions and early infant diagnosis, with 179.4% (19,467) of HIV-exposed infants (HEIs) receiving ARV prophylaxis within 72 hours of delivery and 135.8% (26,445) of HEIs having their DNA PCR samples collected within two months of birth. However, only 59.2% (11,534) infants were started on cotrimoxazole prophylaxis, which is a critical intervention for reducing morbidity and mortality among HIV-exposed infants until HIV infection has been definitively excluded, highlighting a major gap in the continuity of postnatal care. While 86.5% (22,875) of results were returned as negative and 1.2% (319) as positives, 13.3% (3,251) of results remain pending, indicating challenges with turnaround time (TAT) for EID results. Overall, the cascade demonstrates good uptake of early interventions but reveals gaps in CTX initiation and turnaround time for results, and these require attention. Despite decentralized DNA PCR testing on point-of-care platforms such as GeneXpert and m-PIMA across facilities, the gap in result return highlights the need for improved sample transport and turnaround time. The low positivity rate suggests effective PMTCT interventions, however, continuous monitoring remains crucial for sustainable and improved outcomes.

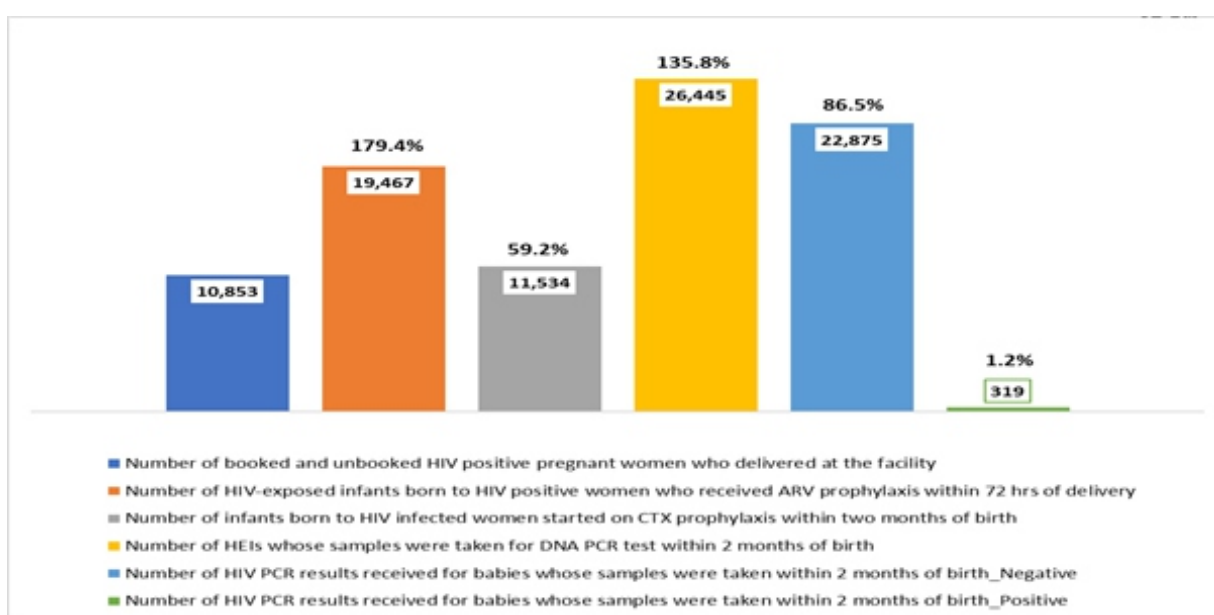


Figure 4.13 EID Final Outcome

Figure 4.13 presents the final HIV rapid test outcomes among HEIs aged 18-24 months who received antiretroviral (ARV) prophylaxis within 72 hours of birth. During the reporting period, 97% (16,297) HEIs out of the 16,827 HEIs who received ARV prophylaxis within 72 hours of birth, had a documented final HIV status outcome at 18-24 months of age.

Of the 16,827 HEIs who received ARV prophylaxis within 72 hours of birth, 16,113 (96%) tested negative to HIV, indicating that the vast majority remained HIV free following completion of the PMTCT cascade. This high proportion of HIV negative outcomes reflects the effectiveness of PMTCT interventions, including timely maternal antiretroviral therapy, infant ARV prophylaxis, appropriate infant feeding practices, and continued follow-up throughout the breastfeeding period.

Conversely, 184 (1%) had a positive final outcome result, indicating residual mother-to-child transmission. These infants require prompt linkage to paediatric antiretroviral therapy and comprehensive HIV care to optimize treatment outcomes and survival.

The remaining 530 (3%) HEIs had no documented final outcome, indicating possible losses along the PMTCT cascade warranting further investigation to improve retention and outcome determination and documentation.

Overall, the findings demonstrate a high rate of HIV negative outcome for HIV-exposed infants, underscoring the effectiveness of Nigeria's PMTCT programme. Nevertheless, the occurrence of residual HIV transmission highlights the need to further strengthen maternal viral load suppression, retention of mother-infant pairs in care, adherence to treatment, and effective uptake of PMTCT services to achieve the goal of eliminating mother-to-child transmission of HIV.

4.3.11 Retesting in PMTCT

Retesting pregnant women for HIV during the third trimester and throughout the postpartum period plays a critical role in the prevention of mother-to-child transmission (PMTCT) of HIV. This strategy increases the likelihood of identifying women who seroconvert after an initial negative test during early pregnancy. Early detection of new infections enables the timely initiation of antiretroviral therapy (ART), thereby reducing the risk of HIV transmission to infants during delivery and breastfeeding. The identification of additional HIVpositive mothers through retesting underscores the importance of integrating routine maternal retesting into the PMTCT cascade, with continued follow-up until the cessation of breastfeeding. This approach is essential for achieving elimination targets and safeguarding infant health.

Maternal HIV retesting provides a vital opportunity to strengthen PMTCT coverage and reduce the risk of mother-to-child transmission (MTCT) of HIV. HIV service providers and health workers in PMTCT settings must ensure routine testing for all pregnant and breastfeeding women with unknown HIV status and retesting for those previously testing negative. Consistent implementation of this strategy is essential to identifying new infections early and initiating timely interventions to protect infants from HIV infection.

Table 4.2 PMTCT Testing by Setting

Setting	ANC	L&D	72hrs Postpartum	>72 hrs - < 6 months Post-Partum	>6 - 12 months Post Partum	Total
Total No. of pregnant women tested and received results	6,034,902	348,048	11,320	0	0	6,394,270
Number that tested HIV positive	7,974	311	119	0	0	8,404
Number that tested HIV negative	6,034,902	347,737	11,201	0	0	6,385,866
Retested after an initial HIV negative result	18,638	22,710	895	1234	533	44,010
Retesting Rate	0.31%	6.53%	7.99%			0.69%

Seroconverted after an initial HIV negative result	110	110	7	27	3	257
Seroconversion Rate	0.59%	50.48%	0.78%			0.58%

A total of 6,394,270 pregnant women were tested for HIV across service delivery points, with 8,404 (0.13%) testing positive and 6,385,866 negatives. Most testing occurred at antenatal clinics (6,034,902), followed by labour and delivery (348,048) and postpartum within 72 hours (11,320). Retesting was conducted for 18,638 women after an initial negative result, mostly at ANC and L&D. While positivity rates remained very low across all settings, the data highlight ANC as the main entry point for testing, with good uptake of retesting though fewer women were reached in the postpartum period.

4.3.12 Syphilis Testing at ANC

Syphilis in pregnancy remains a public health concern in Nigeria. As of 2025, the substantial improvement in syphilis testing coverage among pregnant women observed in 2024 was sustained, with testing levels remaining consistently high throughout the reporting period. This progress is attributed to the integration of syphilis screening into routine antenatal care, increased availability of rapid diagnostic test kits, and enhanced awareness among health workers and pregnant women.

These interventions are part of Nigeria's commitment to the triple elimination of mother-to-child transmission of HIV, syphilis, and hepatitis B. Sustaining the gains will require continued expansion of testing services, strengthened commodity supply chains, capacity building for healthcare providers, and robust monitoring and evaluation systems.

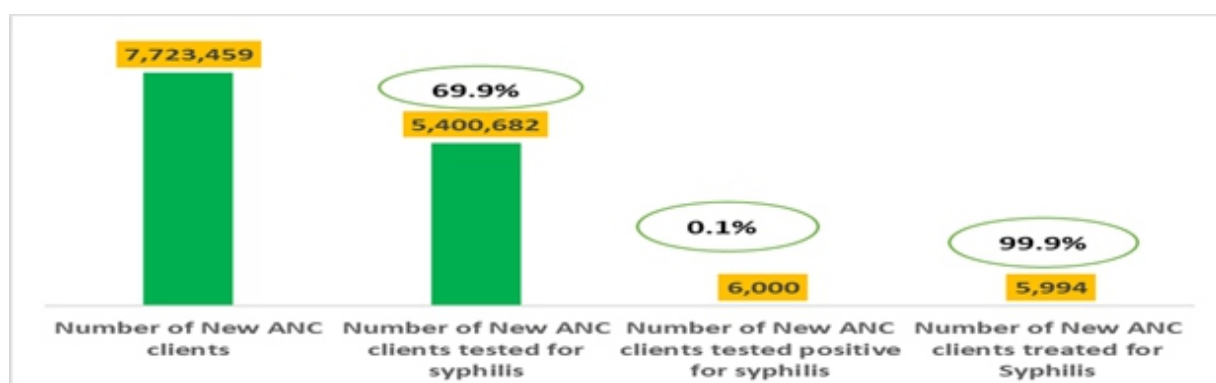


Figure 4.14 Syphilis testing at ANC

Syphilis Testing Coverage: Of the over 7.7 million new ANC clients, approximately 5.4million (69.9%) were tested for syphilis. This highlights that a significant proportion, 30%, of new ANC clients did not undergo syphilis testing.

Syphilis Prevalence among Tested: Among the 5,400,682 clients who were tested, 6,000 yielded positive results for syphilis. This suggests a relatively low prevalence rate within the tested cohort, approximately 0.1%.

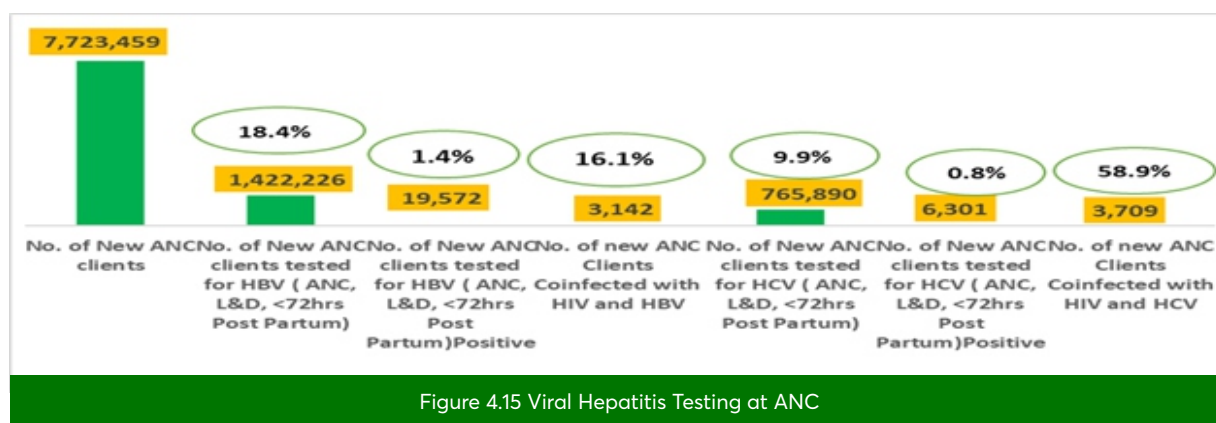
Treatment versus Positive Cases: Notably, the number of ANC clients treated for syphilis (5,994) is lower than the number of new ANC clients who tested positive (6000). This shows a gap in the number of ANC Clients treated for Syphilis.

Implications for PMTCT: The data underscore the imperative of sustained efforts in syphilis screening

during antenatal care to prevent congenital syphilis. The 69.9 % testing rate indicates a necessity to broaden screening coverage to ensure all pregnant women are screened. The lower number of treatments compared to new positive tests warrants further investigation to fully comprehend the scope of treatment interventions.

Hepatitis B virus (HBV) Testing at ANC: Hepatitis B virus (HBV) remains a significant public health concern in Nigeria, with a prevalence of 6–14% among pregnant women. This increases the risk of mother-to-child transmission, which may result in chronic infection and long-term liver complications in infants.

In line with the National HIV, Syphilis, and Hepatitis B Triple Elimination Initiative, national guidelines recommend routine HBV screening during antenatal care (ANC), administration of the Hepatitis B birth-dose vaccine, and provision of Hepatitis B immunoglobulin G (HBIG) to exposed newborns within 24 hours of birth



In 2025, reporting health facilities recorded 7,723,459 new antenatal care (ANC) clients, of whom 1,422,226 (18.4%) were screened for hepatitis B virus (HBV) during antenatal care, labour and delivery, and within 72 hours postpartum in line with the national integrated Elimination of Mother-to-Child Transmission (EMTCT) strategy. Among those screened, 19,572 (1.4%) tested positive for HBV, while 3,142 pregnant women were identified with HIV/HBV co-infection, underscoring the importance of integrated screening, diagnosis, and management of maternal infections to improve maternal and newborn health outcomes.

Although progress has been made in introducing and expanding HBV screening within maternal health services, screening coverage remains far below the national target, leaving a substantial proportion of new ANC clients with unknown HBV status.

Accelerating progress towards the elimination of mother-to-child transmission of HIV, syphilis, and hepatitis B will require scaling up integrated HBV screening as a routine component of quality antenatal care, ensuring uninterrupted availability of quality-assured diagnostic commodities and essential medicines, and strengthening the capacity of healthcare providers to deliver comprehensive EMTCT services. Equally important is the reinforcement of routine health information systems, data quality assurance, and data-driven programme monitoring to improve service coverage, identify implementation gaps, and track progress towards achieving national and global EMTCT elimination targets.

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CHAPTER 5

VIRAL HEPATITIS

5.1 Background

Nigeria carries one of the world's heaviest burdens of viral hepatitis. The National Strategic Framework estimates that approximately 20 million Nigerians are living with hepatitis B or C. This is consistent with the WHO Global Hepatitis Report 2026, which ranks Nigeria second only to Indonesia in the absolute number of people living with chronic hepatitis B, with an estimated 14.4 million chronic HBV infections in 2024¹. Nigeria is also estimated to carry the largest number of children living with chronic hepatitis B of any country, accounting for roughly one-quarter of the global paediatric HBV burden⁵. In response to this public health challenge, the country has been intentional in meeting the global hepatitis elimination target by 2030, defined by WHO as a 90% reduction in new infections and a 65% reduction in hepatitis-related mortality relative to a 2015 baseline¹, through effective prevention, treatment, PMTCT, and support interventions at the national, sub-national, health facility, and community levels, as captured in the National Strategic Framework (2022-2026)³ and delivered through the National AIDS, Viral Hepatitis and STIs Control Programme (NASCP) in collaboration with state governments, implementing partners, and development agencies. The implementation of this framework and the National Guidelines for the Prevention, Treatment and Care of Viral Hepatitis provides the strategic direction for expanding access to hepatitis prevention, diagnosis, treatment, care, surveillance, and monitoring services nationwide.⁴

This chapter presents national programme performance on viral hepatitis in 2025, drawn from routine data generated through HIV Testing Services (HTS), laboratory screening, antenatal care and treatment services as captured on NDARS. The findings assess the country's progress toward the 2030 elimination targets while identifying priority areas for intensified action.

5.2 Epidemiology of Viral Hepatitis

Globally, an estimated 287 million people, accounting for about 3% of the world's population, were living with chronic hepatitis B or C (CHB or CHC) in 2024, comprising 240 million with CHB (2.9% of the global population) and 47 million with CHC (0.6%)¹. Viral hepatitis is now among the leading infectious causes of death worldwide, comparable to tuberculosis: HBV and HCV together claimed an estimated 1.34 million lives in 2024, of which about 1.1 million were attributable to HBV and 240,000 to HCV¹. Transmission continues at more than 4,900 new infections each day - roughly 1.8 million in 2024, split almost evenly between about 0.9 million new hepatitis B and 0.9 million new hepatitis C infections¹. Encouragingly, sustained immunization and prevention efforts have driven a 32% fall in new hepatitis B infections since 2015, and the prevalence of CHB among children under five has declined to 0.6% globally, with 85 countries now meeting or surpassing the 2030 target of 0.1%¹. Progress on treatment, however, has stalled: fewer than 5% of the 240 million people living with CHB were receiving treatment in 2024, despite roughly half being eligible under the 2024 WHO treatment guidelines, while only about 20% of people with hepatitis C have been treated since curative direct-acting antivirals became available in 2015¹.

The burden of HBV is heavily concentrated in the WHO Western Pacific and African Regions, where an estimated 102 million and 64 million people respectively are chronically infected². The WHO African Region carries a chronic HBV prevalence of about 5.4% in the general population and accounted for 68% of all new hepatitis B infections globally in 2024, yet only 17% of newborns in the region received a timely hepatitis B birth-dose (HepB-BD) vaccination - the single most effective intervention for preventing mother-to-child transmission¹. Among people newly infected with HCV, those who inject drugs accounted for 44% of infections, underscoring the importance of harm-reduction and safe-

injection services¹. Other populations at increased risk include health-care workers exposed to needle-stick injuries, people in correctional facilities and other closed settings, and men who have sex with men (MSM).

Viral hepatitis is endemic in Nigeria, with a national HBV prevalence of 8.1% among adolescents and adults aged 15-64 years (10.3% in men and 5.8% in women), peaking at 10.2% for ages 35-39 years and lowest at 2.5% among ages 55-59 years. HCV prevalence is 1.1% among adolescents and adults aged 15-64 years (1.3% in men and 1.0% in women), peaking at 3.3% for ages 50-54 years and lowest (0.4%) for ages 15-19 years⁶. Rural communities are affected more than urban areas, with the Northern states carrying the highest burden. This is corroborated by systematic meta-analyses and state-specific studies showing double-digit prevalence in Northern states such as Nasarawa, Taraba, Benue, Plateau and the FCT. The majority of people infected with viral hepatitis are unaware of their status, as knowledge of viral hepatitis remains limited among policy makers, the general population, key populations, and even health-care providers. These individuals are at greater risk of severe complications and of onward transmission.

5.3 National Programme Performance, 2025

The national viral hepatitis response is delivered through decentralised, integrated services aligned to the National Guidelines for the Prevention, Treatment and Care of Viral Hepatitis, which adopt current WHO recommendations - expanded eligibility for HBV treatment, pan-genotypic Direct-Acting Antivirals (DAAs) for HCV with cure rates above 95%, and strengthened PMTCT⁴. The results presented below summarise testing, case-finding, treatment and viral load performance for 2025, with 2024 shown for comparison where available.

Table 5.1 National viral hepatitis performance scorecard, 2025 (with 2024 comparison)

Indicator	2024	2025	Change
HEPATITIS B			
Clients tested (HTS)	154,333	139,612	▼ 10%
Positive (HTS)	3,665	4,768	▲ 30%
HTS positivity rate	2.4%	3.4%	▲ 1.0 pt
Persons screened (laboratory)	107,315	179,293	▲ 67%
Reactive (laboratory)	8,388	14,924	▲ 78%
Laboratory reactivity rate	7.8%	8.3%	▲ 0.5 pt
Pregnant women screened	—	64,696	*
Newly initiated on treatment	—	653	*

Indicator	2024	2025	Change
HEPATITIS C			
Clients tested (HTS)	127,834	107,295	▼ 16%
HTS positivity rate	2.9%	2.1%	▼ 0.8 pt
Persons screened (laboratory)	68,531	115,680	▲ 69%
Reactive (laboratory)	2,904	4,211	▲ 45%
Laboratory reactivity rate	4.2%	3.6%	▼ 0.6 pt

Arrows indicate direction of change only. A lower positivity rate at higher screening volume reflects broader, lower-threshold screening rather than reduced burden. “—” indicates the indicator was not reported in 2024.

5.3.1 Hepatitis B

Hepatitis B screening through HIV Testing Services, 2025

Outcome of 139,612 clients screened with HBsAg



Total screened: 139,612

Figure 5.1 Hepatitis B screening through HIV Testing Services, 2025

A total of 139,612 individuals were screened for hepatitis B using the hepatitis B surface antigen (HBsAg) test, of whom 134,844 tested negative and 4,768 tested positive, resulting in an overall positivity rate of 3.4%.

Compared with 2024, the number of individuals screened through HTS declined slightly, while the positivity rate increased (3.4% compared with 2.4% in 2024). The improved positivity rate indicates that hepatitis B infection remains a significant public health concern among individuals accessing HIV testing services despite ongoing prevention efforts.

The observed reduction in screening volume may reflect variations in service utilisation, reporting completeness, or testing commodity availability across reporting facilities. Nevertheless, strengthened

programme interventions implemented during 2025 - including enhancement of NDARS, revision of hepatitis reporting tools, capacity-building of programme personnel, routine supportive supervision, mentorship, and data quality assessments - contributed to improvements in data quality and reporting consistency across participating facilities. However, routine programme data likely underestimate the true national burden of hepatitis B because reporting remains dependent on facility participation and completeness of routine reporting.

The findings highlight the continued importance of integrating hepatitis B screening within HIV Testing Services and strengthening linkage of persons diagnosed with hepatitis B to appropriate clinical evaluation and treatment services.

Hepatitis B positivity among HTS clients by sex, 2025

More women tested; higher positivity rate among men

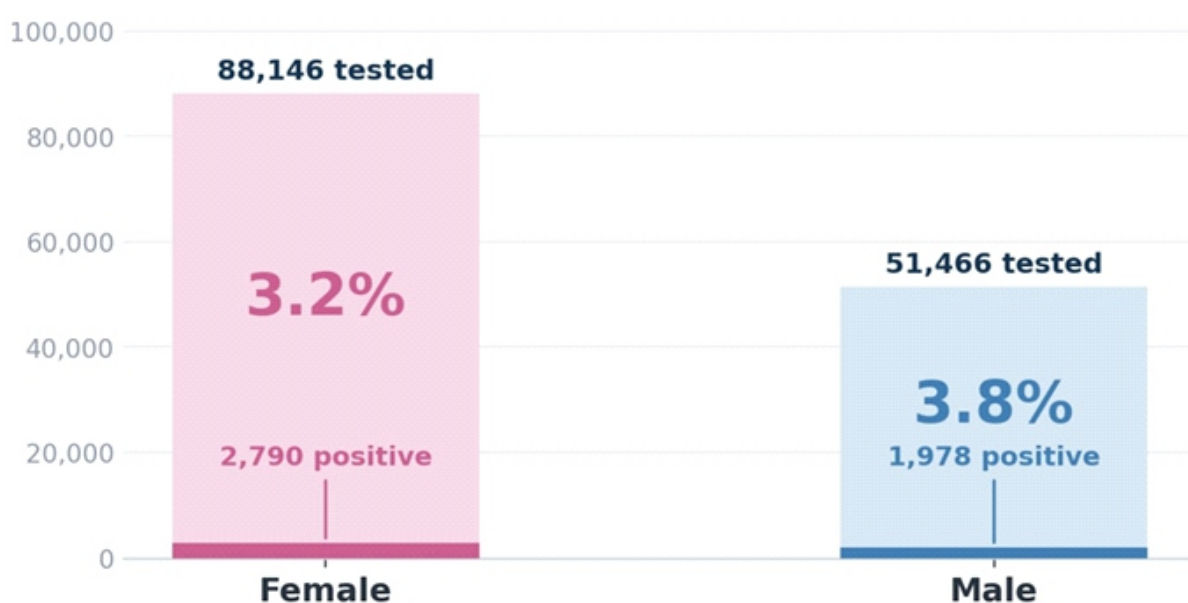


Figure 5.2 Hepatitis B positivity among clients tested through HTS by sex, 2025

Figure 5.2 illustrates the distribution of hepatitis B positivity among male and female clients screened through HIV Testing Services. Of the 139,612 clients screened, 88,146 (63.1%) were female and 51,466 (36.9%) male, reflecting higher female attendance at antenatal and outpatient entry points.

Females accounted for the larger absolute number of positive cases (2,790 compared with 1,978 among males), while males recorded the higher positivity rate (3.8% compared with 3.2% among females). This pattern is consistent with previous findings which have shown higher hepatitis B prevalence among males than females, and indicates that men are being reached in smaller numbers despite carrying a higher risk of infection.

The higher rate observed among males may reflect differences in exposure to behavioural and occupational risk factors, health-seeking behaviour, and utilisation of screening services. Hepatitis B infection nonetheless remains an important public health concern for both sexes, emphasising the need for equitable access to screening, vaccination, prevention services, and linkage to care, alongside deliberate strategies to expand male participation in testing.

Hepatitis B laboratory screening, 2025

Outcome of 179,293 persons screened in laboratories



Total screened: 179,293

Figure 5.3 Hepatitis B laboratory screening, 2025

A total of 179,293 individuals were screened for hepatitis B in laboratories during the 2025 reporting period. Of these, 164,369 tested non-reactive while 14,924 were reactive, representing an overall reactivity rate of 8.3%. Compared with 2024, the number of individuals screened increased from 107,315 to 179,293, a 67% increase in laboratory screening coverage, while reactive cases rose from 8,388 to 14,924.

The increased screening volume observed in 2025 reflects continued efforts to strengthen viral hepatitis programme implementation through expansion of routine screening services and improvements in programme monitoring and reporting. During the reporting period, NASCP implemented several strategic interventions, including revision of hepatitis reporting tools, enhancement of NDARS, step-down capacity-building trainings, supportive supervision, mentorship, routine Data Quality Assessments, state monitoring and evaluation review meetings, and optimisation of electronic reporting systems. These initiatives strengthened reporting capacity, improved data quality, and enhanced the completeness and timeliness of routine hepatitis reporting across participating facilities.

Although these programme investments have improved the visibility of viral hepatitis services, the reported data likely underestimate the true burden of hepatitis B infection in Nigeria. Routine programme data are generated primarily from facilities providing hepatitis screening services and remain influenced by differences in reporting completeness, laboratory capacity, commodity availability, and service coverage across states.

Consequently, the findings presented in this report should be interpreted as programme performance data rather than estimates of national disease prevalence.

Hepatitis B laboratory screening by population, 2025

The three populations sum to the national total: 179,293 screened, 14,924 reactive (8.3%)

All persons screened for HBV in 2025 = 179,293

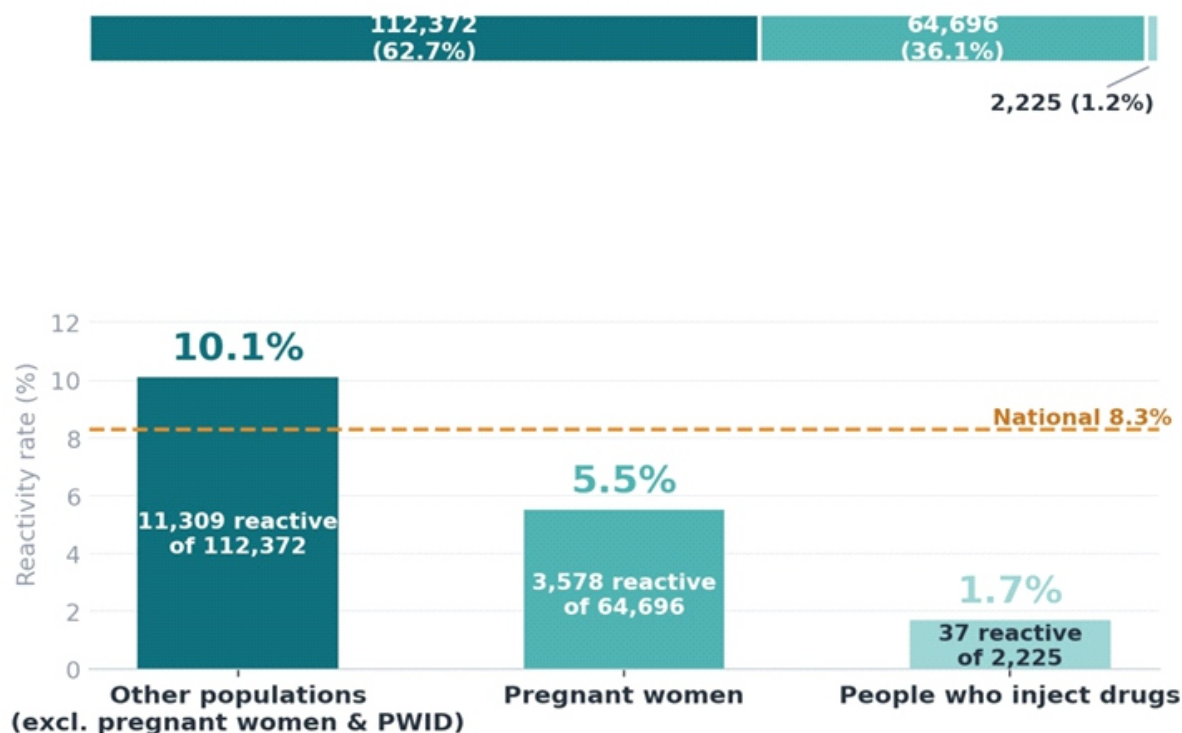


Figure 5.4 Hepatitis B laboratory screening by population, 2025

Figure 5.4 disaggregates the 179,293 persons screened for hepatitis B in 2025 into three mutually exclusive population groups whose totals sum to the national figure. Other populations - that is, persons screened outside antenatal care and outside people who inject drugs (PWID) services - accounted for 112,372 persons screened (62.7%), with 11,309 reactive, a reactivity rate of 10.1%. Antenatal screening covered 64,696 pregnant women (36.1%) with 3,578 reactive, a rate of 5.5%, while 2,225 people who inject drugs (1.2%) were screened, of whom 37 were reactive, a rate of 1.7%.

Reactivity was highest among other populations at 10.1%, above the national average of 8.3%, indicating that general and facility-based screening outside antenatal care is reaching individuals at comparatively higher risk. The lower rate among pregnant women (5.5%) is consistent with an antenatal population screened universally rather than on the basis of risk, and the large antenatal screening volume represents a significant PMTCT gain, positioning the programme to prevent mother-to-child transmission through timely birth-dose vaccination and maternal prophylaxis. Screening among people who inject drugs remains limited in volume, and the low observed reactivity should be interpreted with caution given the small number screened relative to the size of this key population.

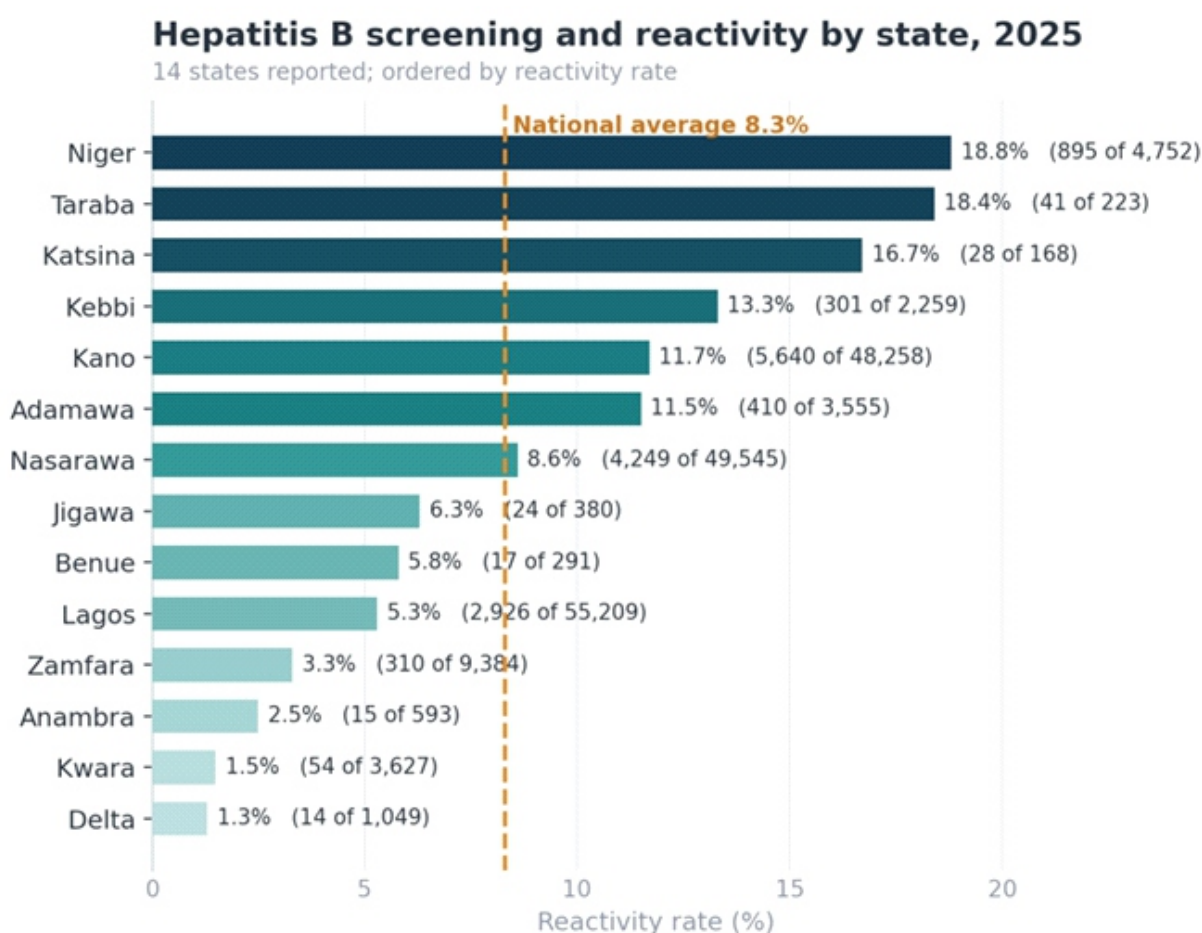


Figure 5.5 Hepatitis B screening and reactivity by state, 2025

Fourteen states reported hepatitis B laboratory screening in 2025, together accounting for all 179,293 persons screened nationally. Lagos (55,209), Nasarawa (49,545) and Kano (48,258) contributed the largest screening volumes, while the highest reactivity rates were recorded in Niger (18.8%), Taraba (18.4%) and Katsina (16.7%) - several Northern states substantially above the national average of 8.3%. The overlap of high screening volume and high reactivity in states such as Kano (11.7%) and Nasarawa (8.6%) signals where treatment scale-up and linkage to care should be prioritised.

Table 5.2 Hepatitis B screening and reactivity by state, 2025

State	Persons screened	Reactive	Rate (%)
Adamawa	3,555	410	11.5%
Anambra	593	15	2.5%
Benue	291	17	5.8%
Delta	1,049	14	1.3%
Jigawa	380	24	6.3%
Kano	48,258	5,640	11.7%
Katsina	168	28	16.7%
Kebbi	2,259	301	13.3%
Kwara	3,627	54	1.5%
Lagos	55,209	2,926	5.3%
Nasarawa	49,545	4,249	8.6%
Niger	4,752	895	18.8%
Taraba	223	41	18.4%
Zamfara	9,384	310	3.3%
Nigeria (total)	179,293	14,924	8.3%

States not listed did not report hepatitis B laboratory screening data for 2025. Expanding sub-national reporting completeness remains a priority for the 2026 reporting cycle.

Hepatitis B treatment initiation and continuation, 2025

Only 150 of 653 clients initiated remained on treatment

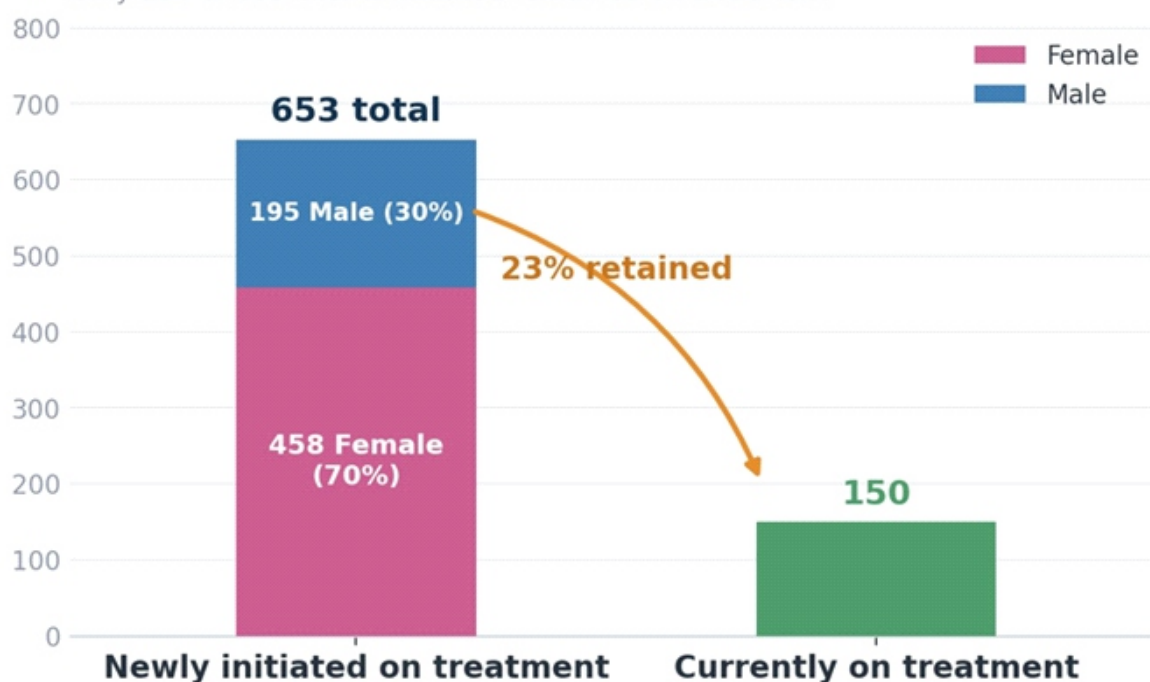


Figure 5.6 Hepatitis B treatment initiation and continuation, 2025

A total of 653 clients were newly initiated on hepatitis B treatment in 2025, comprising 458 women (70%) and 195 men (30%). The strong female representation reflects case-finding through antenatal services. However, only 150 clients were reported as currently on treatment, representing a retention of 23% from the pool newly commenced during the year.

Out-of-pocket payment and the cost of treatment have been major contributing factors to the difficulty newly initiated clients face in continuing and completing treatment. Addressing affordability through improved commodity security, subsidised or integrated financing mechanisms, and stronger client follow-up systems is therefore central to improving treatment continuity and realising the clinical benefit of expanded case-finding.

Hepatitis B viral load distribution, 2025

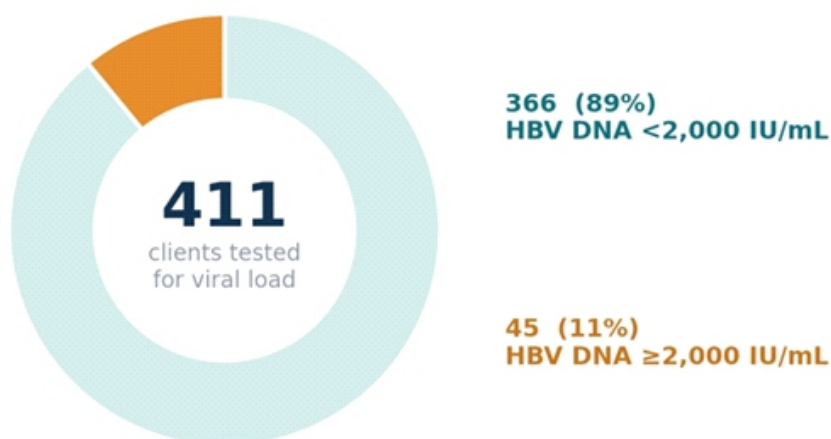


Figure 5.7 Hepatitis B viral load distribution, 2025

Of 411 hepatitis B clients who received viral load testing in 2025, 366 (89%) had HBV DNA below 2,000 IU/mL while 45 (11%) had levels of 2,000 IU/mL or above. Viral load coverage remains low relative to the pool of 14,924 reactive clients identified during the year, and expanding access to HBV DNA testing is a priority for determining treatment eligibility and monitoring treatment response.

5.3.2 Hepatitis C

Hepatitis C is curable with short-course pan-genotypic direct-acting antivirals achieving cure rates above 95%, and national guidelines recommend treatment for all clients with confirmed HCV viraemia⁴. The performance presented below covers testing and laboratory screening; treatment and state-level hepatitis C data were not reported for 2025.

Hepatitis B screening through HIV Testing Services, 2025

Outcome of 139,612 clients screened with HBsAg



Total screened: 139,612

Figure 5.8 Hepatitis C screening through HIV Testing Services, 2025

A total of 107,295 clients were tested for hepatitis C through HIV Testing Services in 2025, of whom 105,011 tested negative and 2,284 tested positive, giving a positivity rate of 2.1%. Both testing volume and positivity declined relative to 2024, when 127,834 clients were tested at a positivity rate of 2.9%. The decline in screening volume may reflect variations in commodity availability and reporting completeness across facilities, and sustained integration of hepatitis C testing within HTS will be required to maintain case-finding.

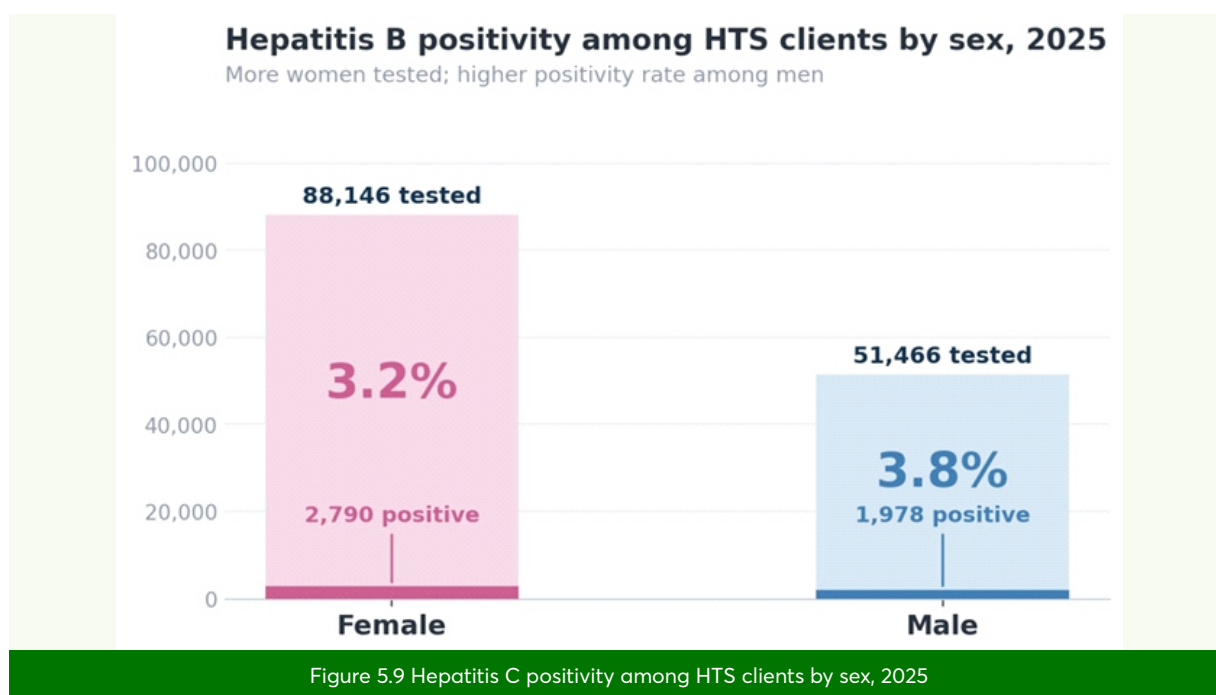


Figure 5.9 Hepatitis C positivity among HTS clients by sex, 2025

As observed with hepatitis B, more women (65,558) than men (41,737) were tested for hepatitis C, while positivity was higher among men (2.5%) than women (1.9%). Females accounted for 1,243 positive cases and males for 1,041. This reinforces the need for targeted strategies to increase male uptake of hepatitis testing services.

Hepatitis B laboratory screening, 2025

Outcome of 179,293 persons screened in laboratories



Total screened: 179,293

Figure 5.10 Hepatitis C laboratory screening, 2025

Laboratory screening for hepatitis C antibody reached 115,680 persons in 2025, of whom 111,469 were nonreactive and 4,211 reactive, a reactivity rate of 3.6%. This represents a 69% increase in screening volume from 68,531 persons in 2024, with reactive cases rising from 2,904 to 4,211 while the reactivity rate declined from 4.2% to 3.6% - a pattern consistent with broader screening reaching a wider population. Linking reactive clients to confirmatory HCV RNA testing and to direct-acting antiviral treatment remains the principal gap, as no hepatitis C treatment data were reported for 2025.

5.3.3 Hepatitis D

Hepatitis D occurs only as a co-infection or super-infection with hepatitis B and is the most severe form of chronic viral hepatitis, progressing rapidly to cirrhosis and hepatocellular carcinoma. It is preventable through hepatitis B vaccination. No hepatitis D-specific programme data were reported in 2025. Introducing HDV testing among clients confirmed HBsAg-positive is a recommended next step for the 2026 reporting cycle.

5.4 Key Achievements and Priority Areas

Achievements in 2025

- Laboratory screening scaled up substantially, rising 67% for hepatitis B (to 179,293 persons) and 69% for hepatitis C (to 115,680 persons).
- Antenatal hepatitis B screening reached 64,696 pregnant women, strengthening the PMTCT platform and creating the basis for timely birth-dose vaccination.
- Hepatitis B treatment initiation was recorded for 653 clients, with strong female representation (70%).
- Hepatitis B case-finding yield in HTS improved, with positivity rising from 2.4% in 2024 to 3.4% in 2025.
- Programme systems were strengthened through enhancement of NDARS, revision of hepatitis reporting tools, capacity-building, supportive supervision, and routine data quality assessments.
- Priority areas toward 2030
- Improve treatment continuity: only 23% of clients newly initiated on hepatitis B treatment were retained, with out-of-pocket costs a principal barrier requiring financing and commodity security solutions.

- Expand male-focused testing, as positivity was higher among men for both hepatitis B and hepatitis C despite lower testing volumes.
- Scale hepatitis B viral load testing, with only 411 clients tested against 14,924 reactive results, to guide treatment eligibility and monitoring.
- Improve sub-national reporting completeness, as only 14 states reported hepatitis B laboratory data in 2025.
- Establish hepatitis C treatment and state-level reporting, neither of which was captured in 2025.
- Introduce hepatitis D testing among clients confirmed HBsAg-positive.

CHAPTER 6

PRE-EXPOSURE PROPHYLAXIS (PREP) – PROGRESS, DATA ANALYSIS AND STRATEGIC DIRECTIONS

6.1 Background and Rationale

Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medication by HIV-negative individuals to reduce the risk of acquiring HIV. Systematic reviews have demonstrated high effectiveness of oral tenofovir-based regimens when adherence is adequate (Fonner et al., 2016). In Nigeria, adult HIV prevalence remains approximately 1.3-1.4 %, yet prevalence among key populations is substantially higher: 15-17 % among female sex workers, approximately 25 % among men who have sex with men, 11 % among people who inject drugs and nearly 29 % among transgender persons (FMOH, 2019; FMOH, 2020b). New infections have declined over the past decade, but tens of thousands of new infections still occur annually, underscoring the need for scaled combination prevention that includes PrEP (NACA, 2025).

The 2020 National Guidelines for HIV Prevention, Treatment and Care formally adopted oral PrEP as an additional prevention option for persons at substantial risk (FMOH, 2020). Priority populations include serodiscordant couples, sex workers, people who inject drugs, individuals who engage in anal sex, high-risk adolescents and young people, and transgender persons. PrEP is to be offered within a combination package that includes condoms, lubricants, harm reduction, STI screening and behavioural counselling (FMOH, 2020; FMOH, 2022).

6.2 Policy and Implementation Framework

6.2.1 National Guidelines and Priority Populations

The 2020 Guidelines recommend daily oral tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) as the preferred regimen, with event-driven (2+1+1) dosing recognised for eligible cisgender men and certain transgender populations (FMOH, 2020). The Standard Operating Procedure for Oral PrEP Service Delivery standardises screening for substantial risk, eligibility determination, initiation, monitoring, follow-up and gender-based violence assessment (FMOH, n.d.).

6.2.2 National Oral PrEP Implementation Plan 2022-2024

The National Oral PrEP Implementation Plan (January 2022-January 2024) provided the operational roadmap for scale-up (FMOH, 2022). Its five objectives were to utilise existing HIV platforms, build provider capacity, increase demand and uptake, ensure commodity availability, and integrate PrEP strategic information into national monitoring systems. Targets were set with the PrEP-it tool for serodiscordant couples, adolescent girls and young women, MSM, female sex workers, PWID and transgender persons. Service delivery prioritised one-stop shops for key populations, selected health facilities, community outreach and private pharmacies (FMOH, 2022). An independent assessment of the Plan (2023-2024) informed subsequent iterations that incorporate long-acting injectable options (MOSAIC/FMOH, 2024).

6.2.3 Alignment with the National HIV Prevention Plan 2026-2030

The National HIV Prevention Plan 2026-2030 ("From Chasing the Epidemic to Outrunning It") places primary prevention, including PrEP, at the centre of the Generation Negative (GEN-N) strategy (NACA, 2025). Scaling PrEP coverage among priority populations is essential for achieving an 80 % reduction in new infections relative to 2010 baselines and ending AIDS as a public-health threat by 2030.

6.3 National Programme Data Analysis, 2025

The analyses below draw on national HTS Monthly Summary and Addendum data for 2025. HIV testing is the entry point for PrEP; clinical STI screening and syphilis testing identify elevated sexual risk; and documented eligibility among key populations quantifies the immediate PrEP-eligible pool (NASCP/NACA programme data, 2025).

6.3.1 HIV Testing Services and HIV-Negative Cascade

In 2025, 6,082,006 individuals were tested for HIV and received results. Approximately 5.76 million tested HIV-negative (94.7 %). Facility-based modalities (CT sites, stand-alone sites, in-patient and outpatient specialty sites) account for most of the HIV-negative results, while community outreach and pregnant-women testing contribute substantial additional volumes (NASCP/NACA, 2025).

Table 6.1 Selected HIV-negative results by modality, Nigeria 2025			
Modality	Female	Male	Total (approx.)
CT Site	1,374,266	988,047	2,362,313
Stand alone	397,604	312,268	709,872
Community – Outreach	612,631	320,882	933,513
Community – Pregnant Women	596,747	—	596,747
In-patient	205,706	149,905	355,611

Source: National HTS Monthly Summary data, 2025 (NASCP/NACA, 2025).

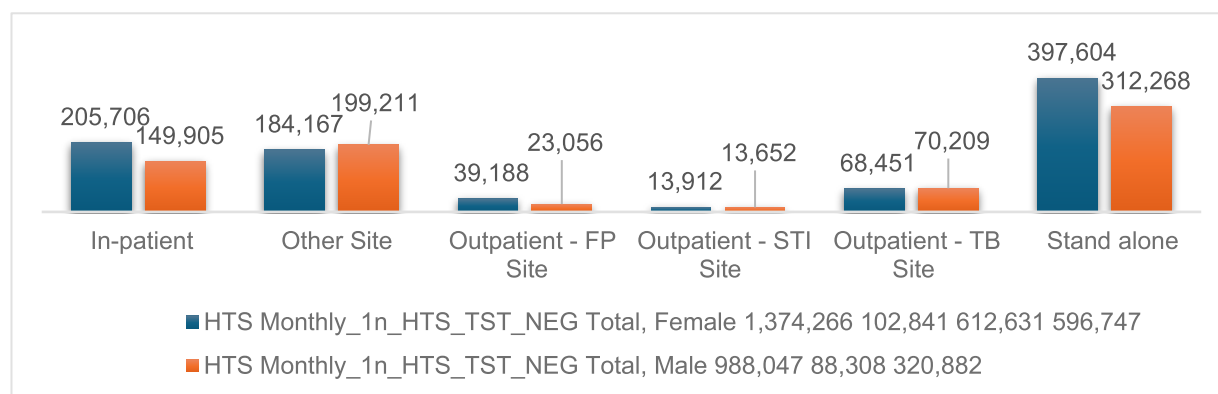


Figure 6.1 HIV-negative results by modality in 2025

6.3.2 Clinical STI Screening and Syphilis Testing as Risk Proxies

Clinical screening for STIs and laboratory syphilis testing are integral to PrEP eligibility assessment. In 2025, 1,882,872 HTS clients (30.96 % of total HTS) were clinically screened for STIs, while 250,745 (4.12 % of HTS; 13.3 % of those screened) received syphilis testing. Of those tested, 10,949 were positive (positivity 4.37 %) (NASCP/NACA, 2025). The substantial gap between clinical screening and laboratory confirmation constitutes a missed opportunity for both STI management and accurate PrEP risk stratification.

Table 6.2 STI clinical screening and syphilis testing cascade relative to HTS, 2025

Indicator	Number	% of Total HTS
Total HTS	6,082,006	100 %
Clinically screened for STIs	1,882,872	30.96 %
Tested for syphilis	250,745	4.12 %
Syphilis positive	10,949	4.37 % positivity

Source: STI_PrEP data and modality summaries, 2025 (NASCP/NACA, 2025).

6.3.3 Facility-Community and Sex Differentials

STI clinical screening is heavily facility-based (about 75 % facility versus 25 % community). Syphilis testing is somewhat more balanced (about 64 % facility / 36 % community). Females accounted for 53 % of clinical STI screens and 68 % of syphilis tests, reflecting higher utilisation of reproductive-health platforms. Lower male participation limits reach among MSM and male partners of high-risk women (NASCP/NACA, 2025).

6.3.4 Key Population PrEP Eligibility

Among key populations (excluding women attending antenatal care), 28,478 individuals were clinically screened for STIs and 9,439 were tested for syphilis (positivity 4.7 %). Critically, 26,496 KP individuals were documented as eligible for PrEP. Concurrently, 192,456 KP individuals tested HIV-negative, indicating a large potential pool beyond currently recorded eligibility (NASCP/NACA, 2025). The gap between HIV-negative KP tests and recorded eligibility suggests incomplete documentation or under offer of PrEP.

Table 6.3 Key population STI screening, syphilis testing and PrEP eligibility, 2025

Indicator (KP)	Number	Notes
Clinically screened for STIs	28,478	M 13,150; F 15,328
Tested for syphilis	9,439	Pos: 445 (4.7 %)
Eligible for PrEP	26,496	Documented eligibility
KP tested HIV-negative	192,456	Potential PrEP pool

6.3.5 National PrEP Uptake Context

National programme reports indicate that approximately 252,000 individuals were newly enrolled on PrEP in 2024, predominantly sex workers, followed by MSM, PWID and transgender persons (NACA, 2025). Early 2025 data signalled volatility in some reporting streams, highlighting fragility linked to commodity availability and funding transitions. Coverage relative to estimated population size and the volume of HIV-negative tests remained modest, indicating the need for sustained scale-up and improved continuation (NACA, 2025; MOSAIC/FMoH, 2024).

6.4 Key Challenges

1. Facility-community imbalance and lower male engagement (NASCP/NACA, 2025).
2. Continuation and persistence challenges that reduce prevention impact (FMoH, 2022;

MOSAIC/FMoH, 2024).

3. Commodity and funding volatility, stigma and incomplete cascade monitoring (NACA, 2025).

6.5 Recommendations

1. Systematically integrate clinical STI screening and syphilis testing into every HTS encounter for sexually active clients aged 15+, with immediate linkage of high-risk negatives to PrEP eligibility assessment (FMoH, 2020; FMoH, 2022).
2. Expand community-based and outreach PrEP initiation through KP one-stop shops, peer-led models and private pharmacies (FMoH, 2022; NACA, n.d.).
3. Strengthen male and MSM engagement, including event-driven PrEP options where appropriate (FMoH, 2020).
4. Close the KP eligibility documentation gap so that every HIV-negative KP client receives a documented risk/eligibility assessment and offer (NASCP/NACA, 2025).
5. Accelerate introduction of long-acting PrEP (cabotegravir and, when available, lenacapavir) within the next national implementation plan while maintaining robust oral programmes (MOSAIC/FMoH, 2024; NACA, 2025).
6. Improve continuation support, secure domestic financing contributions and enhance real-time cascade monitoring in national systems (NACA, 2025).

6.6 Conclusion

Nigeria has established a solid policy foundation and has demonstrated the ability to initiate more than a quarter of a million people on PrEP in a single year. The 2025 data reveal both the scale of opportunity-millions of HIV-negative tests, hundreds of thousands of STI screens and a large KP HIV-negative pool-and persistent gaps in risk assessment, community reach, sex equity and cascade documentation. Closing these gaps while introducing long-acting options and embedding PrEP within the GEN-N architecture of the 2026-2030 National HIV Prevention Plan will be decisive for outrunning the epidemic (NACA, 2025).?

CHAPTER 7

SEXUALLY TRANSMITTED INFECTIONS – SCREENING, EPIDEMIOLOGY, MANAGEMENT AND INTEGRATION

7.1 Background and Rationale

Sexually transmitted infections remain a major public-health challenge in Nigeria and an important cofactor in HIV transmission. Untreated STIs increase biological susceptibility to HIV acquisition and transmission, while HIV infection can alter the clinical course of STIs (WHO, 2022). National policy therefore mandates systematic integration of STI clinical screening and syphilis testing within HTS, antenatal care, family-planning and key-population programmes (FMoH, 2020; NACA, 2021).

This chapter analyses 2025 national HTS-linked STI clinical screening and syphilis testing data, situates the findings within national guidance (including the FSW Guidelines and the Consolidated KP Guidelines), and outlines priorities for integrated service delivery (NACA, n.d.; NACA, 2021; NASCP/NACA, 2025).

7.2 Policy Framework for STI Services

The 2020 National Guidelines for HIV Prevention, Treatment and Care, the National Consolidated Service Delivery Guidelines on HIV and STIs for Key Populations, and the National Guidelines for Implementation of HIV Prevention Programmes for Female Sex Workers all emphasise routine STI screening and treatment as a core biomedical intervention (FMoH, 2020; NACA, 2021; NACA, n.d.). Syndromic management remains the primary approach in many primary-care and community settings, supplemented by laboratory syphilis testing where available. Dual elimination of mother-to-child transmission of HIV and syphilis is a national priority (FMoH, 2020). NASCP coordinates the health-sector response and reports STI indicators through the HTS Monthly Summary Form and related DHIS2 modules (NASCP, n.d.).

7.3 Overall Cascade: HTS, Clinical STI Screening and Syphilis Testing, 2025

In 2025, of the 6,082,006 individuals tested for HIV:

- 1,882,872 (30.96 %) received clinical screening for STIs;
- 250,745 (4.12 % of total HTS; 13.3 % of those clinically screened) were tested for syphilis;
- 10,949 tested syphilis-positive (positivity 4.37 %) (NASCP/NACA, 2025).

The large drop-off from clinical screening to laboratory confirmation represents a critical missed opportunity for case detection and for accurate risk stratification for PrEP and other prevention interventions.

Table 7.1 STI clinical screening and syphilis testing cascade relative to total HTS, 2025

Indicator	Number	% of Total HTS
Total HTS	6,082,006	100 %
Clinically screened for STI	1,882,872	30.96 %
Tested for syphilis	250,745	4.12 %
Syphilis positive	10,949	4.37 % positivity

Source: National HTS Monthly Summary and STI extracts, 2025 (NASCP/NACA, 2025).

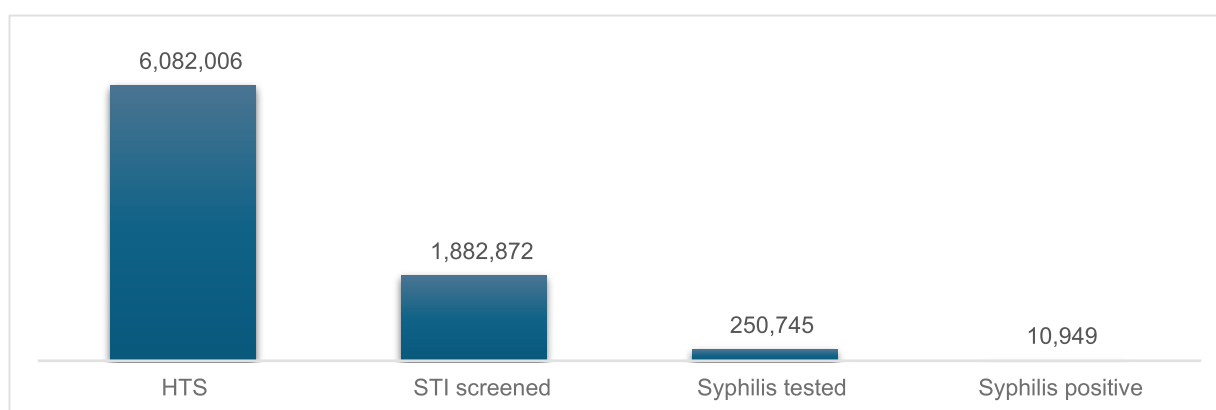


Figure 7.1 HTS, STI clinical screening, syphilis and positives cascade

7.4 Facility versus Community and Sex Differentials

STI clinical screening is predominantly facility-based (about 75 % of screens). Syphilis testing shows a somewhat more balanced distribution (about 64 % facility / 36 % community). Females accounted for 53 % of clinical STI screens and 68 % of syphilis tests. The higher female share of syphilis testing is driven largely by antenatal and reproductive-health platforms; male engagement remains lower (NASCP/NACA, 2025).

Table 7.2 Facility vs Community and sex distribution, 2025

Indicator	Facility / Male	Community / Female	Total
STI screening (setting)	about 75 %	about 25 %	1,882,872
Syphilis testing (setting)	about 64 %	about 36 %	250,745
STI screening (sex)	891,613 (47 %)	991,259 (53 %)	1,882,872
Syphilis testing (sex)	80,100 (32 %)	170,645 (68 %)	250,745

Source: STI_Modality and sex analyses, 2025 (NASCP/NACA, 2025).

7.5 Key Population STI Cascade and Integration

Among key populations in 2025, 28,478 individuals were clinically screened for STIs, and 9,439 were tested for syphilis (positivity 4.7 %). The same data set records 26,496 KP individuals as PrEP-eligible, illustrating the direct programmatic linkage between STI risk assessment and PrEP offer (NASCP/NACA, 2025). The National Guidelines for FSW programmes and the Consolidated KP Guidelines list STI screening and treatment as a core biomedical intervention to be delivered within one-stop shops and outreach models alongside HTS, PrEP, ART, condom/lubricant distribution and hepatitis/TB services (NACA, n.d.; NACA, 2021).

Typology-disaggregated data show variation across sex workers, MSM, PWID, transgender persons and custodial settings, underscoring the need for differentiated service intensity (NASCP/NACA, 2025).

7.6 Challenges

1. Only about 31 % of HTS clients receive clinical STI screening, and a far smaller fraction receive laboratory syphilis testing (NASCP/NACA, 2025).
2. Facility-community imbalance and lower male engagement limit reach (NASCP/NACA, 2025).

3. Among KPs, incomplete laboratory confirmation of clinical findings, stigma, mobility, commodity stock-outs and variable quality of syndromic management persist (NACA, 2021; NACA, n.d.).
4. Data fragmentation between KP programmes and general HTS/STI reporting streams (NASCP/NACA, 2025).

7.7 Recommendations

1. Raise the proportion of HTS clients who receive clinical STI screening toward universal coverage among sexually active clients and close the laboratory gap for syphilis and other STI testing (FMOH, 2020; WHO, 2022).
2. Make clinical STI screening universal at every KP clinical and outreach encounter, with immediate linkage to testing and treatment (NACA, 2021; NACA, n.d.).
3. Scale one-stop-shop and community-based STI treatment capacity, including peer-supported partner notification (NACA, 2021).
4. Integrate STI positivity and clinical findings as explicit eligibility triggers for PrEP (FMOH, 2020; FMOH, 2022).
5. Strengthen supply-chain management for STI commodities and improve real-time, typology-disaggregated cascade reporting (NASCP/NACA, 2025).
6. Invest in provider sensitisation and community-led monitoring to reduce stigma and improve uptake (NACA, 2021).

7.8 Conclusion

STI screening and treatment are both clinical necessities and strategic HIV-prevention interventions. The 2025 data demonstrate substantial absolute volumes of clinical screening yet persistent gaps in laboratory confirmation, community reach and male engagement. Closing these gaps-particularly within key-population programmes-will amplify the impact of PrEP, reduce HIV incidence and advance Nigeria's dual-elimination and 2030 prevention goals (NACA, 2025; WHO, 2022).

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7.9 Analysis of PrEP Reporting Rate by States

The horizontal bar chart illustrates PrEP program reporting rates across Nigeria's 36 states and the Federal Capital Territory (FCT), highlighting significant disparities in reporting performance and systemic challenges.

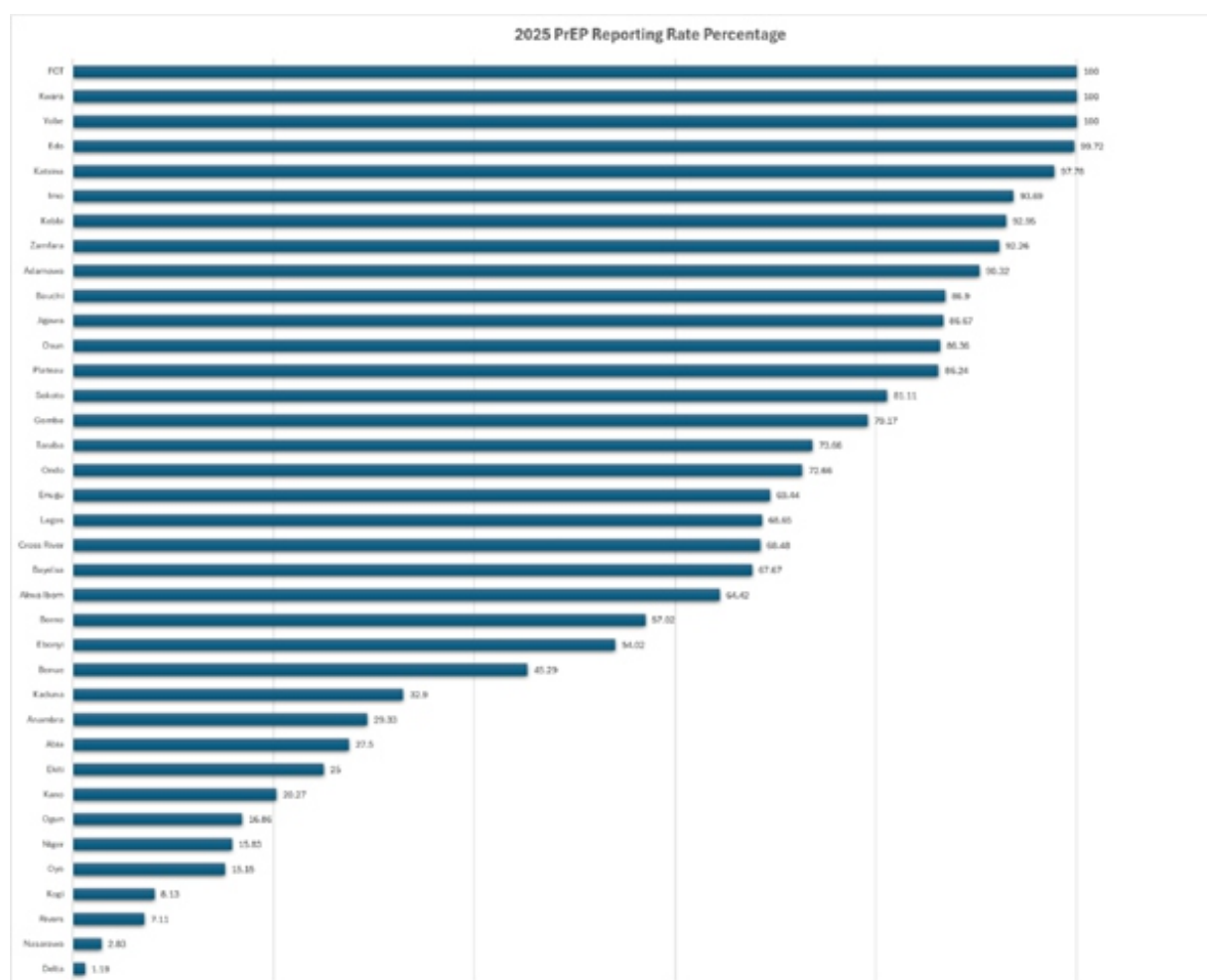


Figure 7.2 2025 PrEP Reporting Percentage

7.9.1 Key Findings

1. Top-Performing States (90-100% Reporting)

- Perfect Reporters (100%): FCT, Kwara, and Yobe demonstrate exceptional reporting compliance, reflecting robust monitoring systems.

- Near-Perfect Performance (99%): Edo and Katsina consistently maintain strong reporting practices.
- Excellent Performers (90%+): Imo, Kebbi, Zamfara and Adamawa also achieved high reporting standards, indicating effective programme oversight.

2. Poor Performance in Major Urban Centres

- Oyo (15%): Underperforming despite strong health infrastructure.
- Kano (20%): This is concerning, being the largest northern city.

3. Critical Performance Gaps (Below 50%)

- Severely Underperforming States:
 - Delta (1%) - Requires immediate intervention
 - Nasarawa (2%) - Urgent support and systemic review needed
 - Rivers (7%) - A worrying figure for such a critical state
 - Kogi (8%) - Major structural or resource issues evident
 - Niger (15%) - Low performance for a large, populous state
 - Anambra (29%) - Unexpected underperformance in a highly developed state.

These results underscore systemic weaknesses even in states with high population density and significant resources.

Key Insights

- Massive Disparity: A striking 99-point gap exists between the best-performing state (100%) and the worst (1%).
- Reporting Performance: Reporting performance across Nigeria is inconsistent and does not track size or economic weight. Lagos state improved its reporting rate from the previous year going from 33% to 68%, while Oyo halved, failing from 30% to 15%. Rivers, Kogi and Nasarawa remain significant underperformers.
- Widespread reporting gaps: With 13 states performing below 50%, there is an urgent need for a strategic intervention targeted at improving PrEP reporting across the country.
- Equity Concerns: High-performing states could serve as mentors or hubs to support weaker states.

CHAPTER 8

HIV PROGRAM TARGET AND ESTIMATES & PROJECTIONS

8.1 Introduction

The National HIV/AIDS, Viral Hepatitis, and STIs Control Programme (NASCP) coordinates the annual HIV program estimates process in Nigeria, in collaboration with the National Agency for the Control of AIDS (NACA), and with technical support from UNAIDS. The estimates development process is inclusive, involving stakeholders from USG, the Global Fund, and other implementing partners who form part of the National HIV Program Estimates Team.

In Nigeria, the HIV program utilizes the Spectrum software to produce these estimates. Spectrum is a collection of modelling tools developed by Avenir Health in partnership with global stakeholders, under the guidance of the UNAIDS Reference Group on Estimates, Modelling and Projections. The Spectrum software integrates data from HIV surveillance, population-based surveys, program reports, and demographic sources to generate historical trends and short-term projections of HIV-related indicators. These estimates are essential for strategic planning, resource allocation, and policy formulation.

In 2023, Nigeria transitioned to the use of a single national Spectrum file, complemented by the Naomi model to produce sub-national estimates. Naomi enables district-level modelling, providing disaggregated estimates that support more targeted and efficient HIV response strategies.

Target setting and Spectrum estimates are central to monitoring and evaluating the HIV response at national and sub-national levels. Together, they form the foundation for strategic planning, enabling stakeholders to align interventions with epidemiological realities, track progress towards national and global goals, and identify gaps that require intensified efforts.

The 2026 estimation cycle included an extended review by UNAIDS and national and international partners. Estimates produced at a national workshop in March 2026 were examined by the UNAIDS Global Centre and discussed at two high-level meetings in May and June 2026, after which a revised Spectrum file was prepared and accepted by the country, subject to documentation of its assumptions. This chapter therefore presents the estimates together with the process through which they were generated, reviewed and agreed: the methodology (Section 8.2), the review and validation of the 2026 estimates (Section 8.4), the resulting key outputs (Section 8.5) and the programme targets (Section 8.6).

8.2 Methodology

8.2.1 Estimation Process and Data Sources

The National HIV/AIDS estimates are generated annually through the collaborative efforts of multiple stakeholders. The process is led by the Government of Nigeria, through NASCP and NACA, with technical support from UNAIDS. Other members of the national estimates team include the U.S. CDC, U.S. DOD, USAID, and the Global Fund, working through their implementing partners.

HIV program data including HTS, PMTCT, ART, and viral load testing and suppression data disaggregated by age and sex were reviewed and updated with the most recently validated figures. Before 2015, ANC sentinel surveys were conducted in 160 sites across the country, but this stopped in 2014 because of funding, and programmatic data was then used from 2015 onward.

The 2026 estimates were generated at the National HIV Program Spectrum Estimation Workshop convened by NASCP in Keffi, Nasarawa State, from 9th to 11th March 2026. The workshop brought

together NASCP, NACA, State AIDS and STIs Control Programmes (SASCPs), UNAIDS, WHO, UNICEF, IHVN, AHF, CHAI and the Global Fund. The assumptions, data inputs and modelling decisions adopted at the 2025 Spectrum Estimates Finalization Workshop were reviewed and retained, with updates to reflect 2025 programme data.

Programme data for 2025 on HTS, ART, PMTCT and viral load were extracted from NDARS, which aggregates data from more than 35,000 health facilities, and were structured into Spectrum-compatible templates by four thematic working groups (ART, HTS, PMTCT Sentinel and PMTCT Census). Other inputs included demographic projections for a national population of approximately 240 million, fertility rates and HIV prevalence from the 2018 NAHS. To ensure consistency, community testing data were sourced exclusively from community testing points recorded in NDARS through the HTS Monthly Summary Form, and ANC routine test data were reviewed and cleaned to remove outliers and inconsistent data points before entry. Data from more than six million pregnant women tested through ANC services were incorporated into the estimation process.

8.2.2 ANC Data Modelling Scenarios

In 2025, three data modelling scenarios were proposed and tested under John Stover's guidance (President and founder of Avenir Health, and Principal developer of Spectrum software):

Scenario 1 (Not Recommended): ANC census routine test button NOT turned on; sentinel data 1991-2014; programmatic data for sentinel sites 2015-2025. Does not include census data for pregnant women.

Scenario 2 (Not Recommended): Census button ON; sentinel data retained 1991-2014; programmatic data REMOVED for sentinel sites 2015-2025. Loses site-level specificity.

Scenario 3 (RECOMMENDED): Census button ON; sentinel data 1991-2014; programmatic data for sentinel sites 2015-2025; census ANC RT data 2018-2025. Retains site-level trends and incorporates elements Scenarios 1 and 2 lack.

Within the census-level ANC data, the proportion of ANC attendees who are HIV positive was calculated as the number of newly identified plus previously known HIV-positive pregnant women, divided by the total number of pregnant women tested plus those previously known to be positive. Scenario 3 was retained for the 2026 estimates because it maintains site-level trends from the sentinel period into the programmatic period while allowing census-level data to capture the national scale of antenatal testing.

However, after the review of the UNAIDS Global Centre of the 2026 Nigeria HIV spectrum file in June 2026, census-level ANC prevalence data before 2024 were excluded and only the 2024 and 2025 census-level inputs were retained.

8.2.3 Supporting Models and Quality Assurance

The 2018 NAHS survey data remained the single survey point in use. Epidemic curves were fitted using the R hybrid model via EPP. The Shiny 90 model estimated Knowledge of Status. The Key Population model estimated HIV prevalence and ART coverage among key populations. Uncertainty analysis was conducted before submission to UNAIDS for final ratification.

The Naomi small-area estimation model integrated ANC, ART, HTS and household survey data to produce sub-national estimates consistent with the national file. Quality assurance measures included open plenary and working-group review by all stakeholders, cross-checking of ANC, ART and PMTCT data against NDARS during the workshop, curve fitting and uncertainty analysis to test the robustness of the selected scenario, and calibration of state-level trends during the Naomi session.

8.3 Map of HIV Prevalence Estimates among 15-49 Population from NAIIS

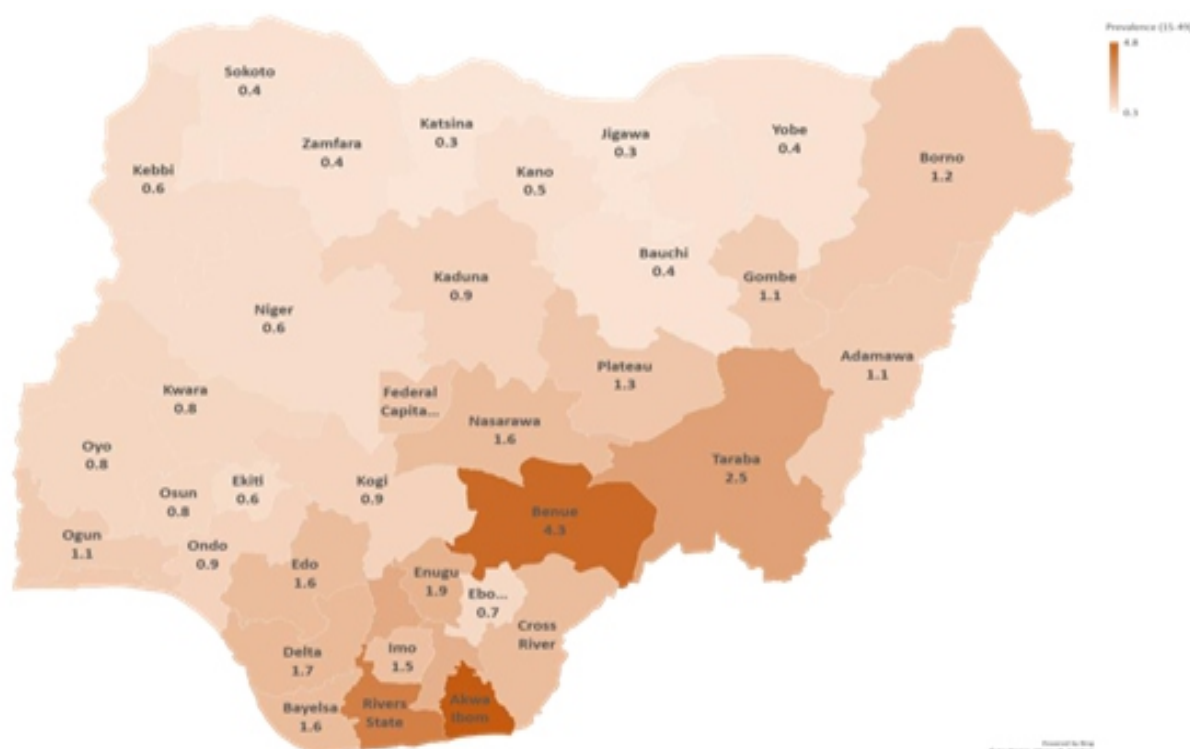


Fig. 8.1: Map of HIV Prevalence Estimates among 15-49 Population from NAIIS 2018. Source: NAIIS 2018, FMoH Nigeria.

The 2018 NAIIS prevalence map shows the national HIV prevalence among adults aged 15-64 years is 1.4% and 1.3% among adults aged 15-49 years. The highest HIV prevalence was seen in Akwa Ibom (4.8%) while the lowest was found in Jigawa (0.3%) and Katsina (0.3%) states. Benue State also recorded a high prevalence of 4.3%, followed by Rivers State and Taraba (2.5%). The 2018 NAIIS is the single survey point currently in use in the Spectrum file while the ANC data predicts the trend in the epidemic.

8.4 Review and Validation of the 2026 Estimates

The 2026 HIV estimates were reviewed extensively before they were finalised. Between late May and early June 2026, the ART and ANC inputs to the national Spectrum file were examined by UNAIDS and by national and international partners, and the file was subsequently revised by the UNAIDS Global Centre. The outputs presented in Section 8.5 are drawn from this revised file. This section sets out the concerns raised, the national response, the adjustments made, their effect on the estimates and the position agreed by the country. Table 8.1 summarises the sequence of events.

Date	Milestone
9–11 March 2026	National HIV Program Spectrum Estimation Workshop, Keffi, Nasarawa State: national and sub-national estimates produced
April 2026	National target setting workshop for the 2026 programme targets
May 2026	NASCP response to Global Fund enquiries on the assumptions, program impact and programme -data alignment of the estimates
29 May 2026	UNAIDS Global Data for Impact team comments on the Spectrum file;- High Level Stakeholders Meeting, Abuja
2 June 2026	Revised Spectrum file shared with Nigeria by the UNAIDS Global Centre
3 June 2026	Country review meeting on the revised file; country position agreed
4 June 2026	Deadline for country feedback to UNAIDS

Table 8.1: Timeline of the 2026 estimation and review process. Source: NASCP Strategic Information, 2026.

8.4.1 Concerns Raised on the 2026 Estimates

In 2025, UNAIDS did not publish Nigeria's HIV prevalence among pregnant women after it fell from over 1% to about 0.5%. Nigeria attributed the decline to the scale-up of routine HIV testing to all ANC sites in all states: as the number of women tested rose while the number of HIV-positive women did not rise in proportion, the calculated prevalence fell. The UNAIDS global estimation team did not accept this as a sufficient explanation for a decline of that size.

On 29th May 2026, the UNAIDS Global Data for Impact team shared comments on the 2026 Spectrum file, together with preliminary survey values from the ART Impact Surveys (AIS) conducted in Akwa Ibom and Lagos States. Three concerns were raised:

- ART coverage. Programme data reported 1.73 million people on ART in 2025, equivalent to about 91% coverage, whereas the AIS found coverage of 46% in Akwa Ibom and 55% in Lagos. UNAIDS noted that programme ART data had already been adjusted downwards for 2018-2025 following the 2023 Getting the Data Right (GDR) process and a USG-supported enhanced data quality assessment, but could not reconcile the remaining gap with the survey results.
- ANC prevalence. Prevalence among pregnant women in the updated file fell from about 1.1% in 2023 to about 0.54% in 2024 and 0.45% in 2025, as the number of ANC tests rose by four to ten times in some states while the number of positive results remained similar. UNAIDS noted that this no longer aligned with the 1.1% prevalence among pregnant women recorded by the 2018 NAIS, that no matching increase in test-kit procurement had been reported, and that data from 19 states, where testing rose more than four-fold, pulled the national prevalence curve downwards.
- Calibration to two data points. The local adjustment to the fertility rate ratio relied on the 2024 and 2025 ANC prevalence values alone. UNAIDS observed that a curve fitted to these two points implies a 2018 prevalence well below the 1.1% recorded by the NAIS, and consequently lower estimates of women needing PMTCT and of children living with HIV, and higher ART coverage among women and children.

UNAIDS further observed that the pathway to elimination of vertical transmission requires at least 95% coverage of a first ANC visit, whereas the 2021 DHS recorded 63%, so that progress would depend on wider health-system improvement beyond HIV services. In the absence of consensus, UNAIDS advised that ART coverage, and the indicators that depend on it (HIV incidence, viral load suppression and AIDS-related mortality), would not be recommended for publication.

8.4.2 National Response and the High-Level Stakeholders Meeting

The national estimates team had set out its position in a response to enquiries from the Global Fund in May 2026. The response explained that the estimates reflect both real programme gains and methodological updates. The real gains included high viral suppression among those tested (96% nationally: 96% among females, 94% among males and 87% among children), continued ART expansion including paediatric ART, a projected decline in PLHIV from 2026 to 2030, and a declining PMTCT cohort. The decline in the PMTCT cohort was attributed to women on ART ageing out of the reproductive age group, falling prevalence and positivity among pregnant women, the fertility-reducing effects of some HIV-related illnesses and medications, and greater uptake of family planning among HIV-positive women.

The methodological updates were principally the activation of census-level ANC routine test data under Scenario 3, the shift from sentinel surveys to programmatic data from 2015 onward, and the removal of outliers from ANC data, among others, which improved the precision of sub-national estimates. The team characterised changes in prevalence estimates as partly methodological and partly real, and reported that the model inputs on viral suppression, the PMTCT cascade and HTS indicators were consistent with NDARS.

These issues were discussed at a High-Level Stakeholders Meeting convened by the Global Fund in Abuja on 29th May 2026, ahead of the submission of the GC8 funding request. The meeting brought

together the Federal Government, NASCP, NACA, UNAIDS, WHO, USG and the Global Fund, and affirmed that the estimates are country data produced jointly through a multi-agency process. The team raised the following points:

- Representativeness of the AIS. Akwa Ibom and Lagos have particular programme histories, geography, and epidemic profiles and cannot stand for the 36 states and the FCT.
- Limits of survey data. People who know their status and are on treatment are more likely to decline blood sample collection in surveys, which can lead to under-counting of people on ART and lower measured coverage. Some people identified as HIV-positive in the AIS had not linked to care, which may be reflecting stigma that also leaves such individuals invisible to programme data.
- Expected decline in prevalence among pregnant women. Pregnancy is age- and time-dependent, fertility has declined, and new infections are falling. These effects compound one another and would be expected to reduce prevalence among pregnant women faster than in the general population.
- Strength of programme data. The GDR process had already reduced the treatment cohort by approximately 400,000 through deduplication and recalibration.
- UNAIDS presented four options for the way forward: accepting a downward adjustment of the treatment cohort in line with the AIS results; targeted retesting of people recorded as being on ART; sub-national surveys in seven to eight high-burden states, supported by sentinel surveillance elsewhere; and, in the longer term, a single interoperable national health information system with unique patient identifiers. There was broad consensus, including from WHO, USG, NACA and NASCP, that mass retesting of people on ART was not advisable at this time. People who are on treatment and virally suppressed may test negative on rapid diagnostic tests and be misclassified, and retesting raises ethical, legal and public-trust concerns

The UNAIDS Global Centre prepared a revised Spectrum file, which was shared with Nigeria.

8.4.3 The Revised Spectrum File

The revised file incorporated data from the AIS in Akwa Ibom and Lagos, the 2018 NAHS, and more recent ANC routine data. Four adjustments were identified during the country review:

- ANC prevalence data. All census-level routine ANC prevalence data before 2024 were removed, leaving only the 2024 and 2025 data points, because earlier census data were not comparable with data collected after the scale-up of HIV testing. Historical sentinel surveillance data, and programme data imputed for sentinel sites from 2015 to 2025, were retained unchanged. The model is therefore anchored on the most recent and comparable data, although a shorter census series limits its ability to capture the long-term trend.
- Local adjustment factor (LAF). When the 2024 and 2025 ANC census data were entered, the model generated an LAF of 0.43, below the minimum of 0.5 accepted by the UNAIDS Reference Group on Estimates, Modelling and Projections. The LAF was therefore constrained to 0.5. This is a manual adjustment rather than an output of the data.
- ART treatment numbers. This was the most consequential adjustment. The March submission showed steep and near-uniform annual increases in ART numbers from 2019 to 2024, and programme coverage differed from survey findings. UNAIDS therefore anchored the treatment cohort close to the 2023 values obtained after the GDR exercise and applied small, conservative increments for 2024 and 2025. The AIS states represent about 17% of adult PLHIV and showed a combined ART coverage of 51%. The number of children (0-14 years) on ART fell from about 49,000 to 40,000 in both 2024 and 2025; the number of adults fell from about 1.5 million to 1.4 million in 2024 and from about 1.6 million to 1.51 million in 2025; and total TX_CURR for 2025 fell from 1,738,404 to 1,550,000, a reduction of 188,404 (10.8%).
- Total fertility rate (TFR). The TFR for 2024 was 4.38 in the revised file, compared with 4.8 in the March submission, which was derived from the 2024 NDHS. A lower TFR reduces the estimated number of pregnancies and births (from about 8.5 million to about 7.6 million) and, with them, the number of women needing PMTCT, the number of children living with HIV and paediatric ART coverage. This change was not explained in the communication accompanying the revised file and was identified by the national team during its review.

8.4.4 Effect of the Revised File on Key Estimates

Table 8.2 compares the main outputs of the March submission with those of the revised file. The revised file describes a larger epidemic, with 1,985,284 PLHIV in 2025 (149,024 more than in the March submission), 63,591 new infections and 82,425 children living with HIV. It also gives a higher PMTCT need and higher MTCT rates, and a smaller number of people on treatment.

Indicator (2025)	March 2026 submission	Revised file	Change
Total PLHIV (all ages)	1,836,260	1,985,284	+149,024
New HIV infections	51,926	63,591	+11,665
Children (0-14) living with HIV	65,638	82,425	+16,787
Mothers needing PMTCT	39,901	45,281	+5,380
MTCT rate at 6 weeks	7.9%	10.6%	+2.7 pp
Final MTCT rate	17.0%	20.4%	+3.4 pp
Total births / expected pregnancies	~8.5 million	~7.6 million	-0.9 million
Total TX_CURR	1,738,404	1,550,000	-188,404

Table 8.2: Key outputs of the March 2026 submission and the revised Spectrum file. Source: NASCP review meeting on the 2026 updated Spectrum file, 3rd June 2026. pp = percentage points.

A larger PLHIV denominator and a smaller treatment cohort together lower the modelled cascade (Table 8.3). The most marked change is in the first 95: knowledge of status falls from 93% to 79% for all ages and from 81% to 58% for children. Estimated ART coverage falls from 90% to 78% for all ages, and from 70% to 49% for children, and PMTCT coverage falls from 69% to 61%. The second and third 95 change little, and viral suppression among children is unchanged at 89%. Nigeria's progress towards epidemic control is therefore real but less advanced than the March estimates indicated, particularly for children and adolescents.

Cascade indicator	Population	March file	Revised file	Change
1st 95 (know status)	All ages	93%	79%	-13 pp
2nd 95 (on ART)	All ages	99%	98%	-1 pp
3rd 95 (virally suppressed)	All ages	96%	94%	-2 pp
ART coverage (static)	All ages	90%	78%	-12 pp
1st 95 (know status)	Children	81%	58%	-23 pp
2nd 95 (on ART)	Children	88%	84%	-4 pp
3rd 95 (virally suppressed)	Children	89%	89%	No change
Paediatric ART coverage	Children	70%	49%	-21 pp
PMTCT coverage	Pregnant women	69%	61%	-8 pp

Table 8.3: 95-95-95 cascade and coverage indicators, March 2026 submission and revised Spectrum file. Source: NASCP review meeting on the 2026 updated Spectrum file, 3rd June 2026.

8.4.5 Issues Considered and the Agreed Country Position

NASCP convened a virtual review meeting with NACA, USG, WHO, UNAIDS Nigeria, the Global Fund and IHVN to examine the revised file, compare its outputs with the March submission and agree a country position. Nigeria agreed to UNAIDS publishing results from the revised file.

8.4.6 Strengthening the Evidence Base: Getting the Data Right and the Way Forward

The GDR framework is a five-pronged approach adopted by the country and its partners to establish

the true number of people on treatment. Its prongs are: (1) enhanced data quality assessment; (2) review of ARV consumption data against supply chain data; (3) a Patient Information Management System with unique patient identification, biometric capture and recapture to eliminate duplication; (4) state-level ART Impact Surveys; and (5) triangulation of the outputs of the other four prongs. Prongs 1 to 4 have been implemented, with the Akwa Ibom AIS complete and the Lagos AIS at the data analysis stage.

The review meetings recognised that Nigeria’s data quality challenges are structural and require structural solutions. The following priorities were identified for the period before the next estimation cycle, which typically begins in December:

- Operationalise the National Identity Number (NIN) as a unique patient identifier in the HIV treatment data system, to enable cross-facility and cross-state deduplication, and accelerate the deployment of electronic patient records.
- Complete the GDR process across all five prongs, with triangulation completed ahead of the next Spectrum workshop.
- Expand the AIS to at least seven to eight high-burden states, with sentinel surveillance in the remaining states, so that future adjustments rest on a more representative evidence base.
- Review state-level ART trends where unexpected increases or declines occurred in 2024 and 2025, and reconcile the data reported by NASCP and by implementing partners at state level.
- Over the longer term, priorities include a single interoperable national health information system that removes fragmentation across databases.

The revised estimates therefore provide a recalibrated baseline against which progress will be tracked, and the key outputs that follow should be read in that light.

8.5 Key Outputs

The outputs presented in this section are drawn from the revised Spectrum file (Nigeria_2026_02Jun_ANC ART Spectrum file).

8.5.1 Number of People Living with HIV, All Ages

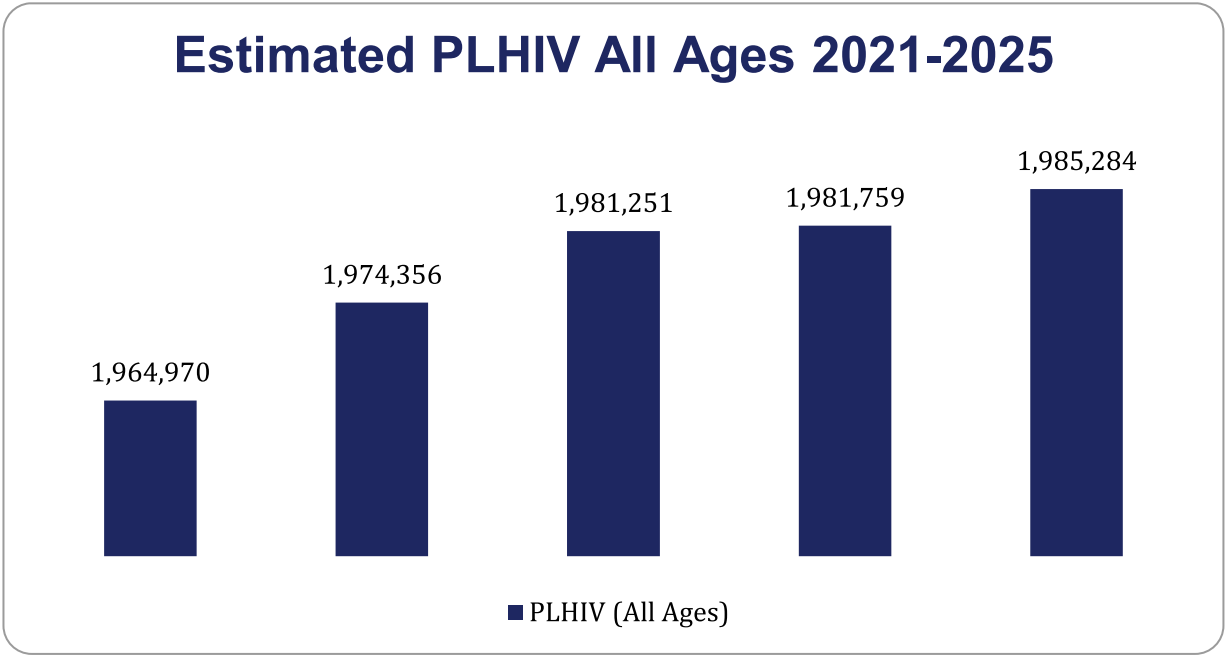


Fig. 8.2: Estimated PLHIV All Ages 2021–2025. Source: Nigeria_2026_02Jun_ANC ART Spectrum file, NASCP 2026

The estimated number of People Living with HIV (PLHIV) in Nigeria shows a gradual upward trend from 1,964,970 in 2021 to 1,985,284 in 2025. This reflects improved data quality uploaded on the Spectrum software, removal of outliers from ANC routine test data, and the expanded ART coverage which reduces AIDS-related mortality through the treatment-as-prevention effect. This is 149,024 (8.1%) higher than the 1,836,260 estimated in the March 2026 submission; the adjustments in the revised file are described in Section 8.4.3.

8.5.2 Children (0–14 Years) Living with HIV (CLHIV)

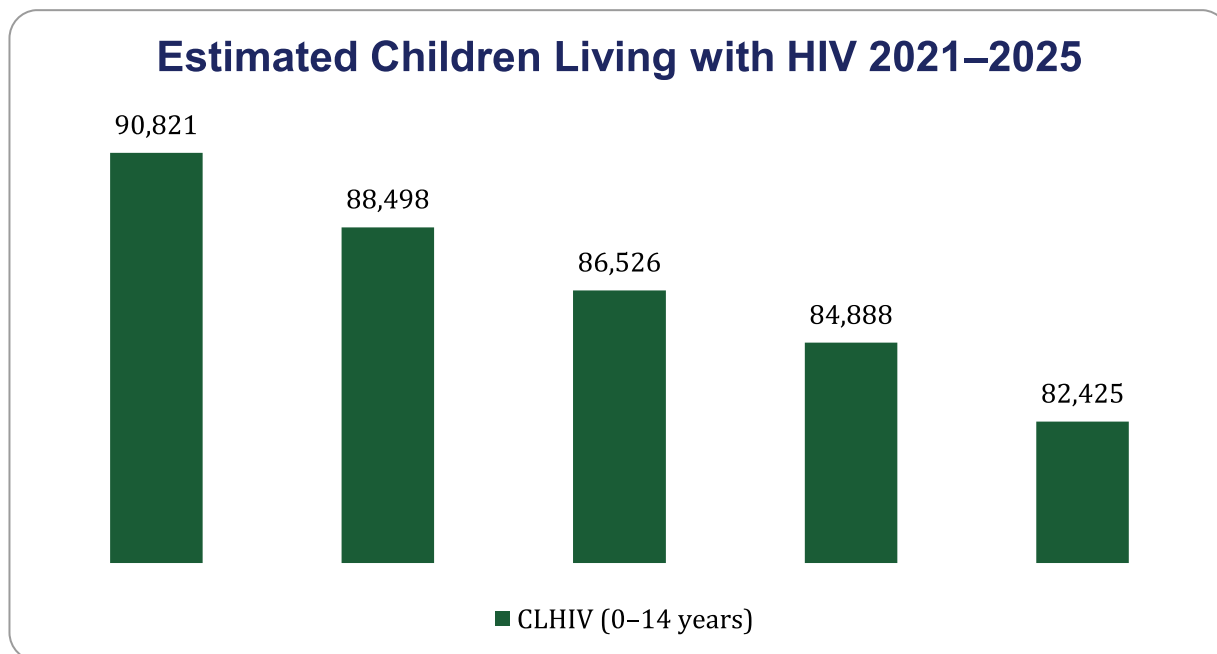


Fig. 8.3: Estimated CLHIV 2021–2025. Source: Nigeria_2026_02Jun_ANC ART Spectrum file, NASCP 2026

The estimated number of children living with HIV (CLHIV) shows a consistent downward trend from 90,821 in 2021 to 82,425 in 2025; a decline of approximately 9.2% over five years. This decline may largely be explained by the interplay between the incidence of new paediatric infections and the rate at which children living with HIV age into adulthood. The March 2026 submission estimated 65,638 children living with HIV in 2025.

8.5.3 Adolescents and Young People (AYP, Ages 15–24) Living with HIV

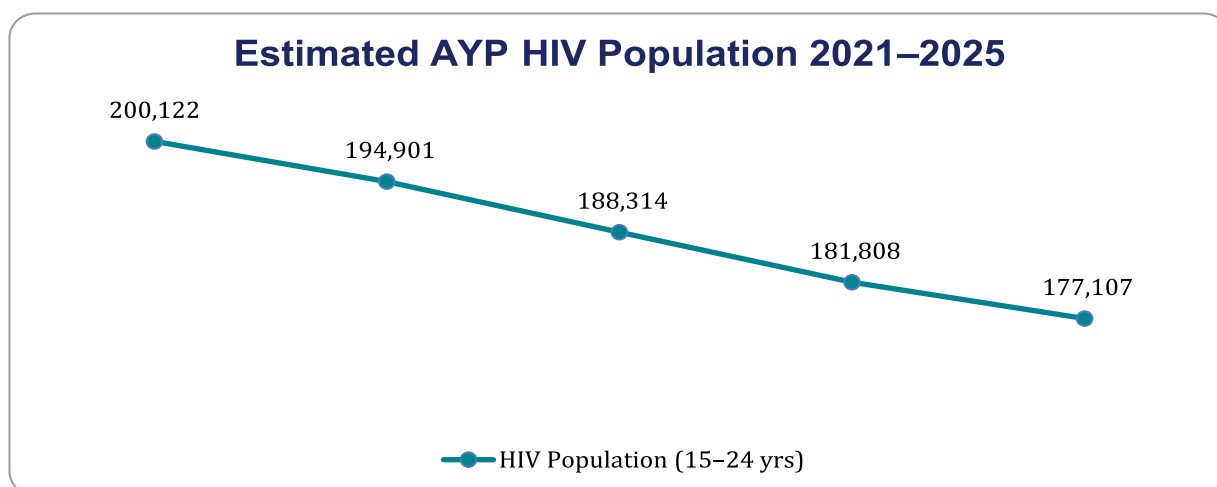


Fig. 8.4: Estimated HIV Population (15–24 years) 2021–2025.
Source: Nigeria_2026_02Jun_ANC ART Spectrum file, NASCP 2026

The estimated number of young people aged 15-24 years living with HIV shows a consistent downward trend, declining from 200,122 in 2021 to 177,107 in 2025; a reduction of approximately 11.5% over five years. This decline reflects improved access to HIV treatment among adolescents and young people, alongside the gradual ageing of this cohort into the 25+ age group. Despite this positive trend, young people aged 15-24 years continue to represent a significant proportion of PLHIV and require dedicated HIV prevention, testing and treatment services. The data underscores the need for targeted, age-appropriate interventions for adolescents and young people, particularly young women who face disproportionately higher HIV risk.

8.5.4 State-Level PLHIV and New Infections Estimates

The table below presents the 2025 Spectrum estimates of PLHIV and new HIV infections by state. The distribution reveals significant geographic variation in HIV burden across Nigeria.

State	New Infections (2025)	PLHIV (2025)
Nigeria	63,589	1,985,284
Abia	1,307	52,322
Adamawa	1,611	26,032
Akwa Ibom	4,004	219,470
Anambra	2,273	90,540
Bauchi	881	16,844
Bayelsa	559	23,866
Benue	4,771	188,314
Borno	1,315	49,442
Cross River	1,212	36,927
Delta	1,420	67,429
Ebonyi	421	12,400
Edo	2,467	49,481
Ekiti	345	18,573
Enugu	1,297	54,814
FCT	544	68,865
Gombe	476	24,723
Imo	1,397	56,678
Jigawa	525	11,540
Kaduna	3,776	53,031
Kano	2,195	40,946
Katsina	996	13,078
Kebbi	1,345	17,764
Kogi	770	25,459
Kwara	545	16,528
Lagos	3,275	197,911
Nasarawa	750	29,560
Niger	1,051	21,882
Ogun	1,945	43,534
Ondo	1,048	26,958
Osun	840	31,693
Oyo	2,489	48,918
Plateau	1,245	41,245
Rivers	4,625	214,354
Sokoto	4,413	16,653
Taraba	1,113	56,372
Yobe	235	8,357
Zamfara	4,108	12,781

Table 8.4: Estimated New HIV Infections and PLHIV by State, 2025.
Source: Nigeria_2026_02Jun_ANC ART Spectrum file, NASCP 2026.

Akwa Ibom (219,470), Benue (188,314), and Rivers (214,354) states have the highest estimated PLHIV burden in 2025. In terms of new infections, Benue (4,771), Sokoto (4,413), Akwa Ibom (4,004), Zamfara (4,108) and Rivers (4,625) recorded the highest estimated new infections. States with the highest new infections combined with low PLHIV counts, such as Sokoto and Zamfara, may reflect ongoing high transmission in populations not yet adequately reached by the HIV programme. Yobe (8,357) and Ebonyi (12,400) states have the lowest PLHIV burden.

Specifically, on the new infections, the state-level distribution of new HIV infections reveals significant geographic variation, as shown above. Rivers State (4,625) continues to record the highest number of new infections, followed closely by Benue (4,771), Sokoto (4,413), Zamfara (4,108), and Akwa Ibom (4,004). Yobe (235) and Ebonyi (421) report the lowest new infections. This distribution underscores the need for differentiated prevention strategies with intensified efforts in high-burden states.

8.5.5 Estimated Number of New HIV Infections

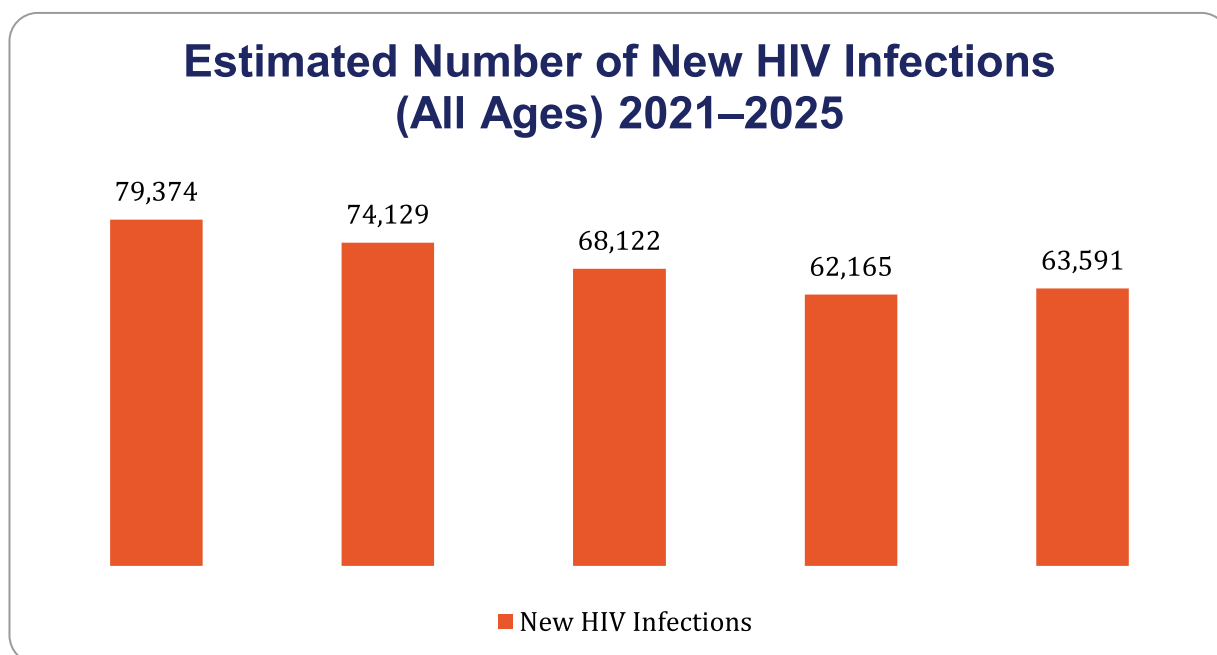


Fig. 8.5: Estimated New HIV Infections 2021–2025.

Source: Nigeria_2026_02Jun_ANC ART Spectrum file, NASCP 2026

The estimated number of new HIV infections shows a declining trend from 79,374 in 2021 to 63,591 in 2025, with a slight increase in 2024 before declining again. This decline could be attributed to the following factors: scale-up of PMTCT, increased ART coverage with better viral suppression (96% in 2025), wider adoption of HTS and PrEP, and concerted prevention efforts. Nigeria has not yet met the GPC target of 22,000 new infections annually; Nigeria must intensify efforts to achieve this. The March 2026 submission estimated 51,926 new infections in 2025.

8.5.6 Estimated New Infections among Children (0-14 years)

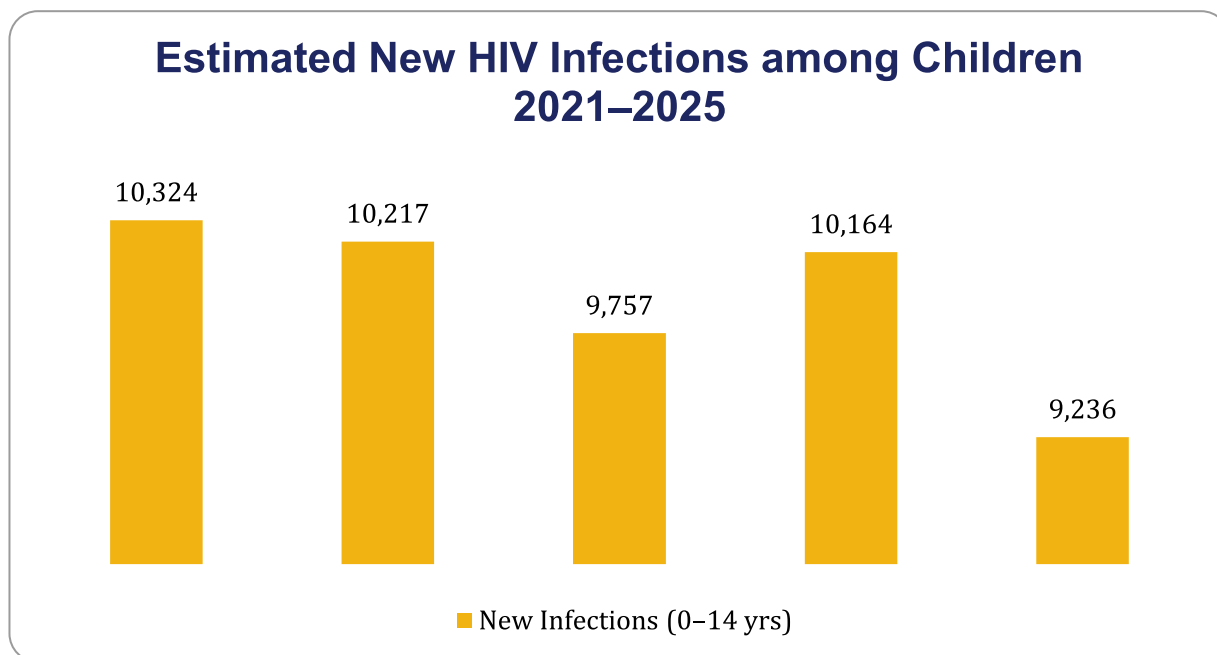


Fig. 8.6: Estimated New HIV Infections Among Children 2021–2025.

Source: Nigeria_2026_02Jun_ANCART Spectrum file, NASCP 2026

The estimated number of new infections among children shows a general downward trend from 10,324 in 2021 to 9,236 in 2025. The decline could be linked to an increasing proportion of HIV-positive pregnant women on ART who achieve viral suppression, thereby reducing vertical transmission risk.

8.5.7 Estimated Number of HIV-Positive Pregnant Women Needing ART-PMTCT Need

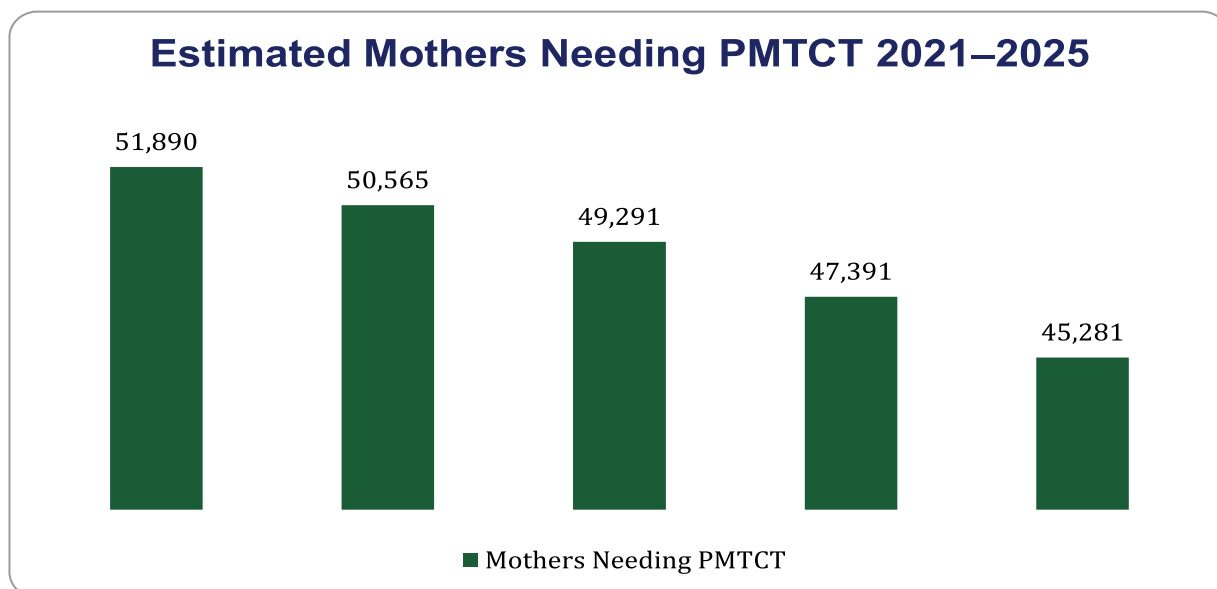


Fig. 8.7: Estimated PMTCT Need 2021–2025.

Source: Nigeria_2026_02Jun_ANCART Spectrum file, NASCP 2026

The estimated national PMTCT need has been steadily declining from 51,890 in 2021 to 45,281 in 2025. This decline reflects a reduction in HIV positivity among pregnant women; ageing of HIV-positive women out of the reproductive age bracket; fertility-reducing effects of certain illnesses and medications; and deliberate family planning choices by HIV positive women. The March 2026 submission estimated a PMTCT need of 39,901 in 2025.

The state-level distribution of PMTCT need for 2025 is presented in the table below.

State	PMTCT Need (2025 — Estimated HIV+ Pregnant Women)
Nigeria	45,283
Abia	1,213
Adamawa	590
Akwa Ibom	5,076
Anambra	2,097
Bauchi	374
Bayelsa	547
Benue	4,244
Borno	1,133
Cross River	838
Delta	1,543
Ebonyi	284
Edo	1,131
Ekiti	429
Enugu	1,247
FCT	1,625
Gombe	572
Imo	1,297
Jigawa	262
Kaduna	1,170
Kano	913
Katsina	283
Kebbi	359
Kogi	579
Kwara	374
Lagos	4,574
Nasarawa	686
Niger	492
Ogun	995
Ondo	609
Osun	725
Oyo	1,102
Plateau	934
Rivers	4,985
Sokoto	273
Taraba	1,292
Yobe	190
Zamfara	246

Table 8.5: Estimated PMTCT Need by State, 2025. Source: Nigeria_2026_02Jun_ANCART Spectrum file, NASCP 2026.

Akwa Ibom (5,076), Rivers (4,985), Benue (4,244) and Lagos (4,574) states have the highest PMTCT need in 2025, reflecting their high PLHIV burden and number of reproductive-age women. Yobe (190), Ebonyi (284) and Jigawa (262) states have the lowest PMTCT need.

8.5.8 MTCT Rate at 6 Weeks (%)

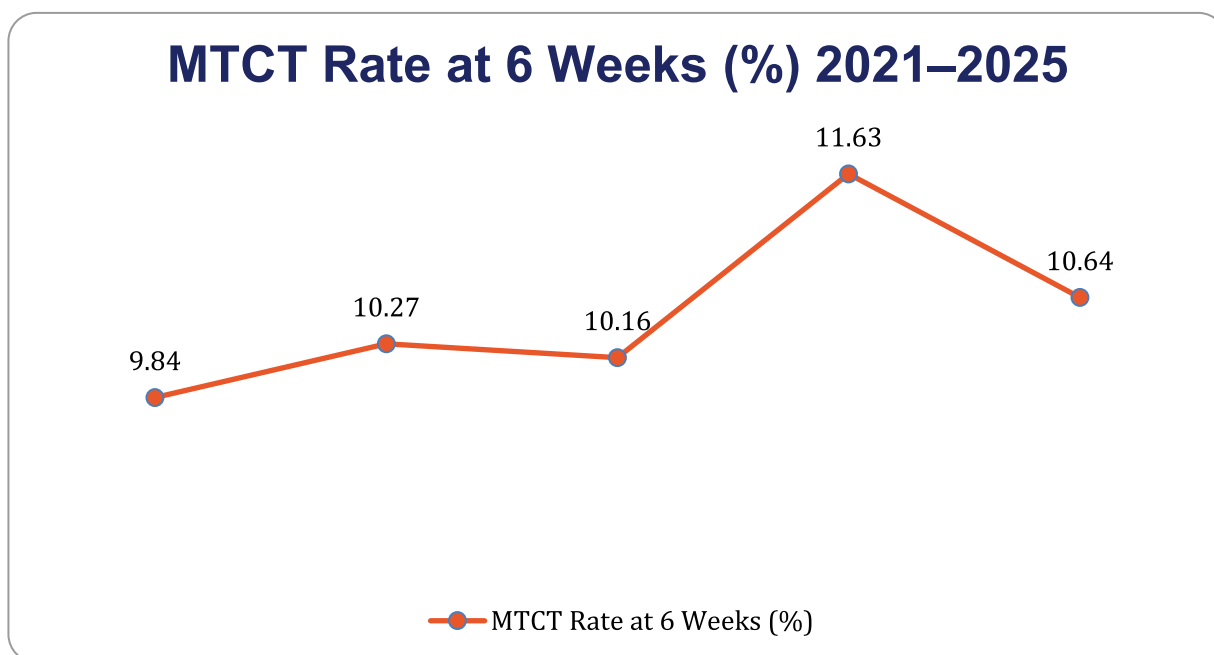


Fig. 8.8a: MTCT Rate at 6 Weeks vs Final MTCT Rate 2021–2025. Source: Nigeria_2026_02Jun_ANC ART Spectrum file, NASCP 2026 WHO EMTCT target: <5%

The MTCT rate at 6 weeks fluctuated from 9.84% in 2021 to a peak of 11.63% in 2024, before declining to 10.64% in 2025. An increasing MTCT rate at 6 weeks can be attributed to: missed opportunities for early HIV testing; late ART initiation or poor adherence; maternal viral load not adequately suppressed by delivery; drug stock-outs; and women attending ANC too late for effective pre-delivery interventions. The March 2026 submission estimated a 6-week rate of 7.9% for 2025.

8.5.9 Final MTCT Rate including Breastfeeding Period (%)

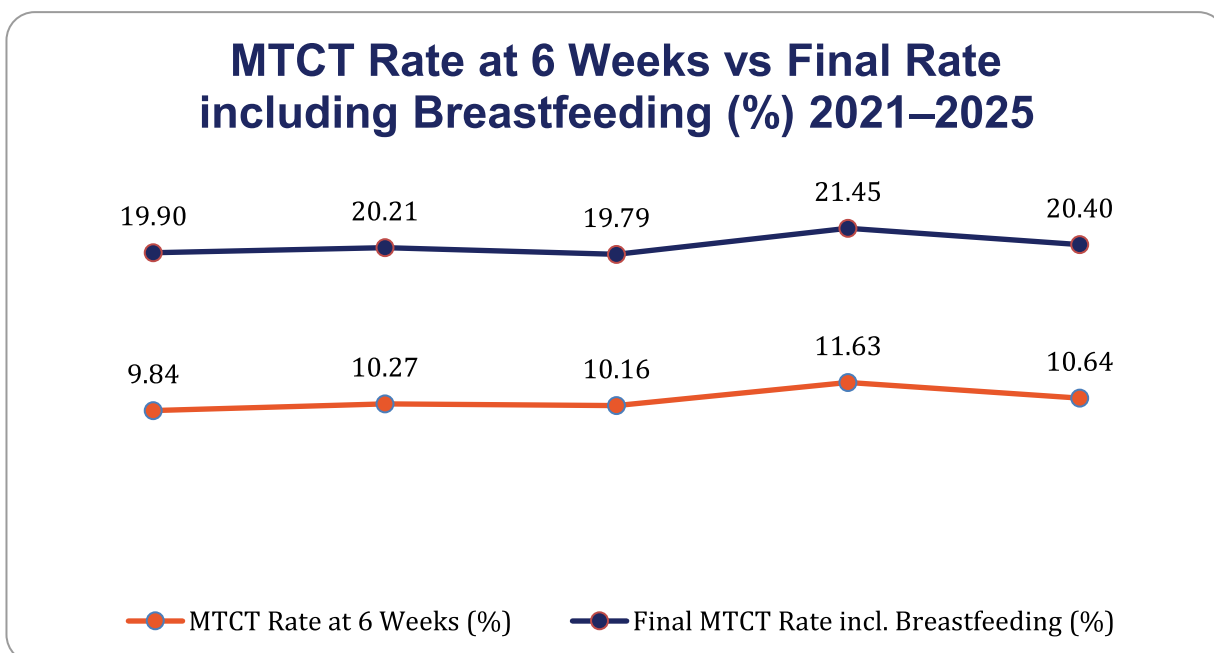


Figure 8.8b MTCT Rate at 6 Weeks vs Final MTCT Rate 2021–2025

The final MTCT rate including the breastfeeding period consistently exceeds the 6-week rate, ranging from 19.79% (2023) to 21.45% (2024), remaining at 20.40% in 2025. Both rates remain significantly

above the WHO EMTCT target of <5%, underscoring the urgent need for intensified PMTCT programme interventions including improved postpartum adherence support. The March 2026 submission estimated a final rate of 17.0% for 2025.

8.5.10 Estimated AIDS Deaths

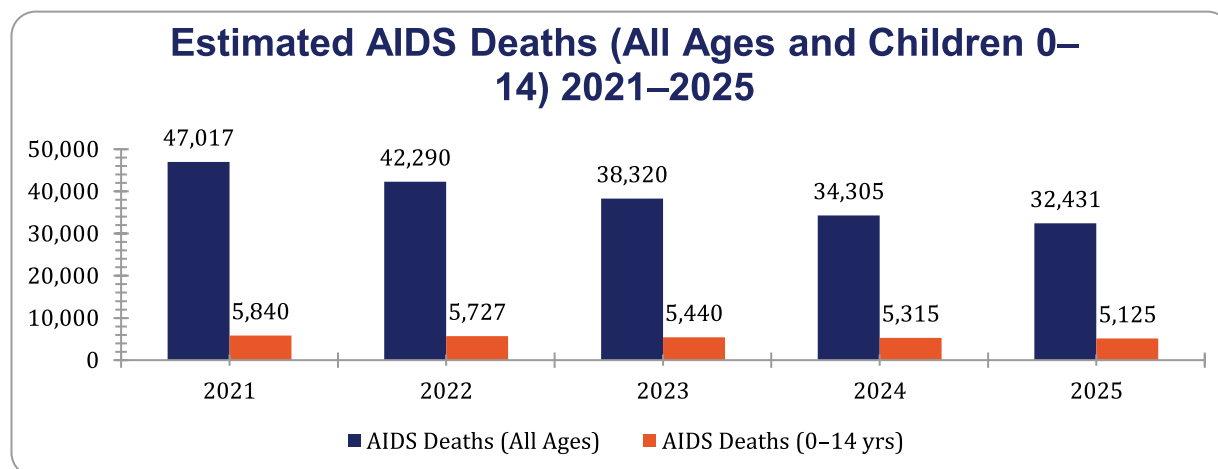


Fig. 8.9: Estimated AIDS Deaths 2021–2025. Source: Nigeria_2026_02Jun_ANCART Spectrum file, NASCP 2026

AIDS-related deaths have declined consistently from 47,017 in 2021 to 32,431 in 2025; a reduction of approximately 31% over five years. AIDS deaths among children (0–14) similarly declined from 5,840 to 5,125 in the same period. The AIDS mortality rate per 100,000 declined from 21.49 in 2021 to 13.63 in 2025, reflecting the sustained scale-up of ART coverage and improved viral suppression across all states.

Spectrum Estimates/Recalibrated Treatment Numbers

Org Unit	Total PLHIV	Total ART	Total VLT	Total VLS
Nigeria	1,985,284	1,550,000	1,290,916	1,213,461
Abia	52,322	45,587	39,545	38,670
Adamawa	26,032	37,331	30,749	29,725
Akwa-Ibom	219,470	131,208	126,383	123,360
Anambra	90,540	49,843	47,594	45,630
Bauchi	16,844	29,162	28,941	28,254
Bayelsa	23,866	20,979	21,075	20,975
Benue	188,314	178,294	169,253	159,648
Borno	49,442	21,248	16,683	14,785
CrossRiver	36,927	53,670	54,067	52,960
Delta	67,429	47,979	27,625	30,462
Ebonyi	12,400	16,001	14,124	13,400
Edo	49,481	24,793	17,916	16,866
Ekiti	18,573	10,677	11,034	10,860
Enugu	54,814	49,091	37,734	34,025
FCT	68,865	43,077	20,627	19,857
Gombe	24,723	24,314	23,490	22,379
Imo	56,678	46,478	46,671	45,592
Jigawa	11,540	12,467	11,895	11,369
Kaduna	53,031	52,347	52,443	50,885
Kano	40,946	40,363	36,067	34,644

Katsina	13,078	17,312	18,759	18,325
Kebbi	17,764	15,624	14,548	13,817
Kogi	25,459	34,265	32,953	33,127
Kwara	16,528	13,664	12,279	11,881
Lagos	197,911	129,941	81,030	78,436
Nasarawa	29,560	62,049	6,225	6,626
Niger	21,882	30,930	30,405	29,471
Ogun	43,534	27,832	27,720	26,586
Ondo	26,958	16,818	17,186	16,524
Osun	31,693	22,150	23,464	22,828
Oyo	48,918	29,062	23,425	18,807
Plateau	41,245	42,194	44,760	42,166
Rivers	214,354	90,717	49,423	45,474
Sokoto	16,653	15,298	9,844	8,241
Taraba	56,372	46,752	47,020	44,838
Yobe	8,357	8,658	5,865	5,627
Zamfara	12,781	11,825	12,094	10,426

8.6 Target Setting

NASCP has the mandate to coordinate the HIV and AIDS health sector response in Nigeria, with the responsibility to measure and report program performance. Setting clear and SMART targets for the HIV response in Nigeria has become a very important tool to measure program performance and progress, strengthen the Program Monitoring and Evaluation, highlight interventions that should be prioritized, and ensure effective and efficient resource mobilization and allocation.

The objectives of the target setting are:

- To develop specific, measurable, achievable, relevant, and time-bound (SMART) targets for the HIV program in Nigeria
- To intensify efforts towards HIV epidemic control and guide resource allocation
- The revised treatment cohort described in Section 8.4 has implications for target setting. The review meeting noted that ART targets would need to be revised at national, state and implementing-partner levels, and agreed to request guidance from UNAIDS on applying the national adjustments proportionally to individual states.

8.6.1 The Target Output

HIV Testing Services - 2026 Targets

State/Organisation	HIV Test and Results	HIV Test and Results (0–14)	HIV Test and Results (15+)
Nigeria	11,514,308	957,581	10,556,669
Abia	294,111	15,667	282,750
Adamawa	341,108	14,583	137,417
Akwa Ibom	648,152	71,583	1,183,500
Anambra	525,404	28,250	488,750
Bauchi	315,935	13,333	87,083
Bayelsa	114,665	10,417	127,417
Benue	554,157	116,000	989,333
Borno	278,868	21,083	264,167
Cross River	293,649	20,000	195,333
Delta	284,757	29,833	359,833
Ebonyi	217,667	5,250	66,250

Edo	188,337	22,583	263,750
Ekiti	54,157	6,333	100,000
Enugu	189,723	28,167	290,667
FCT	279,099	6,833	378,750
Gombe	113,395	8,083	133,333
Imo	265,704	25,167	302,417
Jigawa	210,046	5,917	61,167
Kaduna	417,321	45,083	272,667
Kano	495,265	29,750	212,917
Katsina	177,944	13,750	66,000
Kebbi	209,122	31,083	83,750
Kogi	204,041	13,250	134,917
Kwara	141,686	9,250	87,250
Lagos	1,204,964	66,083	1,066,417
Nasarawa	246,882	8,417	160,000
Niger	228,060	14,083	114,667
Ogun	243,649	20,167	231,917
Ondo	188,799	16,000	141,917
Osun	104,272	14,333	169,000
Oyo	197,690	30,500	256,833
Plateau	251,732	23,250	217,667
Rivers	726,212	56,500	1,162,250
Sokoto	299,307	60,000	63,750
Taraba	567,782	24,250	301,167
Yobe	174,018	4,250	44,333
Zamfara	266,628	28,500	57,333

HIV Treatment 0-14 years

State/Organisation	New on ART	Current on ART	VL Test	Virally Suppression
Nigeria	11,491	46,750	42,074	39,974
Abia	188	42,513	38,261	36,348
Adamawa	175	21,004	18,904	17,959
Akwa Ibom	859	178,218	160,397	152,377
Anambra	339	73,543	66,189	62,880
Bauchi	160	13,506	12,155	11,548
Bayelsa	125	19,321	17,389	16,519
Benue	1,392	151,722	136,550	129,722
Borno	253	40,036	36,033	34,232
Cross River	240	29,811	26,830	25,488
Delta	358	54,580	49,122	46,665
Ebonyi	63	10,043	9,038	8,587
Edo	271	40,038	36,034	34,232
Ekiti	76	15,075	13,567	12,888
Enugu	338	44,283	39,854	37,861
FCT	82	56,255	50,630	48,099
Gombe	97	20,074	18,067	17,163
Imo	302	45,875	41,288	39,224
Jigawa	71	9,323	8,391	7,971
Kaduna	541	42,458	38,212	36,301
Kano	357	32,890	29,601	28,121
Katsina	165	10,413	9,372	8,904
Kebbi	373	13,876	12,488	11,864

Kogi	159	20,564	18,507	17,582
Kwara	111	13,336	12,003	11,403
Lagos	793	160,664	144,597	137,367
Nasarawa	101	24,029	21,626	20,545
Niger	169	17,616	15,854	15,061
Ogun	242	35,218	31,697	30,113
Ondo	192	21,732	19,559	18,581
Osun	172	25,648	23,083	21,929
Oyo	366	39,405	35,464	33,691
Plateau	279	33,276	29,948	28,451
Rivers	678	174,340	156,906	149,061
Sokoto	720	12,338	11,104	10,549
Taraba	291	45,645	41,081	39,027
Yobe	51	6,753	6,077	5,773
Zamfara	342	9,850	8,865	8,421

HIV Treatment - 15+

State/Organisation	New on ART	Current on ART	VL Test	Virally Suppression
Nigeria	126,680	1,558,521	1,402,669	1,332,533
Abia	3,393	766	689	655
Adamawa	1,649	713	642	610
Akwa Ibom	14,202	3,494	3,145	2,988
Anambra	5,865	1,381	1,243	1,181
Bauchi	1,045	650	585	556
Bayelsa	1,529	509	458	435
Benue	11,872	5,663	5,097	4,842
Borno	3,170	1,031	928	882
Cross River	2,344	977	879	835
Delta	4,318	1,457	1,311	1,245
Ebonyi	795	256	230	219
Edo	3,165	1,102	992	942
Ekiti	1,200	307	276	262
Enugu	3,488	1,376	1,238	1,176
FCT	4,545	333	300	285
Gombe	1,600	393	354	336
Imo	3,629	1,230	1,107	1,052
Jigawa	734	289	260	247
Kaduna	3,272	2,199	1,979	1,880
Kano	2,555	1,454	1,309	1,244
Katsina	792	671	604	574
Kebbi	1,005	1,517	1,365	1,297
Kogi	1,619	647	582	553
Kwara	1,047	451	406	386
Lagos	12,797	3,227	2,904	2,759
Nasarawa	1,920	409	368	350
Niger	1,376	688	619	588
Ogun	2,783	985	887	843
Ondo	1,703	783	705	670
Osun	2,028	698	628	597
Oyo	3,082	1,488	1,339	1,272
Plateau	2,612	1,137	1,023	972
Rivers	13,947	2,758	2,482	2,358
Sokoto	765	2,931	2,638	2,506
Taraba	3,614	1,184	1,066	1,013
Yobe	532	206	185	176
Zamfara	688	1,390	1,251	1,188

Triple Elimination

State	VT1 - PW Tested for HIV	# PW Tested Syphilis	# PW Tested HBV	HEI EID ≤2 months	# PPW on ART
Nigeria	6,607,043	5,741,835	4,719,316	27,170	28,528
Abia	100,913	87,699	72,081	728	763
Adamawa	164,128	142,635	117,235	354	364
Akwa Ibom	133,090	115,662	95,065	3,046	3,209
Anambra	163,443	142,040	116,745	1,258	1,322
Bauchi	306,175	266,081	218,696	224	232
Bayelsa	58,792	51,093	41,994	328	343
Benue	153,460	133,364	109,615	2,546	2,668
Borno	278,892	242,370	199,208	680	704
Cross River	83,474	72,543	59,624	503	520
Delta	158,469	137,717	113,192	926	969
Ebonyi	89,396	77,690	63,854	170	177
Edo	105,712	91,869	75,509	679	717
Ekiti	83,375	72,457	59,554	257	278
Enugu	114,883	99,839	82,060	748	776
FCT	43,332	37,658	30,952	975	1,030
Gombe	114,264	99,301	81,617	343	357
Imo	179,473	155,970	128,195	778	814
Jigawa	314,777	273,557	224,841	157	163
Kaduna	380,255	330,459	271,610	702	719
Kano	618,812	537,777	442,009	548	567
Katsina	359,052	312,033	256,466	170	176
Kebbi	213,483	185,527	152,488	215	222
Kogi	159,513	138,624	113,938	347	358
Kwara	89,414	77,705	63,867	224	235
Lagos	347,659	302,132	248,328	2,744	2,959
Nasarawa	64,684	56,214	46,203	412	417
Niger	177,812	154,527	127,009	295	305
Ogun	156,594	136,088	111,853	597	629
Ondo	107,048	93,030	76,463	365	379
Osun	112,799	98,028	80,571	435	459
Oyo	200,940	174,626	143,528	661	694
Plateau	139,351	121,103	99,536	560	581
Rivers	164,821	143,238	117,730	2,991	3,169
Sokoto	200,985	174,666	143,561	164	169
Taraba	104,061	90,434	74,329	775	811
Yobe	157,410	136,797	112,436	114	118
Zamfara	206,298	179,283	147,356	151	155

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