# The Current HIV/AIDS situation in Nigeria

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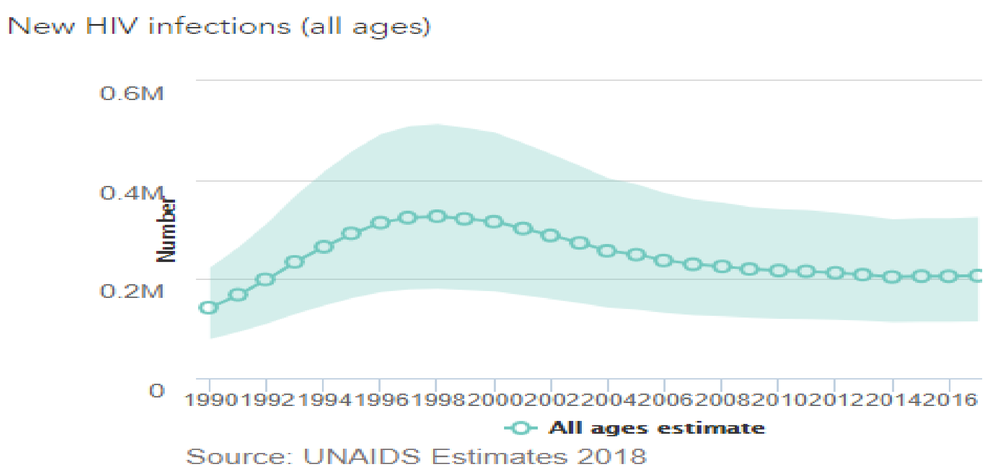
## Overview

Currently about 3.2 million people are living with HIV in Nigeria with about 210,000 new infections recorded in 2017, about a 5% decline since 2010. AIDS-related deaths have slightly declined to 150,000 per annum in 2017 from the peak of 190,000 recorded in 2008. This is related to the steadily improving access to ART and client education and decreasing stigmatization. Currently only about 33% of all people living with HIV in Nigeria are on treatment. However, this is even poorer for children whose ART coverage is about 26%. Challenges facing the control of the epidemic in the country include poor political commitment, high level of stigmatization, weak general health system and poverty.

**THE HIV EPIDEMIC**

| | 2005 | 2010 | 2016 |
|---|---|---|---|
| New HIV infections | 260 000 [190 000–330 000] | 230 000 [160 000–310 000] | 220 000 [150 000–310 000] |
| HIV incidence per 1000 population | 1.94 [1.41–2.51] | 1.51 [1.09–2.05] | 1.23 [0.85–1.8] |
| AIDS-related deaths | 200 000 [140 000–280 000] | 200 000 [140 000–280 000] | 160 000 [110 000–230 000] |
| People living with HIV | 3 100 000 [2 300 000–4 200 000] | 3 100 000 [2 300 000–4 200 000] | 3 200 000 [2 300 000–4 300 000] |



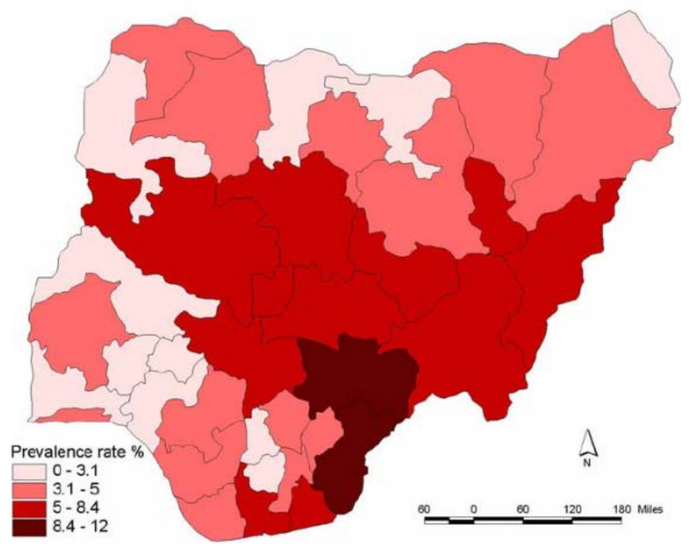

## Current update

Nigeria rolled out TLD regiment late 2017 to gradually phase out TLE. But with the current research findings of risk of NTD to DTG exposed-pregnancies, the country currently considers continuing with TLE especially for adolescents and women of reproductive age, pending the further consideration from other evidences.

## Access to Anti-retroviral therapy

There has been a steady increase in access to ART for PLWHIV. This has largely been courtesy of the Global Fund and PEPFAR.

Nigeria adopted the WHO recommendation of 'test and treat' in 2016, though this came into full implementation in early 2017. This brought about a paradigm shift in PMTCT, with life-long ART replacing option B. There is an expanding number of centers providing ART to clients but this is largely inadequate. There are so many hard to reach areas still having a difficult access to care and treatment. Other factors challenging sustainable ART services in Nigeria include poor linkage to care and treatment after diagnosis. Some centres still report less than 60% ART linkage. Retention into care and treatment is also a priority for all HIV implementing partners as high ART attrition remains a recurrent even in all treatment programs

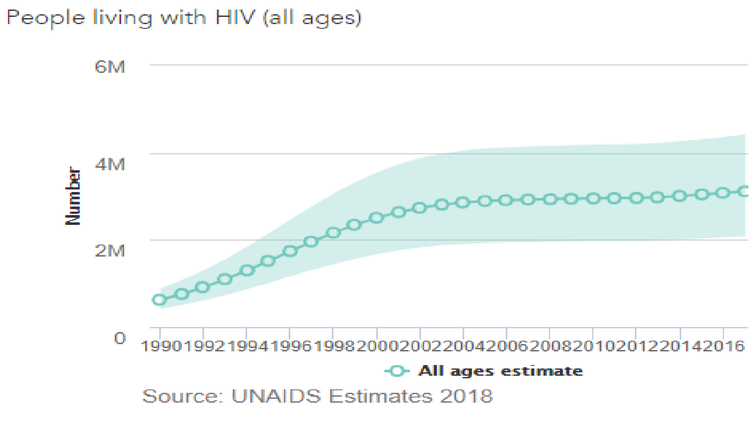



Map of Nigeria showing the working prevalence of HIV by regions

## Viral load, adherence and HIV prevention

Viral load is the gold standard of ART monitoring in Nigeria. But access to viral load is very poor across all regions of the country. DNA-PCR machine network is weak. Average turn-around time for a viral load service is about 3 months.

HIV prevention programs are weak and inconsistent. Condom availability is commendable but uptake is affected by religious and cultural ties, poor personal risk perception, and client choice. Services targeting key populations are not optimum partly because of criminalization of commercial sex and program priority. Combination prevention is integrated into the national HIV program but poorly implemented. Nigeria adopted the use of PrEP only for commercial sex workers and serodiscordant couples. Additionally, post-exposure prophylaxis is available but uptake is affected by client education and fear of stigmatization




The information contained in this poster are mostly extracted from UNAID website http://www.unaids.org/en/regionscountries/countries/nigeria.
Other related information are from MSH Nigeria CaTSS Bill Board and MSH supported facility data extract.