ECEWS
...Improving Education and Health in Nigeria

Data-Driven, Differentiated HIV Testing Services for Diverse Populations

A TECHNICAL BRIEF ON HIV TESTING SERVICES

TABLE OF
CONTENTS

List of acronyms 3
Executive Summary 4
Introduction 5
The Challenge 5
Our Approach 6
Facility Based HIV Testing Services 7
Targeted Community Based HIV Testing Services 7
Index Testing Services 8
HIV Self Testing 8
Community Based HTS for Pregnant & Breastfeeding Women 9
Paediatric & Family Centred HIV Testing 9
HIV Testing for High Risk Populations 9
What We Found 10
What We Learned 13
Future Directions 14
Annex 15
Details of HTS Approaches 15
Facility Based HIV Testing Services 15
Targeted Community Based HTS 15
Index Testing Services 16
HIV Self Testing 16
Community Based HTS for Pregnant & Breastfeeding Women 16
Paediatric & Family Centred HTS 16
HIV Testing for High Risk Populations 17
References 18

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CBOs	Community-Based Organizations
ECEWS	Excellence Community Education Welfare Scheme
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HTS	HIV Testing Services
IPV	Intimate Partner Violence
LGA	Local Government Area
NAIIS	Nigeria AIDS Indicator and Impact Survey
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PPMVs	Private Patent Medicine Vendors
RTK	Rapid Test Kit
SACAs	State Agencies for the Control of AIDS
SASCPs	State AIDS and STI Control Programs
SPHCDA	State Primary Health Care Development Agency
STI	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
UNAIDS	Joint United Nations Programme on HIV/AIDS

EXECUTIVE SUMMARY

HIV testing remains the critical entry point to HIV prevention, treatment, and epidemic control. The 2018 Nigeria AIDS Indicator and Impact Survey (NAIIS) estimated that approximately two-thirds of people living with HIV (PLHIV) in Nigeria knew their status, highlighting substantial diagnostic gaps. Since then, expanded testing efforts and targeted programmatic strategies have improved diagnostic coverage, with UNAIDS estimates indicating that about 84% of PLHIV in Nigeria were aware of their status by 2025.

To accelerate progress toward closing the remaining diagnostic gap, the Excellence Community Education Welfare Scheme (ECEWS) implemented a data-driven, differentiated HIV Testing Services (HTS) approach across seven Nigerian states – Akwa Ibom, Cross River, Delta, Lagos, Osun, Ebonyi, and Ekiti. The strategy combined multiple complementary modalities, including risk-screened facility-based testing, targeted community testing, index testing, HIV self-testing (HIVST), and tailored outreach for high-risk populations. Implementation was guided by granular micro-planning and routine analysis of epidemiologic and programmatic data to prioritize locations and populations with the highest likelihood of undiagnosed HIV infection.

Across these modalities, 4,422,867 HIV tests were conducted, identifying 68,431 PLHIV and linking them to treatment services. Facility-based testing accounted for 55% of all tests and identified the largest number of HIV-positive individuals across most age groups. Community-based testing expanded access to underserved and hard-to-reach populations, while index testing yielded the highest positivity rate, highlighting its importance in identifying infections within sexual and family networks. Additionally, 506,699 HIV self-testing kits were distributed, improving testing access among men, adolescents, and other populations facing barriers to conventional testing services.

Findings demonstrate that no single testing modality is sufficient to address the heterogeneous nature of Nigeria's HIV epidemic. Instead, combining facility-based, community-based, and network-based testing strategies supported by real-time data and strong community partnerships can substantially improve case identification. Sustaining progress toward epidemic control will require continued expansion of high-yield testing strategies, HIV self-testing, family-centred testing approaches, and data-guided micro-planning to ensure that the remaining undiagnosed individuals are identified and linked to care.

INTRODUCTION

The global HIV response has made significant strides over the last decade through expanded access to HIV testing and treatment. These efforts have led to a decrease in AIDS-related mortality and an increase in viral suppression ①. As of 2024, an estimated 40.8 million people were living with HIV, yet only 87% of them knew their HIV status ②. Sub-Saharan Africa bears a disproportionate 65% of the global HIV burden, and consequently accounts for the largest number of undiagnosed HIV infections, approximately 3.4 million people ②. This substantial gap fuels ongoing transmission, while health system gaps delay ART initiation and perpetuate disparities in epidemic control. As global strategies increasingly emphasize precision public health, the effectiveness of HIV Testing Services (HTS) depends on the ability to reach populations with the greatest unmet diagnostic need through differentiated and people-centred approaches.

Nigeria, which has the fourth highest global burden of HIV with an estimated 2 million people living with the virus, has actively expanded HIV testing coverage, integrating facility and community platforms to achieve high impact (3-5). Progress has been driven by national policies, PEPFAR and Global Fund investments, and strengthened state-level health systems. The 2018 Nigeria AIDS Indicator and Impact Survey established a national HIV prevalence of 1.4% among adults, a decline from previous estimates of 2.8% ⑥. Furthermore, UNAIDS data indicate a 52% reduction in new infections between 2016 and 2024 ⑦. More recent programme assessments and the 2024 Nigeria Demographic and Health Survey indicate an improving adult awareness of HIV status, particularly among women of reproductive age ⑧. The 2018 NAIIS survey estimated that about two-thirds of PLHIV in Nigeria knew their status ⑨; by 2025 this had increased to 84%, according to UNAIDS estimates ⑦.

THE CHALLENGE

Nigeria's HIV epidemic is characterized by unique complexities that make effective HTS delivery challenging. The country's vast geography, highly heterogeneous epidemic with considerable sub-national variation, diverse cultural and linguistic landscape, high internal migration and mobility, and large rural, peri-urban, and hard-to-reach populations create significant barriers to service delivery (10-12). Social norms that discourage male health-seeking behaviours, pervasive stigma and discrimination, criminalisation affecting high-risk populations, and fragmented community health platforms further complicate targeted testing efforts (13,14). Additional limitations within the health system, including uneven staffing and competencies, variable data quality, and intermittent commodity supply, affect the consistency and efficiency of HTS (15-17). Consequently, diagnostic gaps persist across multiple population groups despite prior investments and ongoing interventions (18). These population- and geography-specific disparities highlight the limitations of traditional, non-targeted testing approaches within a maturing epidemic where undiagnosed HIV infections are clustered in complex and often hidden networks. Addressing these gaps requires a precision public health approach, integration with broader health systems, rigorous quality assurance, and strong community partnerships.

OUR APPROACH

ECEWS implemented a comprehensive and highly differentiated HIV testing model across Akwa Ibom, Cross River, Delta, Lagos, Osun, Ebonyi, and Ekiti States, which collectively contribute nearly a quarter of Nigeria's HIV burden. HIV prevalence in these states ranges from 4.8% in Akwa Ibom (the highest in the country) to 0.7% in Ekiti (the lowest in the South) [9].

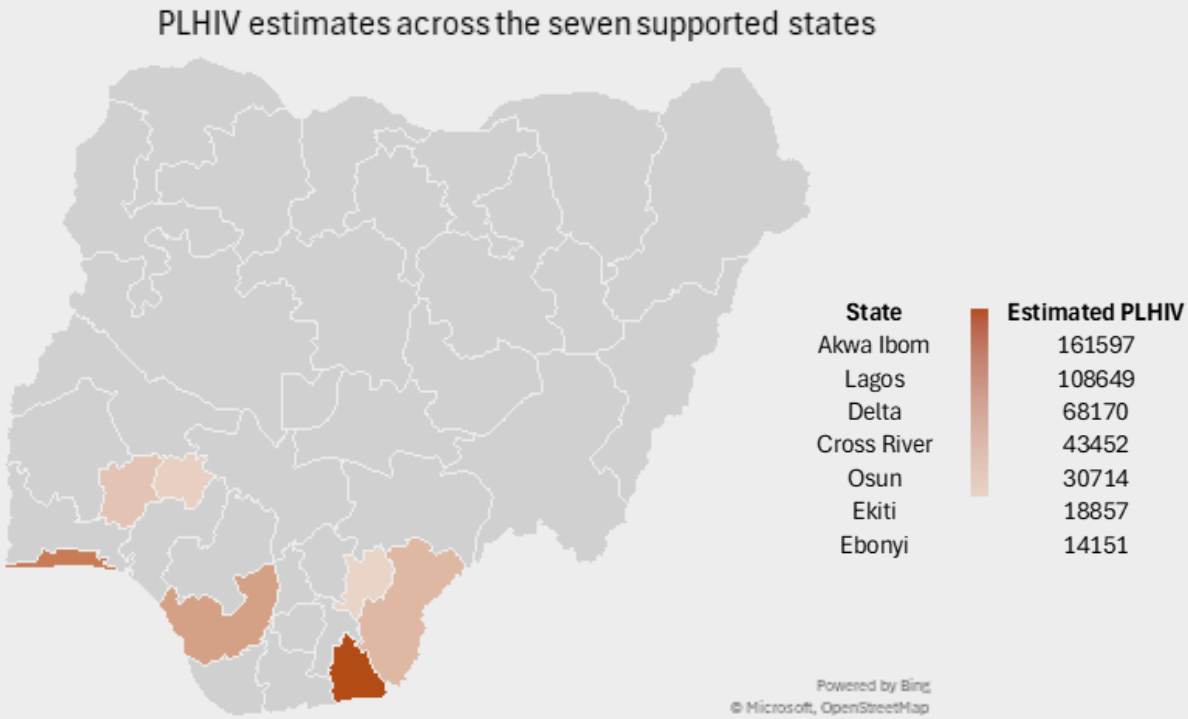

Figure 1: PLHIV estimates across the seven ECEWS-supported states. (Source: NACA 2024 spectrum estimates)

We designed HIV Testing Services to aggressively address persistent HIV diagnostic gaps across all population segments and geographies. The strength of these approaches stemmed from granular micro-planning, continuous use of epidemiological data, and a deliberate alignment of testing resources with evolving transmission patterns. Efforts were concentrated where the probability of finding undiagnosed HIV infection was highest, and where structural, social, and geographic barriers had historically prevented individuals from accessing HIV services. This was done using various HTS modalities described below. Detailed operational steps for each modality are provided in the annex.

Facility-Based HIV Testing Services

Figure 2: HIV testing session in a supported health facility

ECEWS implemented Provider-Initiated Testing and Counselling (PITC) as a structured, routine, facility-wide service designed to ensure that every clinical encounter across the 444 supported health facilities in the seven states became an opportunity to diagnose HIV early. Risk- and symptom-based screening allowed health workers to focus on individuals with higher probability of HIV infection, while immediate point-of-care testing minimised intra-facility movement, stigma, and loss during internal referrals. Facility-based HTS strengthened ART linkage for those testing positive and ensured negative clients were counselled and linked to prevention packages. Individuals who tested positive were linked to same-day ART initiation, or follow-up was arranged if initiation could not occur immediately. Negative clients were counselled and linked to appropriate prevention packages, depending on their needs.

Targeted Community-Based HIV Testing Services

Figure 3: Community HTS outreach to a hard-to-reach inland location

ECEWS implemented a highly targeted and adaptive community HTS model specifically designed to reach populations with limited access to health facilities. Community teams (approximately one per LGA in 133 LGAs acroiss the seven states) conducted micro planning using ward level data, hotspot mapping, positivity trends, and treatment gaps to identify priority communities, including locations with high unmet need such as healing homes, motor parks, PPMVs, construction sites, brothels, slums, fishing camps, workplaces, and rural/peri urban settlements. Reverse hotspot mapping and EPCON AI-generated HIV hotspot maps were used to enable data-informed prioritisation of high- and medium-prevalence areas (18).

HIV testing was provided during flexible testing hours: moonlight sessions, male focused early morning sessions, youth outreach at sports fields, in alignment with the routines of each population. Real time communication and daily reviews enabled rapid adjustment of outreach plans to maintain coverage and improve reach. Strong community and government partnerships further amplified the success of community HTS. Collaborations with State Agencies for the Control of AIDS (SACAs), State AIDS and STI Control Programs (SASCPs), the Network of People Living with HIV and AIDS in Nigeria (NEPWHAN), and adolescent- and youth-led Community-Based Organizations enabled effective community entry, social mobilization, and sustained bi-weekly outreaches.

Index Testing Services

ECEWS implemented Index Testing as a highly structured, operational strategy designed specifically to uncover undiagnosed HIV infections embedded within sexual and biological networks. This approach was particularly necessary to reach undiagnosed contacts early and link them to treatment. Facility teams regularly generated a prioritized line-list of index clients known to have higher transmission potential. This included newly diagnosed individuals, clients returning after treatment interruption, and those with unsuppressed viral load. Biological and sexual contacts were elicited in private sessions, with screening for intimate partner violence, while client-preferred notification methods enabled counsellors to identify sexual partners, injecting partners, and biological children. Contacts were reached through facility appointments, community referrals, home visits, or HIV self-testing kit (HIVST) distribution.

HIV Self-Testing

ECEWS implemented HIV Self-Testing as a complementary strategy integrated within both facility-based and community-based HTS platforms. This approach facilitated confidential and flexible testing for populations who face significant barriers to conventional testing. HIVST was prioritized for adolescents and young people, men, and partners of index clients, who often avoid facility-based testing due to factors such as stigma, fear of being seen, demanding work schedules, restrictive gender norms, or concerns around confidentiality.

HIVST kits were made available at facilities, during community outreach, and through youth-friendly corners, PPMVs, sports venues, and a total market approach in pharmacies. Our “piggybacking” innovation, where provider contact details were attached to kits, improved result reporting and strengthened linkage to confirmatory testing.

Figure 4: Distribution of HIV self-testing kits to men in the community

Community-Based HTS for Pregnant & Breastfeeding Women

ECEWS implemented a targeted community testing model to reach pregnant and breastfeeding women who did not access antenatal care or postnatal services, particularly those delivering at home, relying on traditional birth attendants, or attending informal prayer or healing homes. Working with the state governments, counsellor testers/linkage facilitators conducted scheduled outreach to over 1,000 mapped community birth centres, including centres run by retired healthcare workers, those run by lay providers, faith-based or informal maternity homes. This model provided on-site HTS, same-day accompanied referral of pregnant women diagnosed with HIV to facilities for ART and ANC enrolment, and counselling for HIV negative women on heightened HIV risk during pregnancy and lactation, including universal offer of pre-exposure prophylaxis.

Paediatric & Family-Centred HIV Testing

ECEWS adopted a comprehensive paediatric and family-centred HIV testing approach to address long-standing gaps caused by missed mother-infant follow-up, weak immunisation linkages, caregiver fears, and adolescents' low help-seeking behaviour. This approach systematically identified and tested infants, children, and adolescents connected to a person living with HIV, through family index testing, household based testing, paediatric PITC, caregiver-assisted HIVST, and youth friendly community outreaches.

HIV Testing for High-Risk Populations

ECEWS implemented a targeted HIV testing approach tailored to the realities of high-risk populations, including men who have sex with men, sex workers, people who inject drugs, transgender persons, and people in custodial centres. We deployed strategies to reach these populations wherever they naturally live, work, socialize, or seek services, using trusted peers and community gatekeepers to ensure safety and acceptability. Hotspot mapping, index testing, peer-led testing, and HTS integrated with screening for sexually transmitted infections, tuberculosis, and non-communicable diseases, were strategies deployed to reach each high-risk population. Continuous engagement with relevant stakeholders and pressure groups, including the NEPWHAN, SACAs, Police Action Committee on AIDS, Federal and State Ministries of Health, and their parastatals and agencies, helped secure stigma-free environments, negotiate safe spaces, and reinforce rights-affirming service delivery.

WHAT WE FOUND

Across all modalities, ECEWS administered 4,422,867 HIV tests, leading to the identification of 68,431 HIV-positive individuals.
Facility-based HTS accounted for 55% (2,435,697) of all tests: 7% were among children <15 years, 25% (608,924) among adolescents/young adults aged 15 to 24 years, 60% (1,461,418)

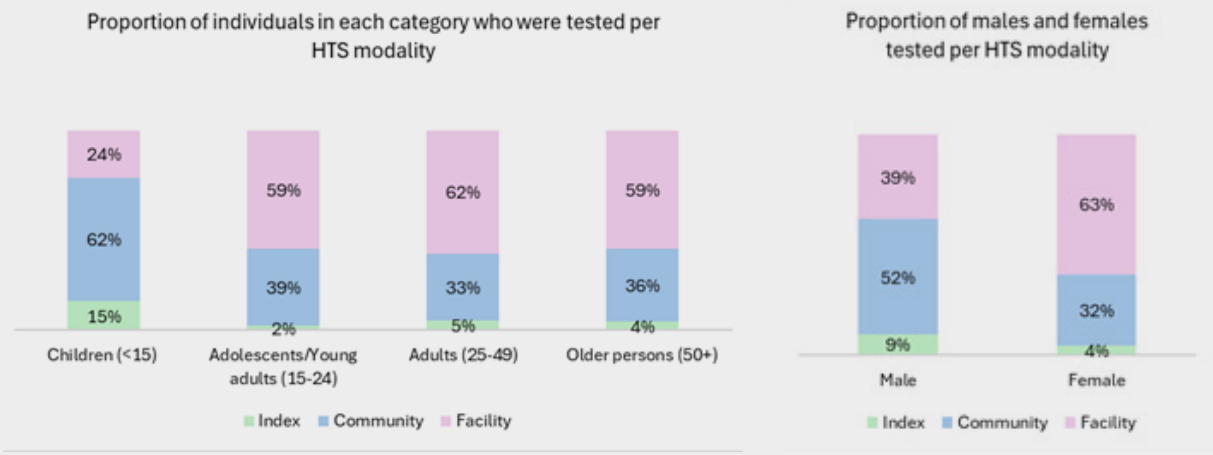

Figure 5 The effectiveness of HTS modalities in reaching various populations across age and sex

among adults aged 25 to 49 years, and 8% (194,856) among older persons aged 50 years and older. This yielded 36,925 positives: 66% (24,370) adults, 19% (7,016) adolescent/young adult positives, 2% (738) paediatric positives, and 13% (4,800) positives among older adults. Facility testing was the most effective modality in reaching adolescents, adults, and older persons with HTS, and the most effective in finding positives in all these groups, accounting for 61%, 52%, and 53% of case finding in each age category, respectively.

Community-based HTS delivered the highest population reach with 39% (1,741,179) of all tests: 26% (452,707) were among children, 12% (208,941) among adolescents/young adults, 21% (365,648) among adults, and 3% (52,235) among older persons. Community testing identified 9,400 adult positives (56%), 1,846 adolescent/young adult positives (11%), 1,007 paediatric positives (6%), and 2,014 positives (12%) among older adults. Community testing was most effective for reaching children with HTS.

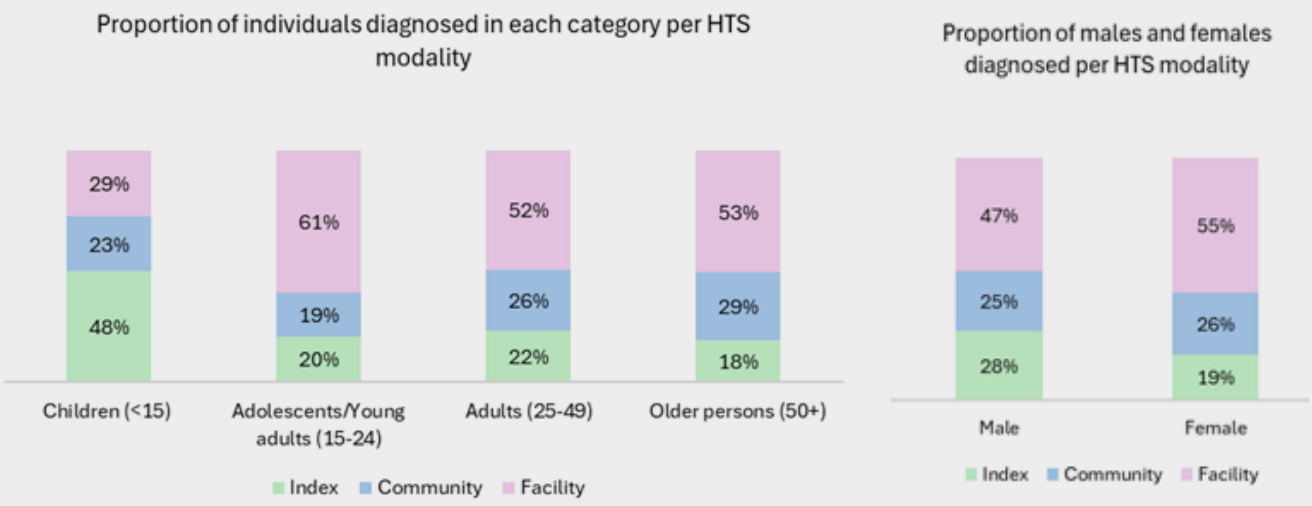

Figure 6The effectiveness of HTS modalities in HIV case finding across age and sex

Index testing contributed the highest case finding yield. Of 200,496 HIV-positive clients offered index testing, 84% accepted, demonstrating high acceptability despite stigma and relationship dynamics, from which 182,990 partners were elicited, and 116,206 biological children were enumerated. In total, 260,320 (87%) partners were tested, yielding 6% positives (10% among adults and 1% among children). Index testing was the most effective modality for finding children living with HIV, accounting for 48% of all paediatric case finding, and 42% of all testing through this modality was among children. This reinforces the role of family index testing in closing paediatric linkage gaps left by PMTCT alone.

HIV self-testing further broadened access to high-risk and high-barrier populations. ECEWS distributed 506,699 HIVST kits, with 476,558 (94%) results reported, 0.7% reactive. HIVST was especially impactful among adolescents and young persons (41% of all HIVST kits distributed). Also, 49% of all HIVST kits were distributed to men, whereas only 35% of conventional testing reached men. This validated HIVST as a private, flexible tool for individuals facing stigma, limited time, or concerns about being seen at testing points.

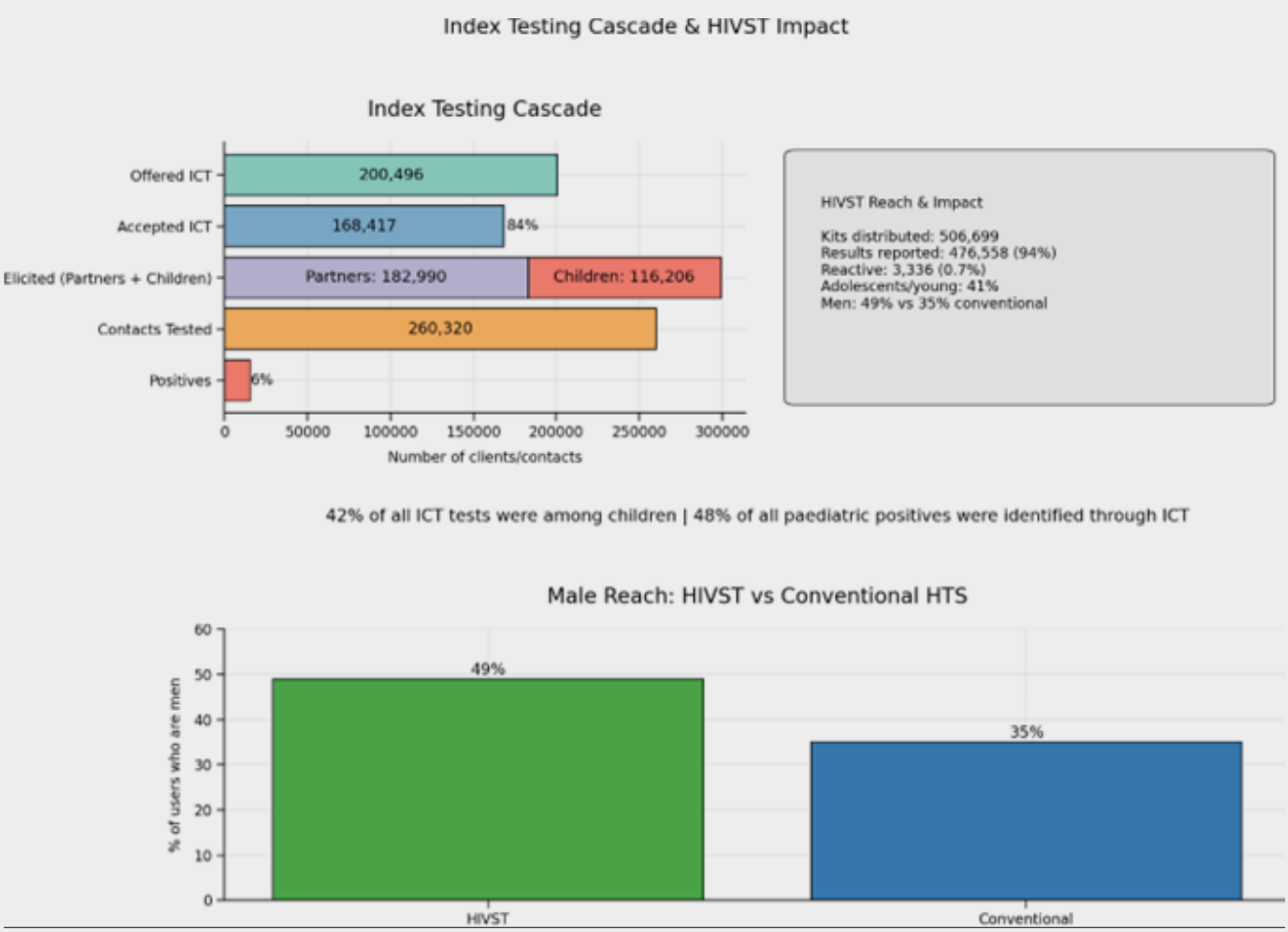

Figure 7 Index testing outcomes and impact of HIV self-testing on case finding

Youth-tailored approaches like peer-supported HIVST, testing during sports and social activities, and nightlife outreaches were essential for overcoming stigma, concerns about confidentiality, and low risk perception in this population. Adults represented the largest share of overall testing. Facility HTS captured symptomatic adults and pregnant women, while community HTS reached men and informal workers with low health-seeking behaviour.

WHAT WE LEARNED

A fundamental lesson derived from this intervention was that no single HTS modality can adequately address the inherent heterogeneity of Nigeria's HIV epidemic. Facility-based PITC, community outreach, index testing, HIV self-testing, and paediatric/family-centred approaches each reached different segments of the population, and their combined application was essential to achieving the depth and breadth of case identification seen across age groups and geographical areas.

A major driver of success was the use of granular, real-time data to guide micro-planning and deployment. By continuously reviewing positivity trends, treatment saturation, gaps among pregnant and breastfeeding women, and geographic hot spots, ECEWS ensured that resources were redirected to places and populations with the highest likelihood of undiagnosed HIV infection. This precision significantly improved efficiency and is a foundation for long-term sustainability, especially in resource-constrained settings. The integration of reverse hotspot mapping and EPCON AI-generated hotspot maps further strengthened this approach, enabling strategic resource alignment and evidence-based geographic prioritization.
Across all modalities, the program demonstrated that bringing services to people, not waiting for people to come to facilities, is essential. Community-based HTS, marine/creek outreaches, and hinterland deployments effectively reached populations historically excluded from the HIV response. The integration of embedded community personnel, who understood local terrain, tides, leadership structures, and cultural nuances, was critical to securing trust and reducing stigma. Strategic partnerships with community stakeholders, including NEPWHAN, adolescent and youth-led CBOs, traditional leaders, TBAs, and faith actors, enhanced community entry and demand creation.

The program confirmed the high-yield potential of network-based and family-centred strategies. Index testing produced the highest positivity yield, validating the importance of structured elicitation, IPV screening, flexible notification options, and the integration of HIVST for unreachable or reluctant partners. Family index testing and household paediatric testing effectively closed long-standing PMTCT and child health gaps, identifying children who would not ordinarily be reached through facility flows or PMTCT service delivery points.
Another key lesson was the centrality of confidentiality and convenience, especially for men and adolescents. HIV self-testing transformed access for these groups, offering a private, self-paced testing option while maintaining strong linkage to confirmatory testing and ART. The use of adolescent peer facilitators, partner-delivered HIVST through index testing, and the total-market approach at community pharmacies expanded reach and reduced stigma, illustrating the value of human-centred design in HIV testing. The "piggybacking" innovation further improved result reporting, strengthened linkage, and fostered trust.

Our interventions highlight the critical role of strong community and facility partnerships. Collaboration with traditional leaders, TBAs, retired health workers, faith structures, youth groups, government agencies, and PLHIV networks strengthened demand creation, improved

acceptability, and made testing safer and more sustainable. Sustained engagement with government structures, including SACA, SASCP, SPHCDA, and local government health authorities, was instrumental for coordination, policy alignment, and long-term program continuity. Public and private sector collaboration ensured smoother referral pathways, stronger oversight, and reinforced ownership essential for sustaining gains beyond donor support.
Limitations and Challenges

Despite strong gains, several limitations continue to affect HTS reach and efficiency. Difficult geography periodically slowed access, but embedded community personnel, specialized transport (boats, motorcycles), and accompanied referrals helped mitigate this barrier.
Stigma, prevailing gender norms, concerns about confidentiality, and inherent constraints within the health system limited testing uptake and partner disclosure. With redistribution of counsellor testers, extended clinic hours, ongoing mentoring, daily review of missed-opportunities, and use of youth-friendly corners, HTS remained accessible to populations at risk.
Periodic RTK stockouts and supply chain delays intermittently disrupted planned testing activities. Rapid redistribution, weekly forecasting, and coordination with state logisticians reduced downtime.

These challenges highlight the ongoing need for reliable supply chains, continuous provider mentoring, digital data systems, and stronger client-responsive approaches to ensure sustainable HTS coverage.

FUTURE DIRECTIONS

Looking ahead, HTS will require greater precision, efficiency, and sustainability to close the remaining diagnostic gaps within Nigeria's maturing epidemic and align with global shifts toward integrated, country-owned HIV responses.

One key future direction is strengthening testing efficiency and reducing low-yield testing through greater reliance on modalities shown to reach the highest-risk populations. At the same time, AI-assisted hotspot mapping and predictive analytics will make micro planning more adaptive by identifying micro clusters of undiagnosed infection and directing outreach efforts to areas where yield is highest.
Sustaining future gains will hinge on expanded task shifting and task sharing, equipping community pharmacists, TBAs, peer navigators, and youth leaders to support testing, counselling, and linkage across facility and community settings. Strengthening state-level stewardship through improved financing, domestic supply chain reliability, supportive supervision structures, and stronger public–community partnerships will be essential to ensuring continuity of HTS beyond donor project cycles.

Collectively, these directions position HTS to deliver high-impact, sustainable case finding, ensuring Nigeria continues closing diagnostic gaps among all populations and geographies as part of the national pathway toward epidemic control.

ANNEX

DETAILS OF ECEWS HTS APPROACHES

Facility-Based HIV Testing Services

Provider-Initiated Testing and Counselling operated as a structured, routine, facility-wide service designed to ensure that every clinical encounter across supported health facilities became an opportunity to diagnose HIV early. Facility teams regularly reviewed clinic attendance to identify high-volume service points. Counsellor testers were strategically positioned within these units to integrate HTS into routine triage.

Clients were screened using the national HIV risk assessment tool to focus on those with symptoms or behaviours linked to higher HIV risk. Pre-test counselling occurred at the point of care, reducing client movement and minimizing stigma. Testing followed the national serial algorithm, and counsellors delivered results privately, even in busy clinical environments. For minors, counsellors engaged caregivers early to address misconceptions around testing children. Positive clients were linked immediately to same-day ART initiation or scheduled for follow-up where initiation was not possible. Negative clients received risk-appropriate prevention counselling. Facility teams conducted daily missed-opportunity reviews, examining registers and client flow to identify eligible clients who might have been missed and to make adjustments such as repositioning counsellors or reorganizing flow.

Targeted Community-Based HIV Testing Services

A highly targeted and adaptive community HTS approach was used to reach populations with limited access to health facilities. The approach began with structured micro-planning using ward-level data, hotspot mapping, positivity trends, treatment coverage gaps, reverse hotspot mapping, and EPCON AI-generated HIV hotspot maps to identify priority sub-populations and locations.

Teams of counsellor testers, case managers, and clinical staff were deployed to typology-specific hotspots and underserved settings including healing homes, PPMVs, motor parks, construction sites, brothels, slums, fishing camps, and rural communities. Testing points were selected for confidentiality: compound corners, church halls, town halls, or other spaces acceptable to the community. Individuals concerned about visibility were offered HIV self-testing with assisted linkage.

Marine/creek communities required specialized access using boats and testers who understood local waterways and leadership structures. Outreach was scheduled around fishing patterns to ensure high presence of men, adolescents, and women involved in fish processing. Testing areas were set up in boat sheds or secluded sites, with on-site ART linkage.

In hinterland and inland hard-to-reach areas, travel was done using motorcycles, tricycles, or on foot. Entry was facilitated through village heads or women/youth leaders, who identified safe, private testing spaces. Counsellors conducted brief sensitisation to address low HIV literacy and

stigma. Daily reviews using SMS, WhatsApp, or voice calls enabled rapid adaptation, e.g., moonlight testing, male-focused outreach, adolescent sports-field sessions, or faith-based outreach after services.

Index Testing Services

Index testing was operated as a structured, daily implementation strategy to uncover undiagnosed HIV infections among sexual and biological networks, especially populations not reached through routine HTS. Facility teams generated prioritized index-client line-lists of newly diagnosed individuals, clients returning after interruptions in treatment, and clients with unsuppressed viral load.

Counsellors conducted private elicitation sessions with rigorous IPV screening to protect clients from harm. Partners and biological children were enumerated and notified through provider, client-led, dual, or contract notification methods. Testing was done through facility appointments, community outreach, home visits, workplace visits, or HIVST distribution where privacy was needed. Children under 18 were tested after engaging caregivers with age-appropriate counselling.

Daily reviews ensured follow-up on unreachable partners, monitoring of adverse events, and corrective measures. Contacts who tested positive were linked to same-day ART; those negative were linked to prevention options.

HIV Self Testing (HIVST)

HIVST was implemented as a confidential and flexible HTS option for adolescents, young people, men, partners of index clients, and other populations who fear stigma or have limited time. Kits were distributed through facility service points, community outreach, PPMVs, youth hubs, sports venues, and via a total-market approach in pharmacies.
Providers placed their contact details ("piggybacking") on kits prior to distribution to strengthen result reporting and support. Adolescents were reached through trained adolescent peer facilitators; index clients received kits to give to partners unwilling or unable to attend facilities. Assisted demonstrations and virtual counselling (phone, WhatsApp) supported correct use. For children 2–11, HIVST was caregiver-assisted only.

Community-Based HTS for Pregnant & Breastfeeding Women

This model reached pregnant and breastfeeding women who do not regularly access ANC or PNC services, particularly those relying on traditional birth attendants, informal maternity homes, and spiritual healing centres. Outreach was conducted at over 1,000 mapped community birth centres. Retired healthcare workers managing some centres were provided with proficiency testing and supervision to conduct HTS. Women testing positive were escorted to facilities for ART/ANC linkage; HIV-negative women were counselled on heightened seroconversion risk and offered universal Pre-exposure prophylaxis.

Paediatric & Family Centred HIV Testing

A multi-platform paediatric and family-centred model addressed gaps caused by missed PMTCT follow-up, weak EID–immunisation linkages, caregiver stigma, and adolescents' low help-seeking behaviour. Infants due for EID, sick children presenting at OPD/IPD, adolescents with STI/TB

symptoms, and children attending immunisation or malnutrition clinics were identified through triage and case-note review.
Index counsellors screened for biological children immediately after adult diagnosis. Testing was conducted at facilities or homes. Adolescents were offered flexible HTS options, including youth-friendly corners, peer-supported HIVST, and virtual kit requests. Integration across ANC, L&D, PNC, immunisation, and adolescent units reduced missed opportunities.

HIV Testing for High Risk Populations

A targeted HTS approach was used for men who have sex with men, sex workers, people who inject drugs, transgender persons, clients of sex workers, and persons in custodial centres. Hotspot mapping identified brothels, night-time sex work areas, drug-use sites, lodges, and bars. Testing was conducted using moonlight sessions, event-driven HTS, and typology-based outreach supported by community gatekeepers. Peer-led testing frameworks empowered typology members to mobilize and counsel within their networks.
Index testing and HIVST were adapted for partner notification in KP networks, with integrated STI, hepatitis, syphilis, TB, and NCD screening offered during HTS sessions.

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