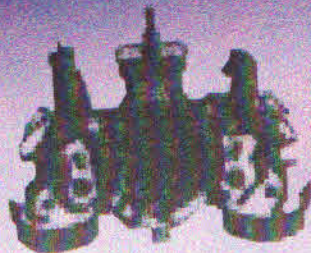




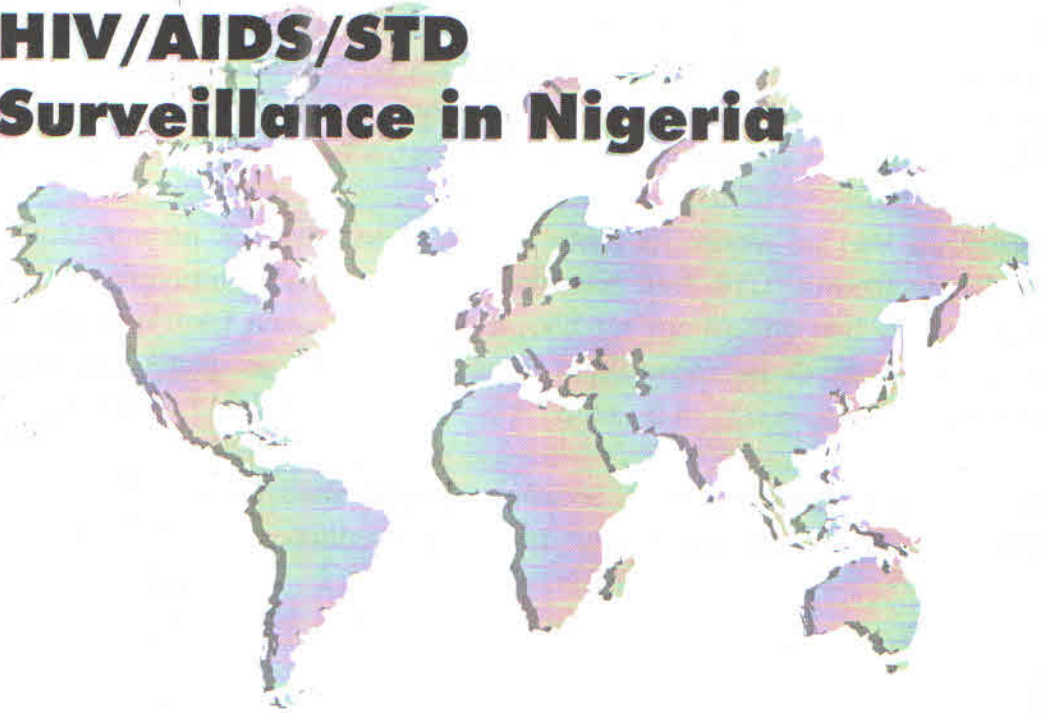
**FEDERAL MINISTRY OF HEALTH
DEPARTMENT OF PUBLIC HEALTH
NATIONAL AIDS/STD CONTROL PROGRAMME**

**GUIDELINES ON HIV/AIDS/STD
SURVEILLANCE IN NIGERIA**



NATIONAL AIDS/STD CONTROL PROGRAMME

**Guidelines on
HIV/AIDS/STD
Surveillance in Nigeria**



*By the Federal Ministry of Health in
collaboration with the National Action Committee
on AIDS and the UNAIDS.*

December 2000

Preface

HIVAIDS/STD Surveillance is recognized worldwide as a useful tool in monitoring HIV prevalence, trends and making of projections and impact for advocacy, planning and review of programmes for intervention.

The Ministry of Health will remain determined and focused in collaborating with relevant stakeholders to develop and strengthen the Nigerian surveillance system as the most appropriate tool for advocacy, decision making and planning interventions on HIV/AIDS/STD in the country.

It was in this vein that local and international technical experts through the support of UNAIDS were brought together to develop this important guideline in line with the principles and concepts of the second-generation surveillance system recently developed by the WHO/UNAIDS.

The Guideline on Surveillance in Nigeria gives an insight on HIV surveillance; AIDS case reporting Behavioural Surveillance and STD surveillance. It also shows the approved national indicators used for monitoring and evaluating the progress and finally outlines the National implementation strategies along with the surveillance plan of action for the future.

It will be useful for all State level surveillance officers, research institutions and also for donors in the country in planning surveillance activities in the country.

S.A Suleiman

Permanent Secretary

Acknowledgement

The Federal Ministry of Health gratefully acknowledges all the inputs of the Stakeholders, facilitators, consultants and state AIDS/STD Programme Officers who participated in the Training Workshop for state surveillance officers on Second Generation Sentinel Surveillance. The development of National guidelines on Surveillance as outcome of this workshop will go along way to strengthen the surveillance system of the Country.

The role of Hon. Minister, Dr Tim Menakaya, the Permanent Secretary, S.A Suleiman, the entire staffs of Federal Ministry of Health for providing the necessary approval and logistics led to the success of the workshop. Also to note is the remarkable contributions of the Chairman of the National Action Committee on AIDS, Prof I Akinsete; technical experts from UNAIDS and Family Health International in facilitating the process of the training workshop successful. Most importantly is the financial and technical support of UNAIDS in the implementation of this important activity.

We also extend our heartfelt thanks to all of the experts and partners who took time from their busy schedules to attend this workshop. Most importantly are the tireless efforts the National AIDS/STD Control Programme and its secretariat staffs in putting this document together.

Dr E. A. Abebe
Director Public Health

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List of Abbreviation

AIDS	Acquired Immuno Deficiency Syndrome disease
CDC	Centre For Disease Control
CSWS	Commercial Sex Workers
FHI	Family Health International
HIV	Human Immuno Deficiency Virus
IDU	Intravenous Drug Users
LDTDS	Long Distance Truck Drivers
MSM	Men Having Sex With Men
NACA	National Action Committee On Aids
SAPCS	State Aids Programme Coordinators
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme On Aids
WHO	World Health Organisation

Introduction

In an effort to strengthen HIV/AIDS surveillance in Nigeria in line with the recommendations of the World Health Organisation, The Federal Ministry of Health in collaboration with National Action Committee on AIDS and UNAIDS organized a 3-day workshop to introduce and train state surveillance Officers on the details of 2nd Generation HIV/AIDS/STD Surveillance system in Nigeria.

Prior to now, the AIDS epidemic in Nigeria has been monitored using the principles of the first generation surveillance system.

However over the years, the HIV epidemic has grown in the country and had become explosive affecting all segments of the society. The strengths of the first generation surveillance system are the following: it helps to generate a public response to HIV, it also helps in targeting prevention activities and plan responses and at the same time monitors the success of the national response while the weaknesses are that it rarely track the risk behaviors that provide warning signs for the spread of HIV, its inability to utilize other useful information, neglect of at risk sub-populations and its inability to explain changes in levels of infection in matured epidemics.

The second generation HIV/AIDS/STD Surveillance system was developed to basically provide solutions to the above limitations. The training workshop is coming up at an appropriate time when political commitment to providing solutions to the epidemic is high.

The training workshop was funded by UNAIDS, Geneva while the National AIDS/STD Control Programme Federal Ministry of Health provided the secretarial support. The UNAIDS and the Family Health International also provided technical support.

Objectives

The overall objective of the workshop was to improve the nations ability and capacity to produce reliable, timely, useful and relevant data for advocacy and the planning of appropriate intervention programmes.

Specific objectives were:

To review the existing surveillance systems in the country.

- To train field surveillance officers and facilitators on the principles of second generation surveillance system
- To develop a Guidelines on the plan of Action for the implementation of second-generation surveillance system in the country.
- To identify the key strategies for implementing the different components of the surveillance system such as HIV, AIDS, STI and BSS.

Methodology

The workshop was conducted through plenary presentations, group work and general discussions.

PARTICIPANTS

The meeting was well attended with a total number of 50 participants made up of the following:

- State AIDS/STD Programme Coordinators.
- Technical officers of National AIDS and STD Control Programme (NASCP)
- National Action Committee on AIDS (NACA).
- Consultants from Research Institutions.
- UNAIDS, Geneva.
- Family Health International, London and Nigeria

OPENING CEREMONY

The meeting was declared open by the representative of the Hon. Commissioner of Health, Plateau State. In his remarks, he welcomed all the participants. In addition, he also informed participants on the recent commitment of the Plateau State Government in the control and prevention of HIV/AIDS/STD strategies adopted especially in the area of advocacy and social mobilization at the Local government level. This he said had led to Plateau State being chosen as a priority state for support by the World Bank.

A welcome address was also presented by the Representative of the Director of Public Health, Federal Ministry of Health. It was recalled that a similar meeting that held in the Nike Lake Resort Hotel in Enugu in 1993 that led to the establishment of the present HIV/AIDS/STD Surveillance System in the country

Goodwill messages from the UNAIDS consultants, Drs Calleja and Pervilhac indicated their commitment to Nigeria developing its surveillance system to the highest recommended standards. They also expressed their satisfaction

on the progress made so far in the country especially with regards to the 1999 surveillance survey.

The consultants from the research institutions also indicated their commitment in supporting the system to develop and function maximally.

Plenary Session

1 Overview of the Global HIV/AIDS

This was presented by the UNAIDS Representative, Dr Calleja. Highlights of the presentation included the information on the total infected HIV population globally estimated at over 36 million people by the end of 2000 and that HIV was now the top cause of death in Africa, causing about 20% of all deaths. The recent decline in prevalence in Uganda was also highlighted. It was also noted that the epidemic seems to have peaked in

some countries.

It was also shown that several factors drive the African Epidemic such as poverty, the status of women, circumcision, migration, behavioral and socio-economic factors among several others.

2. HIV/AIDS/STD SURVEILLANCE - SITUATION IN NIGERIA

A Representative of the National Coordinator gave the presentation. The successes of HIV sentinel surveillance in Nigeria over the past few years were enumerated; noting that the 1999 survey was the first time self-generated data was used for making projections in HIV prevalence in the country. It was noted that results of the last survey were shared with the states before its release to ensure the acceptability of the data. STI Surveillance as well as AIDS case reporting was shown to be still at very unsatisfactory levels. One of the problems noted was the unavailability of forms used in case reporting. Other problems were the absence of standardized AIDS case definition and poorly trained as well as ill-motivated staff. The need to involve the private sector was also emphasized.

3. PRESENTATION OF ZONAL/STATE FIELD EXPERIENCES

The field experiences were presented by the six zonal officers/ coordinators. The Highlights are as follows: The lack of transport facilities in the states, the poor communication services in different parts of the country, Manual analysis and storage of data. Lack of motivation of staff at the state level who performs AIDS surveillance, Poor coordination of Data collection, collation and dissemination and poor training of Staff involved.

The following suggestions were made to strengthen the systems: computerization and a wide area networking between the states and the federal level, counterpart funding approach, capacity building, decentralization of HIV/AIDS surveillance and provision of vehicles to the states. The SAPCs were then asked to develop and submit a proposal on the logistic support requirements to the Federal Ministry of Health.

4. HIV ESTIMATION AND PROJECTIONS IN NIGERIA

It was presented by the Surveillance Epidemiologist from University Teaching Hospital (LUTH), Lagos presented the topic. His presentation was focused on the basis and procedures used in the country in making HIV estimates and projections especially using the 1999 HIV/Syphilis sentinel survey in the country. It was noted that the results of the last sentinel study was already being misquoted as being representative for the whole country while it actually represents the prevalence among the 15-49 age-group only.

5. SECOND GENERATION HIV/AIDS/STD SURVEILLANCE SYSTEM

The UNAIDS and FHI consultants presented the limitations of 1st Generation surveillance and the need for 2nd generation surveillance. They traced the development of HIV/AIDS surveillance from the onset of the epidemic. The limitations were enumerated as follows:

- * That current systems rarely track the risk behaviors that provide warning signs for the spread of HIV.

- * Useful information from other sources are often ignored.
- * Surveillance resources are often targeted in the general population where little infection exists while at risk sub-populations are neglected.
- * Systems have difficulty explaining changes in levels of HIV infection in mature epidemics or in countries where therapy exist.

It was noted that the 2nd generation surveillance was not new or different but improved with the assessment of risk behavior in addition to previous prevalence data. Key points included the need to track behavior trends, linking it to HIV sero-prevalence, the identification of prevention indicators to inform programme design and evaluation. A list of some classical indicators of sexual behavior e.g. median age of first sexual experience, condom use etc were enumerated. Approaches and methods in behavioral surveillance were also presented. These include repeated cross-sectional behavioral studies in selected populations over time, repeated surveys in the general population and large population based studies.

It was emphasized that more partnership and technical organization is required to be able to conduct BSS in any country. Access to marginalized groups was also emphasized. One way to gain access to such groups was to use gatekeepers. These could be NGOs that have been working with such groups. Examples were shown from countries such as Thailand that have a long experience in BSS. Issues that arose from the presentation include the validity of the responses, quality control possibilities, acceptability of results etc. Assurances were given that all these were problems that can be over come. It was also noted that BSS questionnaires always have to be adapted to the local cultures and language and that collaboration with the local facilitators was very important.

6. Role of other Stakeholders on HIV/AIDS/STD Surveillance in Nigeria.

a. Family Health International. (FHI)

The FHI, London representative gave a summary of the activities of FHI in the country. He made it clear that FHI was not a donor agency but a technical body with long years of experience in working for donor agencies in over 40 countries. He enumerated some of the achievements of FHI in Nigeria with particular reference to a just concluded BSS in some selected sites in Nigeria.

He also stated some of FHI priority plans for surveillance in Nigeria, which includes Gonorrhoea sensitivity surveillance among others. He assured participants of Family Health International (FHI) commitment to working closely with all development partners with focus on HIV/STD surveillance.

b. Joint United Nations Programme on HIV/AIDS.

The UNAIDS representative also started by informing participants that they were also not a donor agency, however that they have been involved in HIV surveillance in collaboration with WHO. They are presently involved in the development of 2nd Generation surveillance in different countries around the world. He stated that the current funding of the implementation of the initial series of Surveillance activities in Nigeria was received from the European Union. It was also mentioned that Nigeria's inclusion in the UNAIDS priority list of

Surveillance country was influenced by the 1999 HIV sentinel Sero-prevalence surveillance.

It was stated that the current UNAIDS mission was to assist in developing a consensus for second generation surveillance, providing support in the development of BSS protocol in Nigeria, also to facilitate the preparation of a surveillance plan of action within the Interim Action Plan and the strategic plan and discuss modalities of implementation in the country.

c. National Action Committee on AIDS (NACA)

The chairman of NACA thanked the different agencies present for their efforts. She however pointed out that a lot of other donor agencies have indicated interest in starting off different AIDS related activities in the country. There was therefore a need to coordinate the activities of all these agencies at the federal level so that there is no clash in their activities. At this point there were comments that activities in Nigeria seem to be donor driven and not country driven. It was advised that strategies should be put in place to mobilize local resources in the country.

ISSUES FROM GROUP WORK

Participants through group work deliberated on the following core surveillance elements:

- * HIV Surveillance
- * STD Surveillance
- * AIDS Case reporting

The outcome of the group deliberations led to the development of simple guidelines in the implementation of the second-generation surveillance system in the country. The details is as stated below:

1 GUIDELINES ON HIV SURVEILLANCE

a. Objectives

The general objective of conducting HIV surveillance is to provide information for planning interventions and control of the HIV/AIDS epidemic.

The specific objectives are as follows:

- * *To monitor the spread of HIV and STDs in the Country*
- * *To determine the prevalence of HIV infection among selected sentinel groups*
- * *To monitor the trends of HIV infection among selected sub-population groups.*
- * *To make estimates and projections on HIV infection using ANC data for the country.*

b. Indicators

The following indicators shall be used to monitor the success of HIV surveillance in the country:

- * HIV prevalence among all antenatal women
- * HIV prevalence among antenatal women aged 15-24 and parity 0-1

Syphilis prevalence among antenatal women aged 15-24 using RPR and TPHA testing.

c. Sentinel Population

HIV surveillance in Country shall focus on women attending Antenatal Clinics, blood donors, patients with tuberculosis, patients with Sexually transmitted diseases and Long Distant Transport Workers. Other groups to be covered over time shall be through special studies of Intravenous drug users (IDU); prisoners, Men having sex with men (MSM), Mining workers and Army were also recommended.

d. Surveillance Sites

Sample sites will be selected according to the following criteria:

- * Previous participation in surveillance
- * Availability in sufficient number of sampling population
- * Qualified and willingness of on-site staffs
- * Geographical Representativeness of sites.
- * Provision of specific services to a relatively large number of sentinel populations.
- * Availability of specific interventions for vulnerable groups.

e. Sampling Size

Sample size of 400 is recommended for all ANC surveillance with possibility of over sampling of ages 15-24years to monitor HIV incidence. The minimum sample size of 200 shall be acceptable for all rural sites.

While for other vulnerable groups, sample sizes of 150-250 are acceptable for the country.

c. Sampling Scheme

Sampling population will be based on specific inclusion and exclusion criteria.

In each of the sentinel population, an unlinked anonymous method of testing shall be used. 5mls of blood/or filter paper blot shall be used to collect blood for syphilis and HIV screening. Special coding system shall be used for testing of samples for HIV.

d. Duration of Sampling

The sampling duration shall be 8-12weeks irrespective of the sentinel population covered.

e. Demographic Information

Minimum demographic information is advised while recruiting subjects covering mainly age, sex, marital status, occupation etc.

f. Laboratory Screening of samples

For the ANC, all syphilis and HIV screening shall be carried out at the State central laboratory while central quality control will be managed from the central level using dried blot spots.

Syphilis testing of other specific sentinel groups shall also be carried out at the state level while

HIV screening will be done centrally.

A double Elisa method is recommended in each case for syphilis and HIV testing.

The following measures of internal and external controls must be ensured in order to have accurate, reliable and reproducible laboratory results:

- * *Highly qualified and experienced laboratory personnel should be engaged in all the surveys*
- * *An elaborate practical training should be organized for all laboratory personnel specifically on the kits to be used for HIV and syphilis screening.*
- * *The test kits for the survey must have an acceptable shelf life.*
- * *The storage temperature of all the kits must be maintained between 4C-8C.*
- * *Effort should be made to validate kits before use in any survey.*
- * *Adequate quality control positive and negative samples must be collected from the field for central testing.*

g. Training of Field Staffs.

Due to the high turn-over of staffs at the state level, it is recommended that cascade of training should be planned for the different categories of staffs as follows:

- * *Training on general survey protocol for all staffs*
- * *Training for laboratory personnel*
- * *Training for core supervisors at central and state levels*
- * *State level training of pother staffs.*

h. Supervision

The Federal Ministry of Health shall provide technical and logistic supervision of the survey at the central level while the State AIDS Programme Coordinator shall supervise the activities at the state levels.

A Central Survey Management Committee shall be inaugurated to monitor the progress of the every stage of the survey. The committee shall be made up of all relevant technical partners related to the survey selected from public, private, research institutions and non-governmental organization.

A minimum of three technical supervisory visits is recommended for any surveillance in the country.

i. Description of Responsibilities

At the planning stage of the survey, responsibilities should be spelt out clearly concerning coordination, supervision, blood collection, separation and storage, transportation of specimens, testing of samples, data compilation, analysis, interpretation and feedback, on-site supervision, state level supervision.

j. Data Management

The Federal Ministry of Health shall manage surveillance data centrally with other

stakeholders in participation for the components of surveillance.

Results of screening for syphilis and HIV shall be recorded on the data collection form for appropriate data management. Quality control method must be built into the every stage of the data management.

A consensus meeting of data producers and users are advised to examine data before it is formally released to the public. Official release of HIV data shall be done by the Hon. Minister of Health.

k. Report Dissemination Plan.

Different types of report are advocated to address the different critical audience that will utilize the data. These include a technical report. The report should be distributed as far reaching in the country as possible. There should be strategies to involve the local communities in the understanding of the report through cascade of dissemination workshops.

l. Sustainability of Surveillance

There is need to gradually decentralize surveillance to the states. This should be preceded by appropriate training, logistic support and costing.

m. Coordination and Technical Management of Surveillance in Nigeria

The coordination and central management of HIV surveillance shall be the sole responsibility of the Federal Ministry of Health in collaboration with all relevant stakeholders and development partners.

n. Intervals of Specific component of HIV surveillance

HIV surveillance among ANC shall be conducted annually while other vulnerable high-risk groups shall be conducted every two to three years.

2. GUIDELINES ON STI SURVEILLANCE

The elements of STI surveillance for strengthening as agreed were:

- § STD case reporting,
- § STD Sero-prevalence and
- § STD syndromes were noted.

STD CASE REPORTING

a. Objectives

To assess STD disease burden, by providing an indicator of minimum incidence of recently acquired infections.

- * *Monitor trends in incidence of recently acquired infections.*
- * *Provide information required for management of patients and their sex partners*
- * *Provide information on which providers in the health care system are diagnosis and report the major STIs, to assist in planning and managing programme efforts*
- * *Provide other data necessary for managing health services.*

b. Location of Sites

Two states in each of the health zones shall be strengthened to monitor STD case reporting in the country. The sites in each selected state should include private, secondary and tertiary health facilities.

c. Interval of Reporting

The interval of reporting recommended shall be quarterly from each of the selected sites.

d. Manpower Requirement.

The following manpower shall be required to form a technical team to monitor the progress of STD case reporting in each of the selected sites: STD Medical Officers, STD nurses/matrons, Pharmacist, Medical record officers

e. STD case Reporting Forms

The NHMIS facility based forms already have information on STD etiologies and should be maintained. Strategies need to be developed to collaborate with all relevant stakeholders.

Syndromic case Reporting

Syndromic management of STDs has been found to increase the treat coverage of care but this approach requires large investment in training of health workers and also Behavioural change in the health seeking behaviour of the patients. Also critical is the availability of adequate supplies of drugs and other necessary materials.

Further STD care is an entry point to condom promotion and referral for voluntary testing.

a. Objectives.

- * *To monitor the prevalence in the syndromes of STD*
- * *To monitor the incidence in the syndromes of STD using urethral discharge and genital ulcers.*
- * *To assess the drug resistant pattern using the combination therapy.*
- * *To determine the sensitivity and specificity of the Syndromic algorithms.*

The adoption of Syndromic management of STD in the country commenced in 1995. Forms have been printed centrally in collaboration with the WHO and distributed to all the states designated for Syndromic treatment. Cascade of training for health workers have also been carried out at different levels in these states. An evaluation of the treatment algorithms was carried out in collaboration with the Family Health International. Despite all these efforts by the Federal Ministry of Health, reporting of syndromes still appears to be an Herculean task.

b. Challenges

1. The Health Management information system was not designed to track specific STD syndromes
2. There is lack of baseline information on the quality of STD care in the country.
3. Most treatment of STD is carried out by private and informal health care providers.

c. Strategy of Monitoring

1. The major task of STD control activities is focused on strengthening STD treatment practices in health facilities using the Syndromic approach. There is need to conduct a facility survey for the assessment of the quality of STD services on-going in the country before a scaled up implementation of the Syndromic management of STD concept in the country. This is already planned in collaboration with the WHO-AFRO for early this year.
2. There is need to identify two facility sites per health zones for strengthening as pilot centers in order to assess what is going on in the country.
3. STD Syndromic monitoring shall be integrated to all active HIV/Syphilis surveillance in the country.
4. Conduct special studies to assess the proportion of cases seeking care and those being reported by the health care providers. This estimates the extent of under-reporting.
5. There is need to monitor the sensitivity and specificity of the algorithms regularly in order to evaluate the quality of diagnosis and care.
6. Regular availability of STD Syndromic case reporting forms to the selected sites

d. Indicators

Appropriate diagnosis and treatment of STDs: - Percentage of patients with STDs at the selected health facilities that were appropriately diagnosed and treated.

- * *Advice to STD patients on prevention and referral to HIV testing: - Percentage of STD patients who are given advice on condom use and partner notification and who are referred for HIV testing.*
- * *Drug Supply at STD Clinic:- Percentage of STD clients served by health facilities that have a current supply of essential STD drugs and report no stock-outs lasting longer than one week in the preceding 12 months.*
- * *Care seeking behaviour and trained providers:- Percentage of men and women reporting symptoms of STD in the last 12 months who sought care at a health facility or other services provider with personnel trained in STD care, among all respondents aged 15-49 in a population-based or targeted survey.*

e. Responsibilities

The Federal Ministry of Health in collaboration with relevant stakeholders shall coordinate, supervise, monitor and evaluate regularly the success of the programme.

ETIOLOGICAL STD CASE REPORTING

This requires laboratory diagnosis and shall be done in hospitals with well-developed laboratory diagnosis incorporated into routine STI clinical care. The cases to be monitored in the country are as follows:

- * Syphilis
- * Gonorrhoea
- * Chancroid
- * Chlamydia

a. Case definition

1 SYPHILIS, PRIMARY AND SECONDARY:

Probable: an illness with ulcers or mucocutaneous lesions and a reactive test (non-treponemal or treponemal)

Confirmed: demonstration of treponemal pallidium in clinical specimens by darkfield microscopy, DFA-TP, nucleic acid test, or equivalent methods.

Latent syphilis: no clinical signs and symptoms of syphilis and a reactive non-treponemal and treponemal test in a patient with no prior syphilis diagnosis; or a non-treponemal test titre demonstrating four fold or greater increase from the last non treponemal test titre in a patient with a prior syphilis diagnosis.

2. CHANCROID

Probable: an illness with genital or anal ulcers with no evidence of *T. pallidium* infection by darkfield examination of ulcer exudates or by serological test for syphilis performed >/7 days after ulcer onset.

Confirmation: identification of *Haemophilus ducrey*

3. CHLAMYDIA:

Positive culture, direct fluorescent antibody test, antigen detection test, or nucleic acid-based test for *C. Trachomatis*.

4. GONORRHEA:

Isolation of typical gram negative, oxidase positive diplococci from a clinical specimen and confirmed NS by nucleic acid-based test.

b. Selection of Sentinel Sites.

Two health facilities in each of the health zones shall be selected for the monitoring of cases. The health facilities to be chosen shall include private sector and laboratory based facilities.

c. Data elements

Core data elements that are essential to reporting a case would be collected such as: diagnosis, reporting sites, date of visit, gender and age group.

d. Reporting Internals and Format

Data will be analyzed quarterly and annually. Quarterly analysis shall consist of comparison of the most recent data with the same quarter in the previous year, trend analysis by gender and geographical areas, age groups, provider types and reporting sites.

5. STI PREVALENCE ASSESSMENT AND MONITORING

a. Objectives

The main purpose of STI prevalence assessment and monitoring are the following:

- * Identify sub-population groups with high prevalence of STI

- * Monitor trends in STI prevalence among defined populations. Prevalence data are of great use in STI programme planning, management and evaluation as it can be used to identify populations at high risk for HIV infection as evidenced by high rates of STIs; guide funding and resource allocation for STI and HIV prevention programmes; monitor effectiveness of STI and HIV prevention programmes and develop National estimates of STI. However, such data can be used in the management of individual patients or their sex partners.

b. *Stis Used For Prevalence Assessment And Monitoring In Nigeria*

So far we shall maintain syphilis as the main STI in proxy for others. Efforts should be made to include gonorrhoea, chlamydia and trichomonas in the nearest future.

c. *Laboratory Requirements*

We are aware that only cervical gonococcal and chlamydia testing is specific for active infection, non-treponemal syphilis serology test does not unless titers are examined in relation to reliable treatment history. Treponemal test alone (which usually remain active for life) are of no use in distinguishing adequately treated syphilis from active syphilis infection. The National laboratory strategy is to use non-treponemal test titre cut off (e.g. 1:4 or 1:8) which may assist in monitoring trends in prevalence of active syphilis infection.

d. *Implementation strategy*

STI prevalence assessment shall remain integrated into the HIV surveillance process in the country.

6. MONITORING STD ANTIMICROBIAL RESISTANCE

Due to the substantial use of drugs for the treatment of STD and its increasing rates of resistance in the country, it is important to monitor antimicrobial resistance in *Neisseria gonorrhoea* as a core component of STI surveillance.

The other agents such as *H. ducreyi* may be added as we foundate the system.

a. *Objectives*

- * To obtain data necessary for planning guidelines for STD treatment in the country
- * To detect newly emerging resistance

b. *Laboratory Requirement*

Designated laboratory within the country capable of performing susceptibility testing for *N. gonorrhoea* should be able to culture the organism, to perform biochemical and serologic confirmatory tests and possibly capability to perform minimum inhibitory concentration (MIC) agar dilution testing of Antimicrobial agents.

There is need to link up with the Regional laboratory on areas of limitation. Efforts shall be made to link up with the Regional network for Antimicrobial susceptibility testing for *N. gonorrhoea*, currently supported by WHO collaborating centers.

c. Selection of Gonococcal isolates sites

A maximum of four sentinel sites shall be selected for the monitoring and collection of gonococcal isolates. Isolates are acceptable from urethral discharge and from women.

d. Sample size

A minimum sample size of 100 isolates per sentinel site in each quarter is recommended.

7. SPECIAL STUDY COMPONENT OF STI SURVEILLANCE.

The following are special studies recommended for inclusion in the surveillance system of the country:

1. Evaluation of STI management algorithms
2. Incidence and prevalence of STI related complications: PID, Ectopic pregnancy, and cervical cancer
3. Prevalence of viral STI
4. Prevalence of bacterial vaginosis and associated sequelae
5. Assessment of STI incidence and prevalence among persons who are HIV positive
6. Development and evaluation of STI screening criteria
7. Country specific estimates of incidence and prevalence of STIs
8. Estimation of economic costs of STI
9. Perinatally acquired STIs

Dissemination Plan

All STI surveillance data shall be disseminated to all relevant stakeholders including data producers using the following format:

- * Annual report with case number, rates and trends
- * Fact sheets with tables and graphs
- * Newsletter
- * Press release.

EVALUATION OF STI SURVEILLANCE SYSTEMS

STI surveillance system shall be evaluated every two years.

AIDS CASE REPORTING IN NIGERIA

a. Situation Analysis

AIDS cases are reported passively through the routine national reporting system. Case reporting is important as an advocacy tool and also validate data generated by sentinel surveillance as the age structure, sex ratio and reported modes of transmission of both AIDS and HIV cases can be compared with that of HIV prevalence. It could also reveal the presence of the virus in missed sub-population groups thereby suggesting a reappraisal of surveillance needs.

The cases diagnosis was based on National case definition as follows:

- * WHO clinical criteria
- * Single Elisa
- * Confirmation

While for the purpose of epidemiological research and surveillance it is advocated that double

Elisa method be used. But the experience so far in the country as shown that several case definition now exist and are used by different states.

So far the AIDS case reporting is very unreliable as there is under reporting, late reporting, delay reporting and under diagnosis of cases. Even where it is reporting it is very incomplete with respect to age and gender information.

The factors responsible for delay in reporting, incompleteness, and absence reported were attributed to lack of commitment of personnel, poor diagnosis skills, absence of reporting forms and lack of standardized case definition.

b. Objectives

The consensus on the objectives to be maintained for implementation of AIDS case reporting are as follows:

- * To have data that will act as the visible part of the epidemic used for advocacy and the continuum of care.
- * There is a need to produce data forms that are easy to fill, standardized and with minimal and manageable information.

c. Indicators

The following indicators shall be used to monitor progress of implementation of the strategies:

1. No cases reported per quarter per designated state
2. No cases with complete information and reported at the scheduled time.
3. Number of times feedback report are sent back to the end user and producer

d. Coverage

The coverage was agreed to be in all states i.e. two sites per state. But two states per health zone shall be strengthened and trained mainly for AIDS case reporting. The selected states are expected to form a technical team made up of: the State AIDS Programme Coordinator, The medical records officer of selected institution and the Chief Medical Directors of Teaching Hospitals (one secondary and one tertiary health facility per state). The selection of the sites will be based on hot and cold spot; availability of diagnosis facilities and personnel and trained medical record officer.

e. Strategies

1. There is need to develop and print a seed stock of AIDS case reporting forms
2. All selected states must form technical teams
3. There is urgent need to provide pre-paid stamped envelopes for one year to facilitate communication between the states and the federal.
4. Training of selected members of the technical team
5. Improving the working relation of NASCP, SAPC and the state health institutions through communication and feedback.
6. Development of wide area networking for all the six zonal offices
7. Empowerment of all the zonal officers to coordinate surveillance activities within their respective zones.
8. Improving communication between the federal and the zonal offices

sex workers
distant truck drivers

National Behavioural Surveillance Sites and Coverage in Nigeria

One site per health zone shall be covered for the youths and the general population. Vulnerable groups, specific transport tracks and routes availability of long distant shall be used to estimate extent of coverage. Other criteria to be used especially for selection of sites shall be evidence of interventions on going in the site and experience of previous BSS

Types of Experts for BSS in Nigeria

Experts involved in the implementation of BSS shall be as follows:

- Government (Federal state and community)
- Non Government Organizations /Civil society
- International partners (multilateral and bilateral donors)
- Academic Institutions

Responsibility of National Behavioural Surveillance in Nigeria

The Federal Ministry of Health shall technical supervise the implementation of BSS in the country.

Implementation Team

The implementation team led by a Behavioural scientist from the University as the principal investigator shall coordinate the National AIDS/STD Control Programme shall implement BSS in the country. The team shall be made up of the following

- Federal Ministry of Health ----- Implementation
- National Action Committee on AIDS ----- Stakeholder
- Relevant line Ministries -----Stakeholder
- NADS Programme Coordinators ----- Field Supervisors
- State AIDS Programme Coordinators -----Field Coordinators
- Trade Unions and Non Governmental Agencies----- Field team
- Academic and other research institutions-----technical participants
- International partners -----technical partners

Steps of Implementing National Behavioural Surveillance in Nigeria

- Development of Standard Protocol
- Building of partnership
- Mobilization of human and financial resources
- Formation of central management committee
- Ethical clearance
- Development of Implementation plan
- In country capacity building for relevant field workers and supervisors
- Development of BSS Budget.
- Data management
- Data utilization Plan for advocacy and community support and
- Mobilization
- Dissemination Plan of BSS Results in Nigeria

Nigerian HIV/AIDS/STD Surveillance Plan of Action

Objective 1: HIV Surveillance: To monitor the spread and trends of HIV/Syphilis in the country

Strategy	Activities	Responsibility	Support	Duration/time	Estimated Cost (N)
Annual HIV/syphilis sentinel sero-prevalence survey among women in all state of the Federation	1.1 Procurement of HIV kits 1.2 Procurement of Syphilis kits 1.3 Procurement of required consumable 1.4 Procurement of Supervisory Vehicle (land cruisers) 1.5 Central training of core field workers (3 per state) 1.6 State level training of other field workers 1.7 Cost of three active supervisory visits 1.8 Cost of three meetings of the Central Management Committee 1.9 Payment of allowances of field staffs 1.10 Cost of Central Quality control testing 1.11 Cost of Data Management 1.12 Cost of Data Producer and user meetings 1.13 Report Production 1.14 Dissemination plan	FMOH SMOH NACA	FMOH NACA UNAIDS CDC DFID WHO UNICEF UNFPA UNDP POLICY PROJECT	February 2001 February 2002 February 2003	20 million 23million 25million
HIV/Syphilis Sero-prevalence among STD and PTB patients	1.1 Procurement of HIV kits 1.2 Procurement of Syphilis kits 1.3 Procurement of required consumable 1.4 Review of Survey Protocol 1.5 Central training of core field workers (3 per state) 1.6 State level training of other field workers 1.7 Cost of three active supervisory visits 1.8 Cost of three meetings of the Central Management Committee 1.9 Payment of allowances of field staffs 1.10 Cost of Central Quality control testing 1.11 Cost of Data Management 1.12 Cost of Data Producer and user meetings 1.13 Report Production 1.13 Dissemination	FMOH SMOH NACA	FMOH NACA UNAIDS CDC DFID WHO UNICEF UNFPA UNDP POLICY PROJECT	August 2000 August 2002 August 2004	10 million 12million 15million

National AIDS/STD Control Programme

<p>HIV/Syphilis Prevalence among long Distant Transport Workers (LDTW) and Female Sex workers (FSW)</p>	<p>1.1 Procurement of HIV kits 1.2 Procurement of Syphilis kits 1.3 Procurement of required consumable 1.4 Procurement of two zonal vehicles (Peugeot 504 wagon) 1.5 Review of Survey Protocol 1.6 Central training of core field workers (3 per state) 1.7 State level training of other field workers 1.8 Cost of three active supervisory visits 1.9 Cost of three meetings of the Central Management Committee 1.10 Payment of allowances of field staffs 1.11 Cost of Central Quality control testing 1.12 Cost of Data Management 1.13 Cost of Data Producer and user meetings 1.14 Report Production 1.15 Dissemination plan</p>	<p>FMOH SMOH NACA</p>	<p>FMOH NACA UNAIDS CDC DFID WHO UNICEF UNFPA UNDP POLICY PROJECT</p>	<p>August 2001 August 2003 August 2005</p>	<p>17 million 15million 18million</p>
<p>HIV Surveillance among Blood Donors</p>	<p>1.1 Identification of 15 sentinel sites in the country 1.2 Formation of Blood safety Team 1.3 Development of Protocol 1.4 Training of Surveillance officers 1.5 Printing of Surveillance forms 1.6 Provision prepaid stamped envelopes for all site sites for one year 1.7 Procurement of six computers for zonal offices 1.8 Quarterly Supervision visit 1.9 Data management 1.10 Report Production 1.11 Report Dissemination Plan</p>	<p>FMOH SMOH NACA</p>	<p>FMOH WHO CDC DFID UNAIDS</p>	<p>2001 2002 2003</p>	<p>5 million 3million 3million</p>
<p>Objective 2: HIV Estimations and Projections</p>					
<p>HIV/AIDS/STD Estimation, impact analysis and projections</p>	<p>1.1 Formation of Projection team 1.2 Development of Protocol 1.3 Consensus on computers models for use in Nigeria 1.4 Consensus meeting on Assumptions 1.5 Small scale survey to complete the annex needed information 1.6 Report Production 1.7 Report Dissemination meeting 1.8 Annual review of Projections based on HIV sentinel Data 1.9 Impact Analysis</p>	<p>SMOH NACA</p>	<p>FMOH NACA WHO UNAIDS DFID POLICY</p>	<p>2000 2001 2002</p>	<p>N1million N2million N2million</p>

Objective 3: Strengthening STD Surveillance in Nigeria

1. STD Case Reporting	1.1 STD Health facility Survey in Six States 1.2 Selection of Sentinel sites	FMOH SMOH NACA	FMOH NACA DFID WHO UNAIDS	2001 2002 2003	5 million 4million 3million
2. Syndromic Case Reporting	1.3 Identification of Team 1.4 Development of STD surveillance Protocol				
3. Etiological Case Reporting	1.5 Training of Field officers 1.6 Procurement of kits 1.7 Supervision of surveillance activities				
4. Monitoring of Antimicrobial Drug Resistant	1.8 Development of Data base 1.9 Development and production STD forms				
5. Special STI Surveillance	1.10 Data management 1.11 Quarterly feedback meeting 1.12 Quarterly Dissemination of STD cases				

Objective 4: Strengthen AIDS Case Reporting in the Country

AIDS Case Reporting	1.1 Identification of 12 sentinel sites 1.2 Formation of Surveillance team 1.3 Development of Surveillance protocol 1.4 Training on the Surveillance protocol 1.5 Consensus meeting on AIDS Case Definition 1.6 Development and Preventing of AIDS case reporting Forms 1.7 Development of database 1.8 Supervisory Visit 1.9 Data management 1.10 Report Production 1.11 Quarterly feedback meeting 1.12 Development of Wide area networking	FMOH NACA	FMOH WHO UNAIDS	2001 2002 2003	5 million 4million 3million
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Objective 5: Integration of Behavioural Surveillance into the National Surveillance system

1. Conduct of BSS for the General Population in Nigeria	1.1 Building of Partners 1.2 Formation of National BSS team 1.3 Development of National BSS Protocol 1.4 Identification of BSS sentinel sites	FMOH SMOH NACA	FMOH NACA UNAIDS FHI WHO DFID POLICY PROJECT	2001 (General population and Youths) 2002 (Vulnerable groups)	N15million N20million
2. BSS among Youths	1.5 Formation of Central Management Committee				
3. BSS of Vulnerable Population	1.6 Development of Implementation plan 1.7 Consensus meeting on Minimum indicators and data collection form 1.8 Training Workshop for core				

	<p>members 1.9 Supervisory Modalities and development of Checklist 1.10 Site/State Level Training of Site Officers 1.11 Data Collection 1.12 Data Management 1.13 Report Writing Team 1.14 Report Dissemination Plan</p>				
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