HIV NON-HEALTH SECTOR DATA QUALITY ASSESMENT

TECHNICAL REPORT

December 2024

Acknowledgement

The 2024 National Joint Data Quality Assessment (DQA) exercise was made possible through financial support from the Global Fund and the collaboration with the Federal Ministry of Health (NASCP) and various implementing partners in the HIV/AIDS response. This assessment marked the first time that the focus was exclusively on community-based interventions in the state. The quality of the data generated by our Monitoring and Evaluation (M&E) system would not have been achievable without this assistance, and NACA is grateful to its partners.

As the Chairman of the Technical Committee on the National Joint DQA, I would like to acknowledge the planning and coordination efforts of the National Joint DQA Planning team for driving this process and ensuring that the data quality assessment was successfully conducted.

I also want to appreciate the commitment and technical support provided by the various State Agencies for the Control of HIV/AIDS (SACAs) and the State Ministries of Health (SASCPs) during our visits to the states.

Furthermore, I recognize and commend the hard work of the staff and heads of the various One Stop Shop (OSS) and community-based organizations that provide critical services.

Finally, I would like to specifically commend the dedication and technical expertise of the data validation teams, as well as the report writing and editing teams, for their essential roles in facilitating and ensuring that this process was concluded in record time.

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Abbreviations

1. NJDQA - National Joint Data Quality Assessment
2. NACA - National Agency for the Control of AIDS
3. NASCP - National AIDS and STIs Control Programme
4. M&E - Monitoring and Evaluation
5. SACAs - State Agencies for the Control of HIV/AIDS
6. SASCPs - State Ministries of Health (likely State AIDS and STIs Control Programmes)
7. KP - Key Populations
8. HTS - HIV Testing Services
9. ART - Anti-Retroviral Treatment
10. MSM - Men who have Sex with Men
11. FSW - Female Sex Workers
12. PWID - People Who Inject Drugs
13. TG - Transgender
14. MSF - Monthly Summary Form
15. eNNRIMS DHIS 2.0 - electronic Nigeria National Response Information Management System (District Health Information Software 2.0)
16. NDR - National Data Repository
17. EMR - Electronic Medical Records
18. CBO - Community-Based Organization
19. OSS - One Stop Shop
20. SDP - Service Delivery Point
21. IP - Implementing Partner
22. NHS - Non-Health Sector
23. GB-V - Gender-Based Violence (likely)
24. C&S - Care and Support
25. TWG - Technical Working Group
26. CPHI - Center for Population Health Initiative
27. IAH - Initiative for Advancement of Humanity
28. EHWEI - Equitable Health for Women Empowerment Initiative
29. ORHI - Olive Right to Health Initiative

Executive Summary

Background

The National Joint Data Quality Assessment (NJDQA)focused exclusively on Non- health Sector (NHS) data was conducted in December 2024 by NACA and NASCP with financial support from Global Fund. The assessment aimed to evaluate the data availability, completeness, accuracy, and reliability of the HIV programme data to strengthen data management and reporting systems across the selected 20 states (Adamawa, Bauchi, Bayelsa, Borno, Cross River, Ebonyi, Ekiti, Gombe, Imo, Kano, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Osun, Rivers, Sokoto, and Taraba) in Nigeria.

The NJDQA was conducted using a Kobo collect tool an open-source data collection tool, assessing Key populations' KPs data on HIV Testing Services (HTS), Minimum Prevention Package of Intervention (MPPI), and treatment (ART) indicators. Data availability, system assessment, and data management were performed to measure the consistency of reported data with One Stop Shop (OSS) and Community Base Organization (CBO) Level records.

Key Findings

- **Data Availability:** 100% of HTS data on the Registers and 74% of data on the Monthly Summary Form (MSF). For Prevention data on the Prevention Tracking Form 46%, Prevention Register 69%, and Prevention MSF 60%
- **Data Level Concurrence: High** concurrence of data on Registers and HTS MSF 80%,, HTS MSF and eNNRIMS DHIS2.0 49% showed lower accuracy indicating reporting challenges. Furthermore, Data on Prevention Registers and Prevention MSF 71%, Prevention MSF and eNNRIMS DHIS 2.0 48% showed the same trend across the data reporting.
- **Data System Management:** Performance on criteria assessed ranged from 83% (decision-making based on data) to 100% (availability of M&E staff). With low utilization of data for program improvement.

Challenges Identified

- Limited M&E capacity and enforcement at the state level
- Overdependence on donor-funded data entry staff rather than government personnel.
- Poor documentation practices, including incomplete documentation and data transcription errors
- Inconsistent data across Registers, MSF, and eNNRIMS DHIS 2.0

Recommendations-

- Immediate deploy the DQA tracker to monitor specific recommendations in each state
- Strengthening the capacity of the State Monitoring and Evaluation (M&E) team through targeted training
- Improved supervision and conducted quarterly validation exercises to cross-check reported data and eNNRIMs DHI2.0 for consistency at the state level
- Enforce the use of the national non-health sector tools
- Conduct regular deep dives to monitor progress and ensure continuous improvement.

Conclusion

The 2024 NJDQA performed a comprehensive assessment of data availability, accuracy, and system performance across selected OSS/CBOs. While many OSS showcased commendable reporting practices, this assessment identified gaps and opportunities to enhance data quality, as well as areas for improvement in state monitoring and evaluation capacity and OSS site-level data management. The report encourages stakeholders at the national, sub-national, and OSS site levels to prioritize initiatives aimed at improving data quality, viewing this as a vital step toward achieving more reliable and actionable data.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

The National Agency for the Control of AIDS (NACA) is responsible for collating data from community-based programs and as well coordinate the multi-sectoral response of HIV AIDS programs in Nigeria. The community-based service data is being generated from civil society organizations, or implementers of community services on HIV/AIDS, with a well-structured and standardized tool on global and national indicators widely acceptable by implementers of HIV/AIDS programmes on treatment, prevention, care and support. These standardized tools were reviewed and deployed by NACA to the 36+1 states of the federation with the technical backing of the relevant stakeholders in the response.

The data is being collected using these standardized tools that are reported on the electronic Nigeria National Response Information Management System (eNNRIMS-DHIS 2.0) every month. The eNNRIMS-DHIS 2.0 is customized to collate Non-Health Sector (NHS) data from the community on an aggregate level for global reporting. The quality of data generated from HIV/AIDS programs is crucial for effective decision-making and program effectiveness. The accuracy and reliability of this data inform the planning, monitoring, and evaluation of HIV/AIDS programs, making data quality assessments (DQA) an essential component of program management. However, challenges such as missing values, bias, measurement, and human errors in data entry and computation affect the quality of the collected data, raising concerns about its reliability.

The National Joint Data Quality Assessment (NJDQA) is a critical exercise aimed at ensuring the accuracy, completeness, consistency, and reliability of data generated from HIV/AIDS programs in Nigeria. Given the significance of monitoring and evaluating HIV/AIDS response interventions, the NJDQA serves as a mechanism for identifying gaps in data collection, management, and reporting systems while proposing actionable solutions for improvement.

1.1.2 Overview of the NJDQA Process in Nigeria

The National Joint Data Quality Assessment (NJDQA) process in Nigeria has evolved over the years as an integral part of the HIV/AIDS Monitoring and Evaluation (M&E) framework. Initially launched in 2008, the NJDQA has undergone several iterations to align with global best practices,

ensuring robust data verification and validation. The assessment brings together stakeholders from NACA, FMoH, UN agencies, USG partners, CSOs, and relevant MDAs (line ministries) to review and enhance the quality of HIV/AIDS data reported at various levels.

Over the years, the NJDQA has contributed significantly to strengthening Nigeria's HIV/AIDS data management system, improving data integrity, and supporting informed decision-making processes. The 2024 NJDQA exercise continues this culture by focusing on community-based programs, emphasizing data quality in Non-Health Sector (NHS) interventions such as HIV testing, prevention services, and care and support for key populations.

1.1.3 Rationale for the 2024 NJDQA in Nigeria

Accurate and reliable HIV/AIDS data are essential for monitoring progress toward epidemic control and achieving global targets, including the UNAIDS 95-95-95 goals. However, persistent challenges in data quality, particularly in community-based programs, necessitate regular assessments to identify and address gaps.

The 2024 NJDQA aims to:

- Strengthen the monitoring and evaluation (M&E) framework for HIV/AIDS programs.
- Improve confidence in reported data on the eNNRIMS-DHIS 2.0 platform.
- Facilitate evidence-based decision-making through accurate, complete, and timely data.
- Address systemic weaknesses in data collection and reporting at service delivery points (SDPs).
- Enhance capacity-building efforts for M&E personnel at state and community levels.

By addressing these issues, the NJDQA will contribute to improved program outcomes, better resource allocation, and enhanced accountability in Nigeria's HIV/AIDS response.

1.1.4 Goal and Objectives

1.1.4.1 Goal of the 2024 NJDQA Exercise:

The primary goal of the 2024 NJDQA is to enhance the quality of HIV/AIDS data used for program review, performance evaluation, planning, and decision-making at the national and sub-national levels.

1.1.4.2 Objectives of the 2024 NJDQA Exercise:

- Assess the technical and infrastructural capacity of SDPs in data management and reporting.

- Verify and validate reported data from January to September 2024.
- Evaluate compliance with nationally approved data collection and reporting tools.
- Provide on-the-spot technical assistance to improve data collection, management, and reporting systems.
- Map Community-Based Organizations (CBOs), One Stop Shops (OSSs), and Implementing Partners (IPs) at sub-national levels.
- Generate action points to address data and program management gaps identified during the assessment.
- Train M&E personnel at the sub-national level on the DQA process, methodology, and best practices.

1.1.5 Scope of the 2024 NJDQA Exercise

The 2024 NJDQA focused exclusively on Non-Health Sector (NHS) HIV/AIDS programs, covering key indicators related to HIV testing, treatment, and prevention for key populations (KPs). Twenty (20) states were purposively selected based on the following criteria:

- Engagement in KP programming
- Historical data quality challenges
- High M&E staff attrition rate.

Selected states included Lagos, Rivers, Ogun, Ekiti, Osun, Borno, Sokoto, Cross River, Nasarawa, Gombe, Ebonyi, Bayelsa, Kwara, Kogi, Taraba, Adamawa, Kano, Bauchi, Imo, and Niger. The exercise was carried out at OSSs and CBOs in these states.

CHAPTER TWO

2.0 METHODOLOGY

2.1 2024 NJDQA Processes

The 2024 NJDQA employed a structured approach to assess the accuracy, completeness, consistency, and timeliness of HIV/AIDS data. The methodology includes:

- Stakeholder engagement
- Site selection
- Data verification
- Capacity building.

2.1.1 Stakeholder Engagement

At national level, a one-day stakeholder meeting was convened, bringing together all relevant stakeholders, to:

- Present the NJDQA concept note.
- Establish a technical committee to oversee the assessment.
- Define the modalities and scope of the assessment

2.1.2 State and Site Selection

Twenty (20) states were selected based on engagement in KP programming, historical data quality challenges, and high M&E staff attrition rate. Site selection was done using purposive sampling technique, with emphasis on sites with high clients' load and significant contributions to HIV/AIDS data reporting. A total of five (5) SDPs comprising of OSSs and CBOs were selected in each state.

List of States selected for the NJDQA

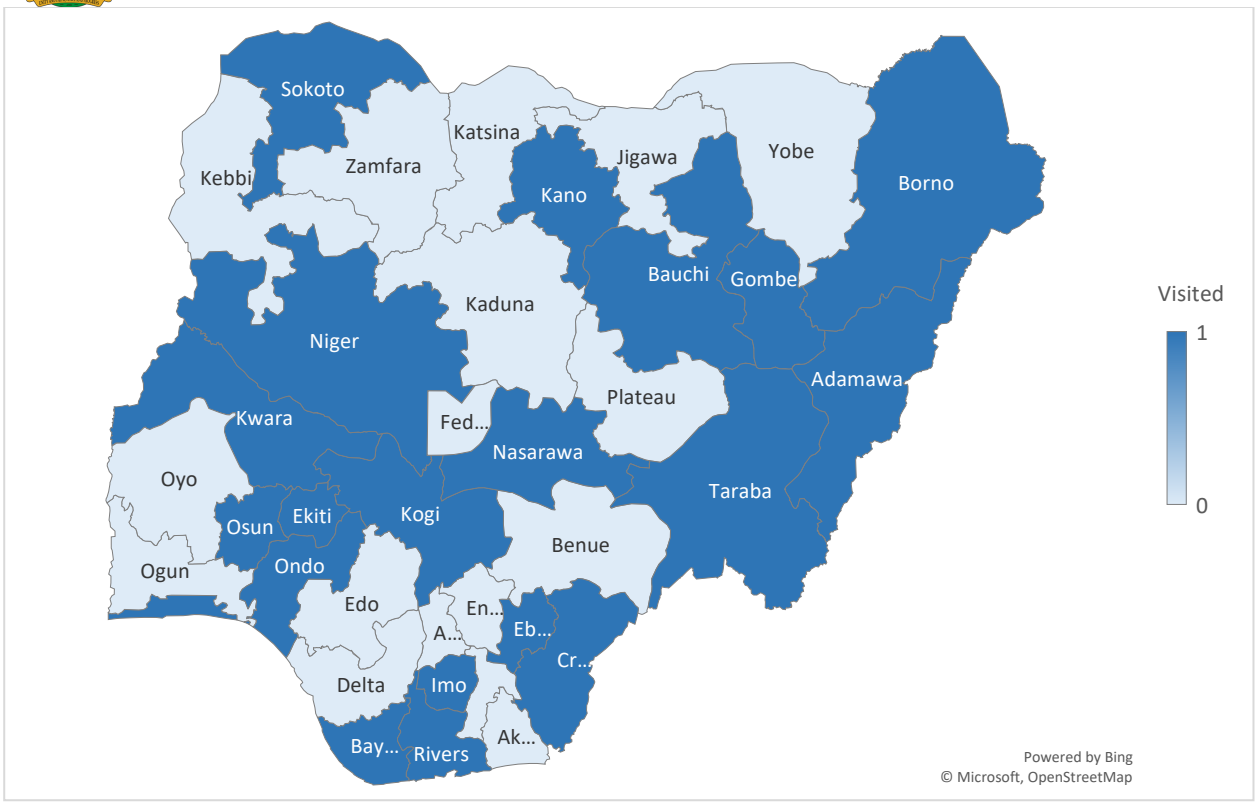

Table 1 List of States selected for the NJDQA

S/N	GEO POLITICAL ZONES	STATES
1	North Central	Kogi, Kwara, Nasarawa and Niger
2	North East	Adamawa, Bauchi, Borno Gombe and Taraba
3	North West	Kano and Sokoto
4	South East	Ebonyi and Imo
5	South South	Bayelsa, Cross River, and Rivers
6	South West	Ekiti, Lagos, Ondo and Osun,

2.1.3 Description of the NJDQA Tool

The tool was customised using Kobo Collect, Kobo Collect is an open-source data collection tool selected because of its ability to collect data both offline and online, allowing data collectors to carry out their activities in remote areas. The previous paper-based tool was customized on Kobo

Collect to allow for electronic data collection using mobile phone/ laptop/handheld device. The questions in the Kobo collect were grouped into two main components:

- Data quality assessment: this includes data availability, data consistency, and data validity
- M&E system Assessment: these includes the M&E structure, function and capabilities, indicator definition and reporting guidelines, data collection and reporting forms and tools, data management process and use of data for decision making.

2.1.4 Data Verification and Validation

The verification section of the tool compared data from the register, MSF & EMR with the reference data from eNNRIMS-DHIS 2.0 and NDR. The section assessed the availability, consistency and validity of data reported using the source document. The verified data were focused on KP target group, which includes female sex workers (FSW), Men who have sex with men (MSM), people who inject drugs (PWID), and Transgender (TG).

The data verification section of the NJDQA tool was used to assess:

- The service delivery and intermediate aggregation sites
- The data reported at the facilities with the state-validated data.
- The availability and completeness of all indicator source documents for the reporting period.
- Data from the source documents, and the reported data by the site
- Reported data with other data sources.
- Compliance with national data collection guidelines.

List of Indicators

Table 2 List of Indicators

HTS INDICATORS		
Total Number of KP who tested for HIV and received results	Compare Register/MSF	Compare MSF/eNNRIMS
Total number of KP who tested HIV positive and received results		
PREVENTION INDICATORS		
Number of KP reached with prevention services	Compare Register/MSF	Compare MSF/eNNRIMS
ART INDICATORS		
Number of KP newly enrolled on ART	Compare MSF/EMR	Compare EMR/NDR
Total number of KP who are currently receiving ART during the month		
Number of KP on ART with a viral load test result during the month		
Number of KP on ART who are virologically Suppressed		
CARE AND SUPPORT INDICATORS		
Number of GB-V Cases reported by Typology	Compare Register/MSF	Compare MSF/eNNRIMS

2.1.5 Data Management Systems Assessment

The data management systems assessment, which is a qualitative assessment of the strengths and weaknesses of functional areas in data management and reporting systems. It assesses strengths and weaknesses of the system and targets four main domains of the data management system, which was conducted, focusing on:

- M&E structure, functions, and capabilities.
- Indicator definitions and reporting guidelines.
- Data collection, storage, and retrieval processes.
- Data use for decision-making at the state and facility levels.

2.1.6 2024 NJDQA Training

A virtual orientation session was held to familiarize field teams with the revised NJDQA tools and assessment methodology. The training covered data collection procedures, validation techniques, and the use of electronic data capture tools (Kobo Collect).

2.1.7 Field Visits

A five-day data quality assessment was conducted in the selected states, with teams visiting designated OSSs and CBOs to review and validate data collection and reporting practices.

An entry meeting was held with key stakeholders in each state upon arrival. During the assessment, technical assistance was provided to support the process, and several challenges were promptly addressed on-site. At the conclusion of the assessment, a debriefing meeting was conducted where the findings from the exercise were presented to stakeholders at the state level. Additionally, a feedback mechanism was established to address any issues that could not be resolved in the field.

2.1.8 Report Writing and Dissemination

Result from the NJDQA was consolidated into a comprehensive report, highlighting key findings, gaps, recommendations, and action points. The final report will be presented at the National M&E TWG meeting for validation and subsequent implementation of recommended interventions.

CHAPTER THREE

3.0 Results/Findings

3.1 Data Verification analysis by the thematic areas

3.1.1 HIV TESTING SERVICES (HTS) Indicators

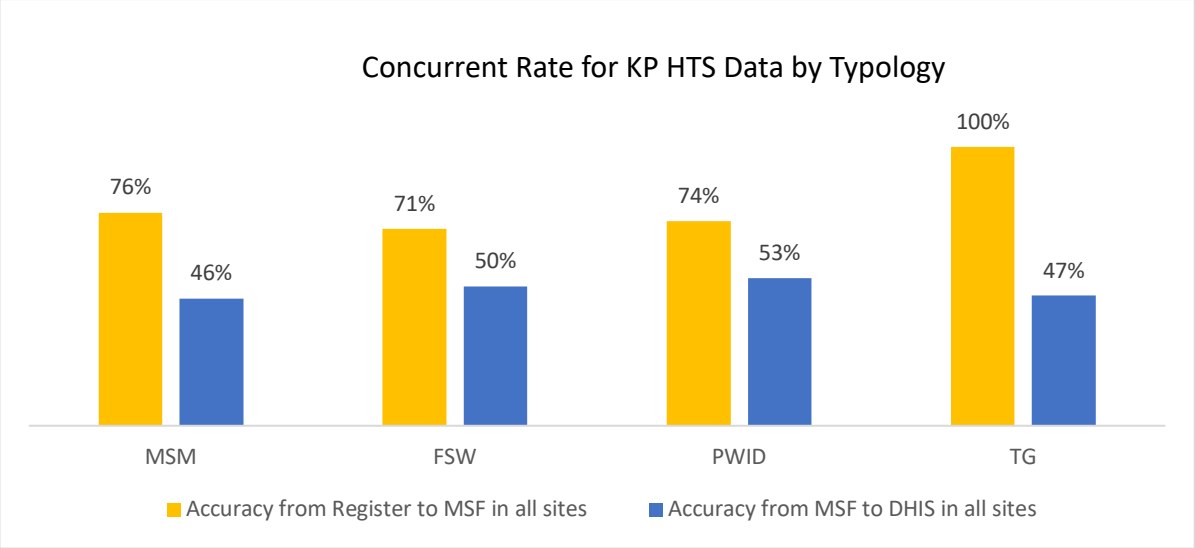

Figure 1 Concurrent rate for KP HTS Data by Typology

Figure 1 shows the concurrent rate for KP HTS data by typology, comparing accuracy from Register to MSF and MSF to eNNRIMS DHIS2.0. The data shows significantly lower accuracy in transmission from MSF to eNNRIMS DHIS2.0, with an average concurrence rate of 49%, compared to a higher average concurrence rate of 80% from Register to MSF.

Among the four typologies, TG shows the highest overall concurrence rate, achieving 100% accuracy from Register to MSF, but still experiencing a drop to 47% accuracy from MSF to DHIS. The chart displays that the data transmission error occurred more from the MSF to DHIS than the Register to MSF.

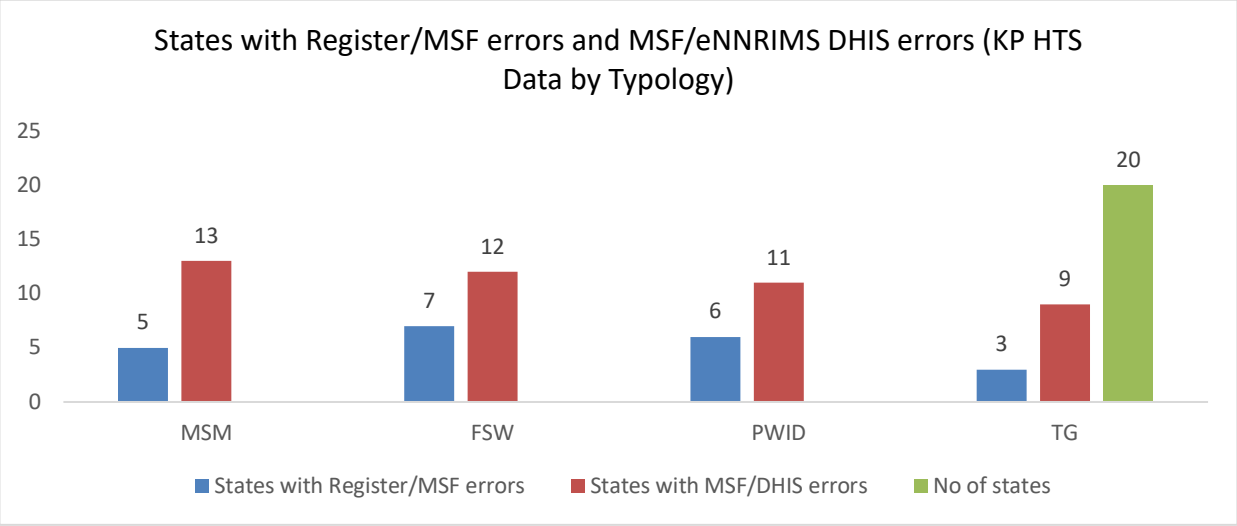

Figure 2 States with Register/MSF errors and MSF/eNNRIMS DHIS errors (KP HTS Data by Typology)

Figure 2 highlights the states with data transmission errors from Register to MSF and MSF to eNNRIMS DHIS2.0 for KP HTS across different typologies (MSM, FSW, PWID, TG).

1. Register to MSF Errors:

Below is the list of states where errors were recorded in data transmission from the Register to MSF across typologies:

- MSM: 5 states (Lagos, Rivers, Nasarawa, Taraba, Kwara)
- FSW: 7 states (Lagos, Cross River, Rivers, Nasarawa, Gombe, Taraba, Kwara)
- PWID: 6 states (Lagos, Rivers, Nasarawa, Gombe, Taraba, Kwara)
- TG: 3 states (Rivers, Nasarawa, Gombe)

2. MSF to eNNRIMS DHIS Errors:

The following states had data transmission errors from MSF to eNNRIMS DHIS2.0 across typologies:

- MSM: 13 states (Lagos, Cross River, Ebonyi, Niger, Ekiti, Bauchi, Rivers, Kano, Osun, Nasarawa, Gombe, Bayelsa, Kwara)
- FSW: 12 states (Lagos, Sokoto, Cross River, Ebonyi, Bauchi, Rivers, Kano, Osun, Nasarawa, Gombe, Bayelsa, Kwara)
- PWID: 11 states (Lagos, Cross River, Ebonyi, Bauchi, Rivers, Kano, Osun, Nasarawa, Gombe, Bayelsa, Kwara)
- TG: 9 states (Cross River, Sokoto, Ebonyi, Rivers, Kano, Nasarawa, Gombe, Bayelsa, Kwara)

The highest number of data transmission errors occur between MSF and eNNRIMS DHIS2.0, with MSM typology being the most affected across states. While TG typology has the least number of states with errors, Additionally, several states consistently appear across multiple typologies, indicating a systemic challenge in data reporting that needs targeted intervention.

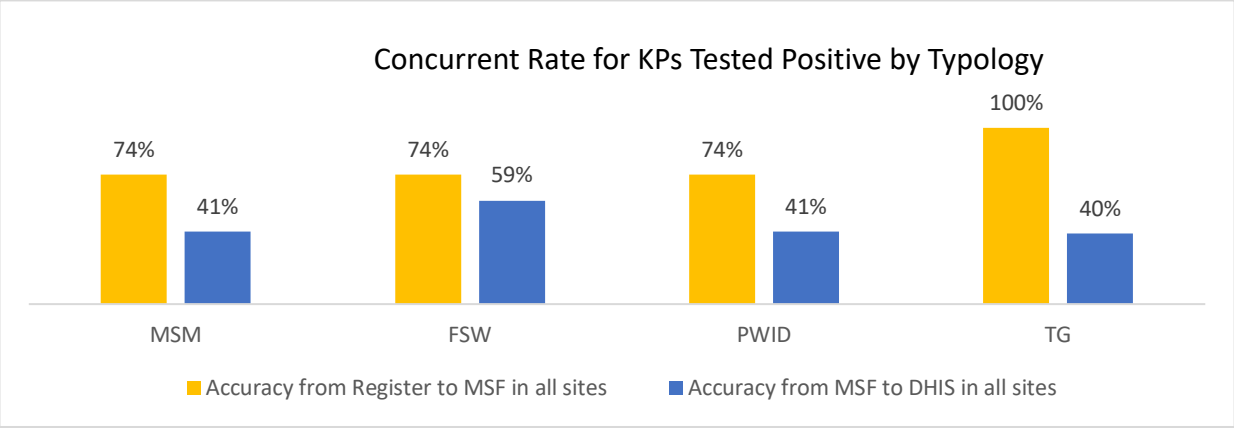

Figure 3 Concurrent Rate for KPs Tested Positive by Typology

Figure 3 shows the concurrent rate for KPs tested positive by typology across all sites. The average concurrence rate from Register to MSF is 81%. However, accuracy drops significantly to an average of 45% when data is transmitted from MSF to DHIS, highlighting major inconsistencies in data reporting at this stage. TG (Transgender) has the highest accuracy from Register to MSF at 100%, but this drops to 40% when the data is transferred from MSF to eNNRIMS DHIS2.0.

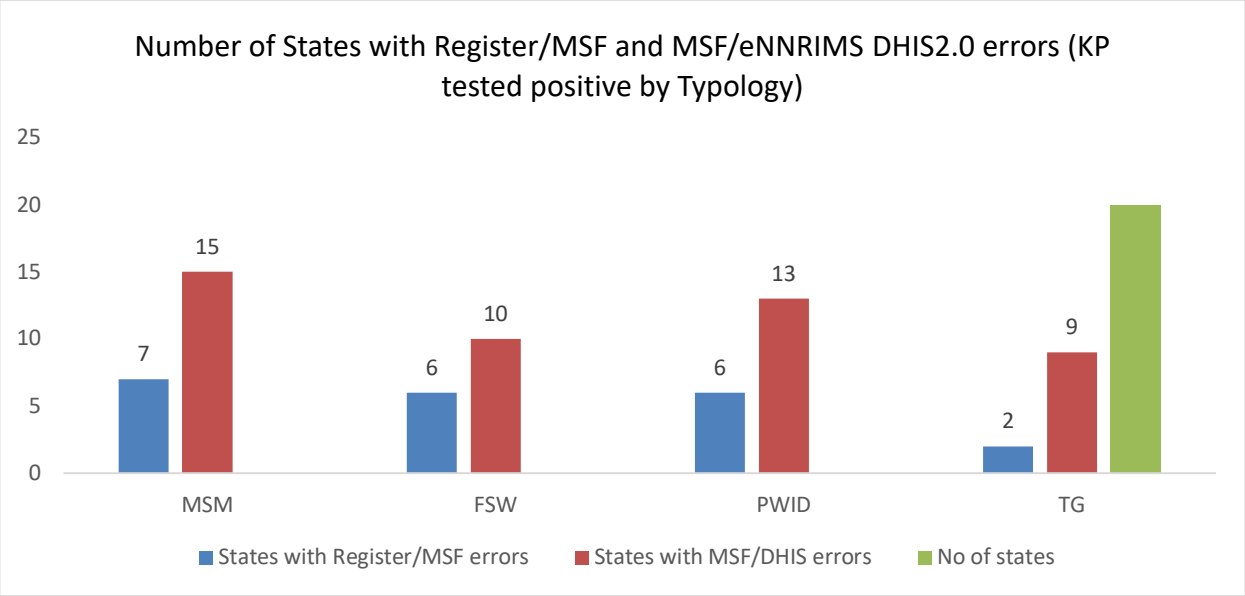

Figure 4 Number of States with Register/MSF and MSF/eNNRIMS DHIS2.0 errors (KP tested positive by Typology)

Figure 4 highlights the states with data transmission errors from Register to MSF and MSF to eNNRIMS DHIS2.0 for KPs who tested positive across all typologies.

Register to MSF Errors:

- MSM: 7 states (Lagos, Rivers, Kogi, Nasarawa, Gombe, Taraba, Kwara)
- FSW: 6 states (Lagos, Rivers, Nasarawa, Gombe, Taraba, Kwara)
- PWID: 6 states (Lagos, Cross River, Rivers, Nasarawa, Taraba, Kwara)
- TG: 2 states (Rivers, Kwara)

MSF to eNNRIMS DHIS2.0 Errors:

- MSM: 15 states (Lagos, Adamawa, Cross River, Sokoto, Ebonyi, Ekiti, Bauchi, Rivers, Kogi, Kano, Osun, Nasarawa, Gombe, Bayelsa, Kwara)
- FSW: 10 states (Lagos, Sokoto, Bauchi, Rivers, Kano, Osun, Nasarawa, Gombe, Bayelsa, Kwara)
- PWID: 13 states (Lagos, Cross River, Sokoto, Ebonyi, Niger, Bauchi, Rivers, Kano, Osun, Nasarawa, Bayelsa, Taraba, Kwara)
- TG: 9 states (Cross River, Sokoto, Ebonyi, Ekiti, Rivers, Kano, Gombe, Bayelsa, Kwara)

MSF to eNNRIMS DHIS2.0 errors is significantly higher than register to MSF errors, with MSM and PWID having the most affected states. While TG has the fewest Register to MSF errors, it still faces major MSF to eNNRIMS DHIS2.0 challenges. These gaps highlight the need for improved data transmission and reporting accuracy in KP testing.

3.1.2 Prevention Indicators

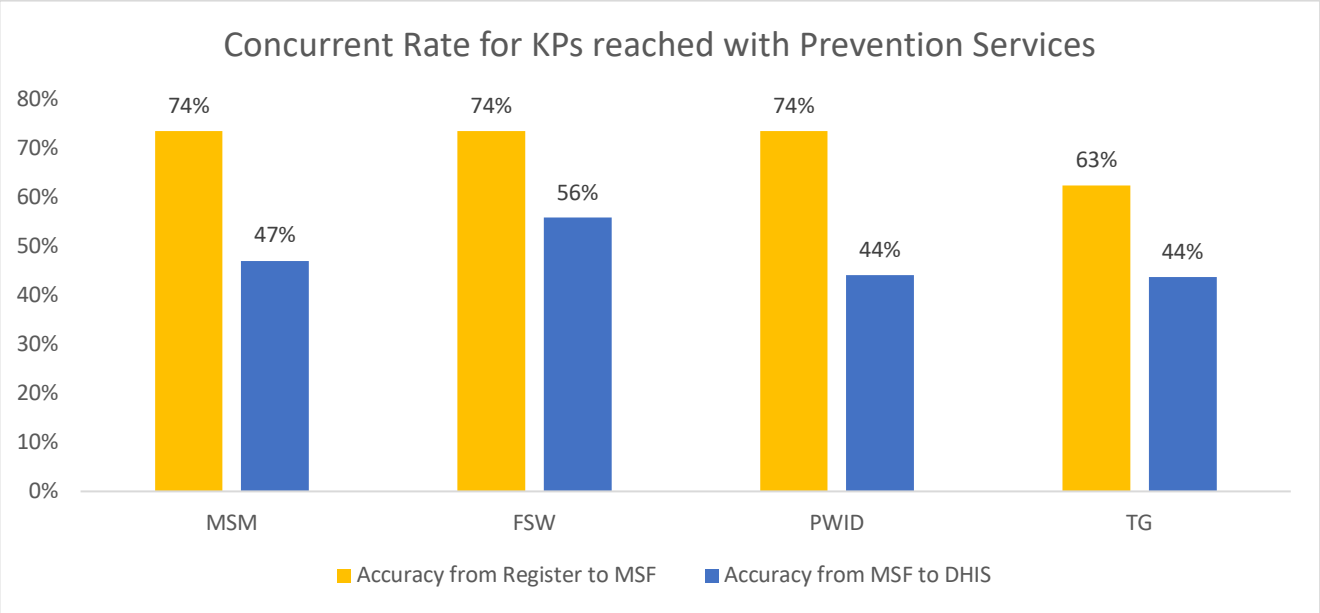

Figure 5 Concurrent Rate for KPs reached with Prevention Services

Figure 5 presents data on the concurrent rate for KPs reached with prevention services by typology, comparing accuracy from Register to MSF and MSF to eNNRIMS DHIS2.0. The average concurrence rate from Register to MSF is 71%, indicating relatively high accuracy in initial data capture, but this drops significantly to 48% when transmitted from MSF to eNNRIMS DHIS2.0, highlighting a gap in data quality and reporting consistency. FSW has the highest MSF to eNNRIMS DHIS2.0 accuracy (56%), while PWID and TG have the lowest (44%). This discrepancy suggests data transmission issues likely caused by inconsistent reporting, data entry errors, or verification gaps.

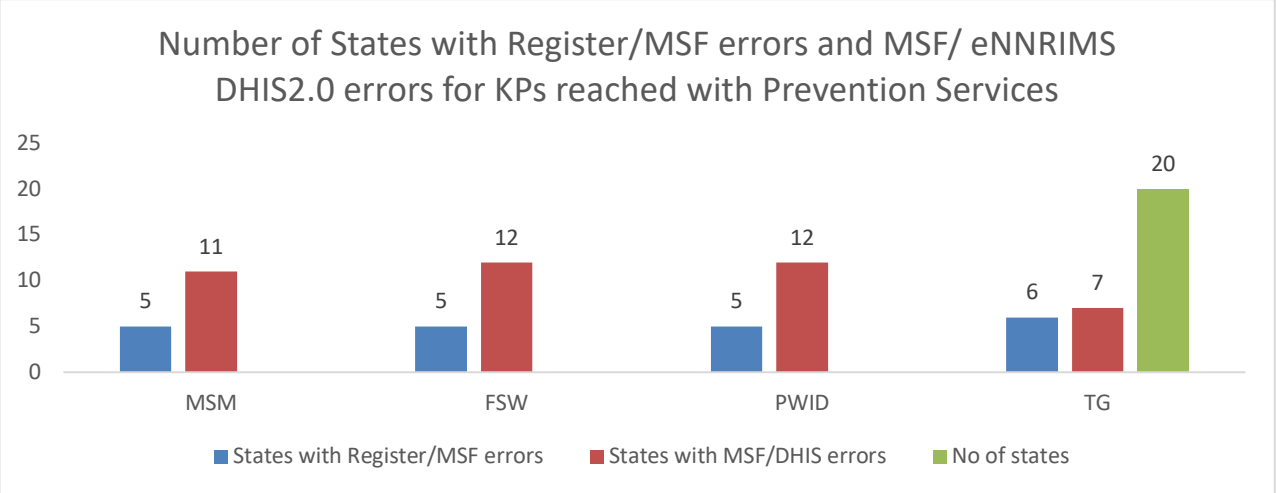

Figure 6 Number of States with Register/MSF errors and MSF/ eNNRIMS DHIS2.0 errors for KPs reached with Prevention Services

Figure 6 presents the states with data transmission errors from Register to MSF and MSF to eNNRIMS DHIS2.0 for KPs reached with prevention services across the four typologies.

Register to MSF Errors:

- MSM: 5 states (Lagos, Rivers, Nasarawa, Gombe, Kwara)
- FSW: 5 states (Lagos, Rivers, Nasarawa, Gombe, Kwara)
- PWID: 5 states (Lagos, Rivers, Nasarawa, Gombe, Kwara)
- TG: 6 states (Lagos, Rivers, Kano, Nasarawa, Gombe, Kwara)

MSF to eNNRIMS DHIS2.0 Errors:

- MSM: 11 states (Lagos, Ebonyi, Niger, Ekiti, Bauchi, Rivers, Kano, Nasarawa, Bayelsa, Kwara)
- FSW: 12 states (Lagos, Ebonyi, Niger, Ekiti, Bauchi, Rivers, Kano, Nasarawa, Gombe, Bayelsa, Ogun, Kwara)
- PWID: 12 states (Lagos, Ebonyi, Niger, Ekiti, Bauchi, Rivers, Kano, Nasarawa, Gombe, Bayelsa, Ogun, Kwara)
- TG: 7 states (Ebonyi, Ekiti, Rivers, Kano, Nasarawa, Gombe, Kwara)

MSF to eNNRIMS DHIS2.0 transmission errors are more prevalent than registers to MSF errors, particularly for FSW and PWID, where 12 states recorded errors. TG has the fewest MSF to eNNRIMS DHIS2.0errors (7 states) but the highest Register to MSF errors. The repeated occurrence of certain states across typologies indicates persistent reporting challenges, highlighting the need for targeted interventions to improve data accuracy and validation.

3.1.3 Anti-Retroviral Treatment (ART) Indicators

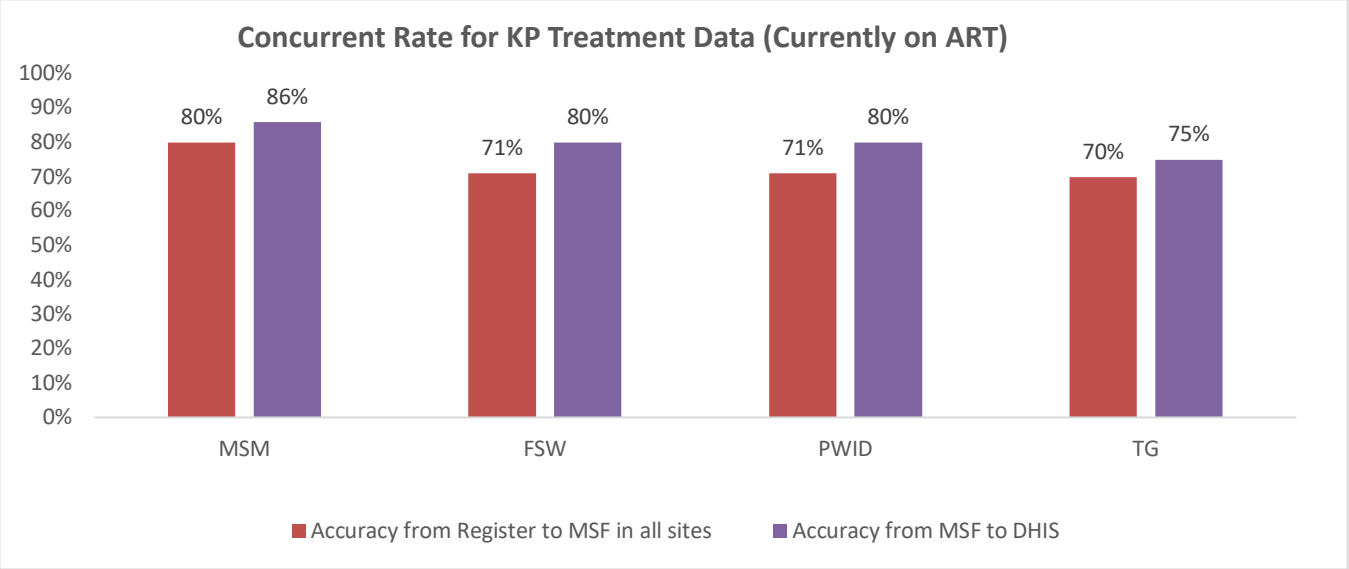

Figure 7 Concurrent Rate for KP Treatment Data (Currently on ART)

Figure 7 shows the concurrence rate for KPs currently on ART by typology from Register to MSF and MSF to DHIS, with a high accuracy rate for data transmission from MSF to eNNRIMS DHIS2.0 at an average of 86%, while the average concurrence rate from Register to MSF is 80%.

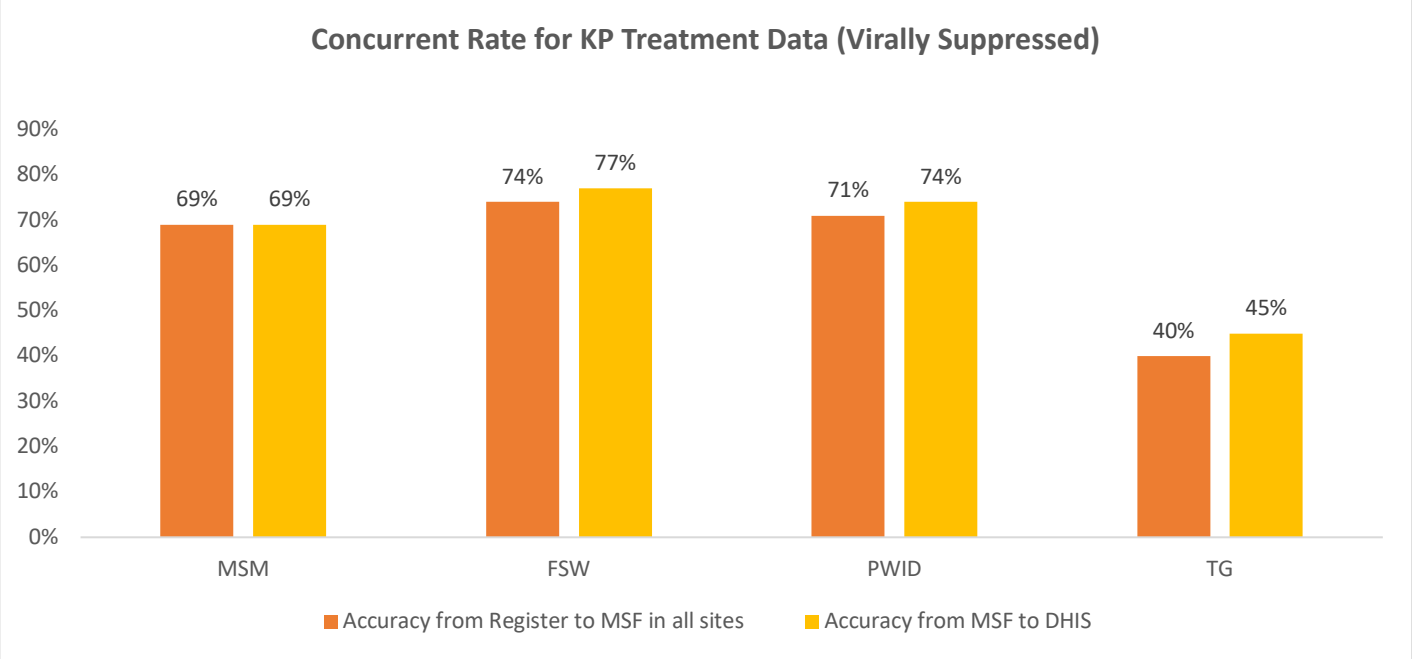

Figure 8 Concurrent Rate for KP Treatment Data (Virally Suppressed)

Figure 8 shows the concurrent rate for KPs currently on ART by typology from Register to MSF and MSF to eNNRIMS DHIS2.0, with a high accuracy rate for data transmission from MSF to eNNRIMS DHIS2.0at an average of 77%, while the average concurrence rate from Register to MSF is 74%.

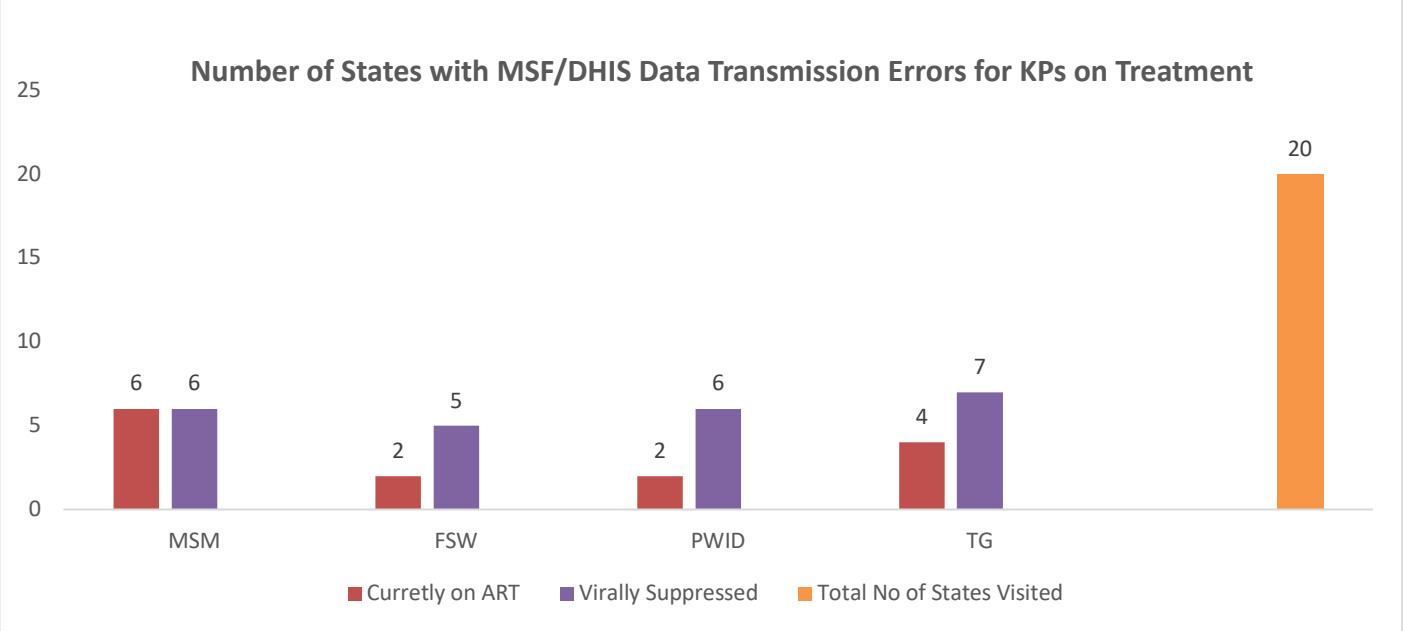

Figure 9 Number of States with MSF/DHIS Data Transmission Errors for KPs on Treatment

The figure highlights states with data transmission errors from MSF to eNNRIMS DHIS2.0 for KP ART, specifically those currently on ART and those virally suppressed across 20 states.

Table 3 Number of States with MSF/DHIS Data Transmission Errors for KPs on Treatment

KP Typology	States with Errors (Currently on ART)	States with Errors (Virally Suppressed)
MSM	Lagos, Ekiti, Bauchi, Kwara	Lagos, Ebonyi, Rivers, Kogi, Nasarawa, Kwara
FSW	Sokoto	Kwara, Nasarawa, Rivers, Ebonyi, Lagos
PWID	Taraba, Rivers	Nasarawa, Kwara, Rivers, Ekiti, Ebonyi, Lagos
TG	Kwara, Nasarawa, Rivers, Ekiti, Ebonyi, Lagos	Kwara, Nasarawa, Rivers, Ekiti, Ebonyi, Lagos

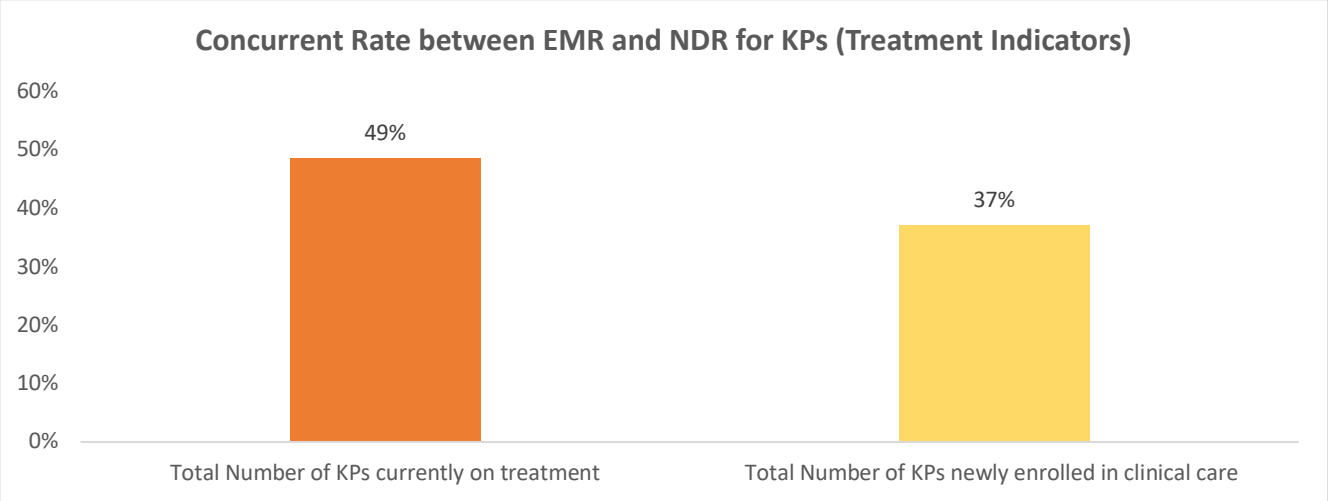

Figure 10 CONCURRENT RATE BETWEEN EMR AND NDR FOR KPs (TREATMENT INDICATORS)

Figure 10 shows the concurrent rate between data from EMR and NDR for KP treatment Indicators. The concurrence rate for KPs currently on treatment is 49% while the average concurrence rate for KPs newly enrolled in clinical care is 37%.

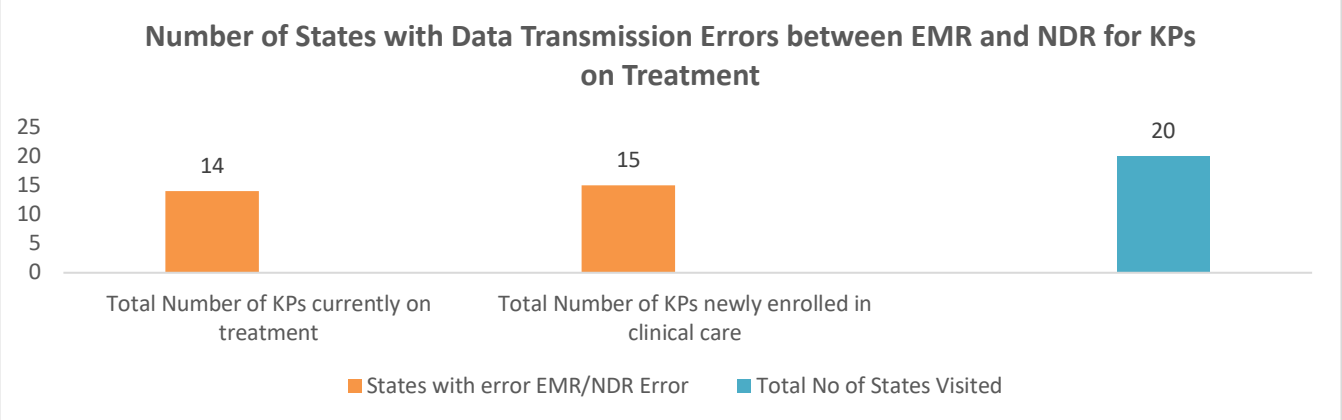

Figure 11 Number of States with Data Transmission Errors between EMR and NDR for KPs on Treatment

Figure 11 shows data transmission errors between EMR and NDR for KPs across 20 states.

Below summarizes the affected states:

Table 4 Number of States with Data Transmission Errors between EMR and NDR for KPs on Treatment

Indicator	**States with EMR/NDR Errors (Virologically Suppressed)**
Currently Treatment	Lagos, Borno, Sokoto, Cross River, Ebonyi, Niger, Bauchi, Rivers, Kogi, Kano, Nasarawa, Gombe, Taraba, Kwara.
Newly Enrolled in Clinical Care	Lagos, Borno, Sokoto, Cross River, Ebonyi, Niger, Rivers, Kogi, Kano, Osun, Nasarawa, Gombe, Bayelsa, Taraba, Kwara.

3.2 Data availability by the thematic areas

3.2.1 HTS data availability

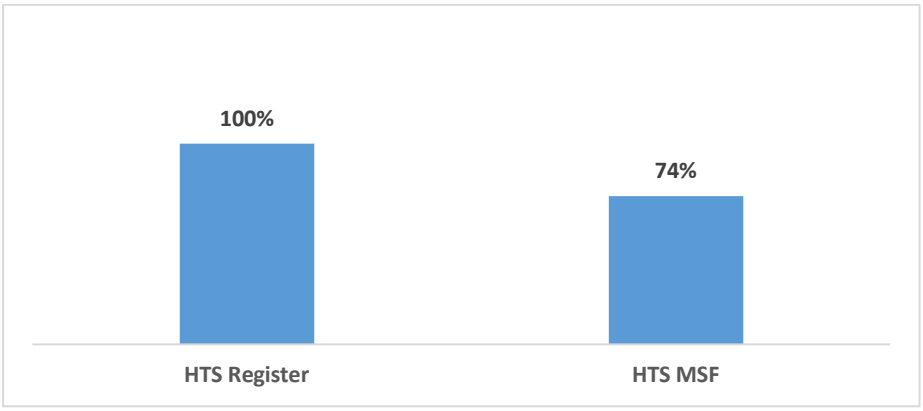

Figure 12 HTS Data Availability

Figure 12 summarizes the availability of HIV Testing Services (HTS) data across 35 sites. Data were documented on all the HTS Register across all sites, achieving 100% data availability. HTS data were also reported on the Monthly Summary Form (MSF) across 26 sites, resulting in 74% data availability. Although all sites have 100% completeness of data on the register, however, 9 sites did not have data reported on the HTS MSF. These sites are from the following states: Lagos, Rivers, Nasarawa, Gombe, and Ogun**.**

3.2.2 Prevention data availability

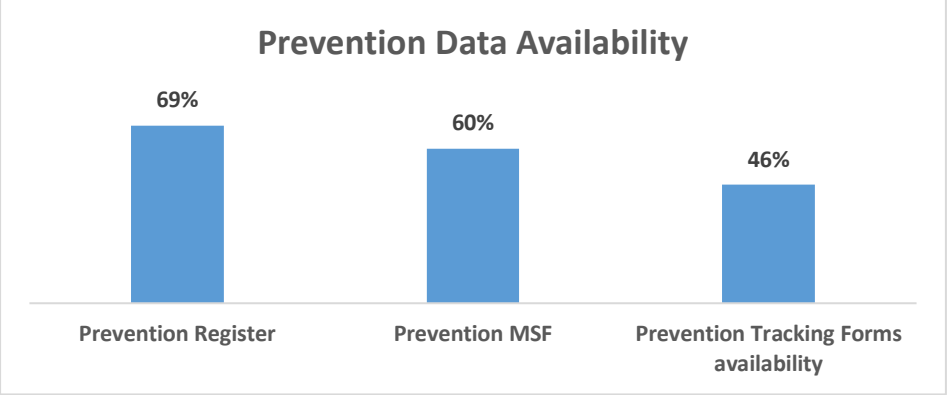

Figure 13 Prevention Data Availability

Figure 13 above graph summarizes the availability of prevention data across 35 sites: Data were documented in the Prevention Register at 24 sites, representing 69% availability except in the following states: Lagos, Cross River, Rivers, Kano, Nasarawa and Gombe.

Similarly, data were documented in the Prevention Monthly Summary Form (MSF) at 21 sites (60%), except the following states: Lagos, Rivers, Kano and Nasarawa. However, data were largely not recorded in the Prevention Tracking Forms in most of the sites. Only 16 sites (46%) had these tools available, which accounts for less than half of the sites visited. The states where data and tools were not recorded include Lagos, Rivers, Nasarawa, Gombe, Ogun, Bayelsa, and Kano.

These findings highlighted significant gaps in data availability, particularly in the Prevention Tracking Forms (46%), which may hinder effective monitoring and evaluation efforts

3.2.3 Care& Support data availability

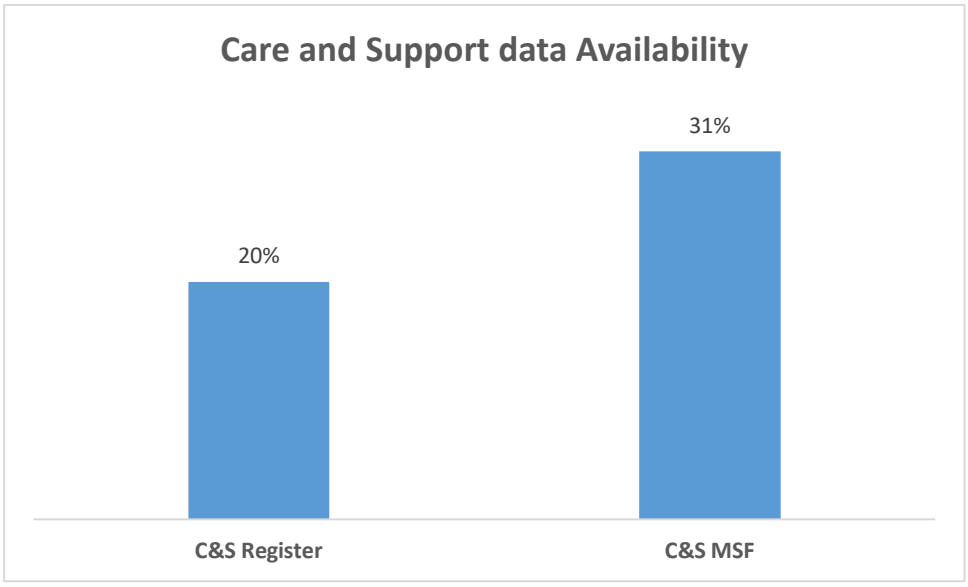

Figure 14 Care & Support Data Availability

Figure 14 summarizes the availability of data on Care and Support (C&S) across 35 sites. Data in the C&S Register were available at 7 sites, representing 20% availability. The States where data

were documented on the tool includes: Taraba, Bayelsa, Borno, Imo, Sokoto, Kwara and Niger. Similarly, data were recorded in C&S Monthly Summary Form (MSF) at 11 sites (31% availability). However, data were not documented in these tools in the following: Lagos, Adamawa, Cross River, Rivers, Ebonyi, Kogi, Kano, Osun, Nasarawa, Gombe, and Ogun.

This highlights the issue of low data availability, with the C&S Register having the lowest coverage (20%) which may affect service tracking and reporting accuracy.

3.2.4 eNNRIMS-DHIS data availability

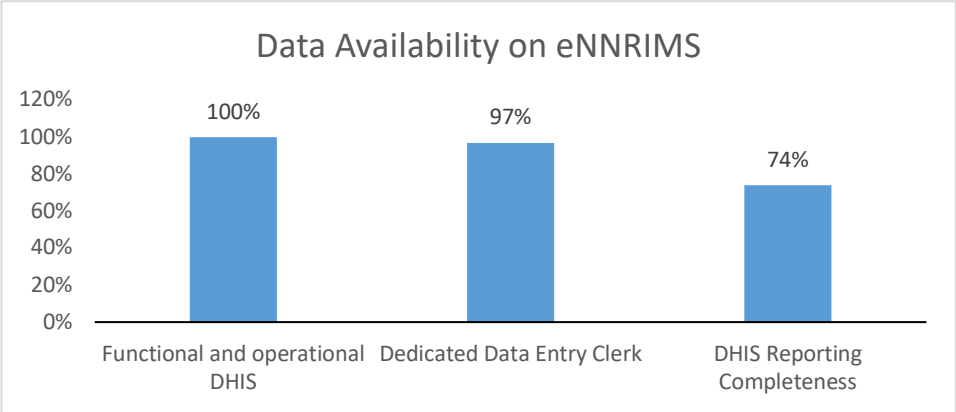

Figure 15 eNNRIMS DHIS 2.0 Data Availability

Figure 15 summarizes the availability of eNNRIMS DHIS2.0across 35 sites:

- A functional and operational eNNRIMS DHIS2.0 is available at all 35 sites, ensuring (100% availability).
- A dedicated Data Entry Clerk is available at 34 sites (97% availability) except in Lagos
- DHIS Reporting Completeness has been achieved at 26 sites (74% availability).

- These findings indicate that while DHIS 2.0 is fully operational, data completeness remains at (74%), which may impact the overall quality of data reporting

3.3 M&E system assessment Analysis

Table 5 M&E Structure, Functions and Capabilities

M&E Structure, Functions and Capabilities	YES	NO	States with issues on the M&E system assessment	No of sites
Staff received appropriate training on data management	83%	17%	Kogi, Nasarawa, Gombe, Kwara	6
The service delivery unit has an assigned staff with responsibility for data documentation	100%	0%	N/A	0
Staff responsible for reviewing periodic reports before submission to the next level	97%	3%	Kogi	1

Process in place to ensure data compilation and reporting is completed if the responsible staff is not available.	91%	9%	Kogi, Nasarawa	3
SDPs receive regular feedback on the quality of their submitted reports according to the guidelines	86%	14%	Ebonyi, Rivers, Kogi, Nasarawa	5
SDPs receive regular supportive supervisory visits from either State, LGA or National level staff according to the guidelines.	100%	0%	N/A	0
…If yes, was the last visit within the past three months.	97%	3%	Nasarawa	1

Interpretation

1. The majority of staff have received training on data management. However, gaps remain in Kogi, Nasarawa, Gombe, and Kwara, requiring additional training efforts.
2. All service delivery units have designated personnel for data documentation
3. Most SDPs ensure reports are reviewed before submission, except one in Kogi state
4. A backup process exists for most SDPs to ensure data compilation and reporting during staff absence except for Kogi and Nasarawa.
5. About 5 SDPs in Ebonyi, Rivers, Kogi, Nasarawa do not receive regular feedback on report quality.
6. Supervision is consistent across all SDPs, reinforcing compliance and quality assurance.
7. Most SDPs have received recent visits, except for one site in Nasarawa, where visit frequency should be improved.

Table 6 Indicator Definitions and Reporting Guidelines

Indicator Definitions and Reporting Guidelines	YES	NO	States with issues on the M&E system assessment	No of sites
SDPs have an up-to-date copy of written guidance on indicator definitions provided by the National Program/M&E Unit	71%	29%	Lagos, Sokoto, Rivers, Kogi, Nasarawa, Gombe	10
SDPs have a copy of written guidelines provided by the National Program/M&E Unit on reporting requirements and deadlines	71%	29%	Lagos, Sokoto, Rivers, Osun, Nasarawa, Gombe.	10

Interpretation

1. About 10 SDPs lack up-to-date guidance on indicator definitions, particularly in Lagos, Sokoto, Rivers, Kogi, Nasarawa, and Gombe
2. 10 SDPs do not have any copy written guidelines provided by the National Program/M&E Unit on reporting requirements and deadlines in Lagos, Sokoto, Rivers, Osun, Nasarawa, Gombe

Table 7 Data-collection and Reporting Forms and Tools

Data-collection and Reporting Forms and Tools	YES	NO		No of sites
SDPs consistently making use of the National Program standard reporting forms/tools at all reporting service delivery points	63%	37%	Lagos, Sokoto, Ebonyi, Kano, Osun, Nasarawa, Gombe, Kwara.	13
Clear instruction on how to complete the data collection and reporting forms/tools provided by the National Program/Project.	71%	29%	Lagos, Kano, Kogi, Nasarawa, Gombe	10
Sufficient stocks of blank data collection and reporting forms at the service site	77%	23%	Niger, Kogi, Kano, Nasarawa, Gombe, Ogun, Kwara	8

Interpretation

1. A significant proportion of SDPs (about 37%) do not use standard reporting tools, particularly in Lagos, Sokoto, Ebonyi, Kano, Osun, Nasarawa, Gombe, and Kwara.
2. Lagos, Kano, Kogi, Nasarawa, Gombe do not have clear instructions on how to complete the data collection and reporting forms/tools.
3. About 23% of the SDPs (8) have a shortage of blank data collection and reporting forms at the service site

Table 8 Data Management Processes

Data Management Processes	YES	NO	States with issues on M&E system assessment	No of sites
client's data maintained according to national or international confidentiality guidelines.	100%	0%	N/A	0
SDPs maintains an adequate archive of program documents (i.e. clean, dry, with sufficient space, shelves, filing system etc.)	100%	0%	N/A	0

Interpretation

1. There is full compliance with data confidentiality standards, ensuring patient information remains protected.
2. All SDPs adhere to proper archival procedures, maintaining well-organized and secure records.

Table 9 Use of data for decision making

Use of data for decision making	YES	NO	States with issues on M&E system assessment	No of sites with issues

SDPs visibly display service charts/tables across various thematic units	91%	9%	Nasarawa, Gombe	3
Analysed data/results presented/disseminated to other information system stakeholders promptly.	91%	9%	Nasarawa	3

Interpretation

1. Most SDPs visibly display service charts/tables except for 2 SDPs in Nasarawa and Gombe.
2. Timely data dissemination is mostly achieved, but Nasarawa requires process improvements to ensure faster data sharing.

CHAPTER FOUR

This chapter presents the comprehensive findings and observations from the assessment of community-based facilities, along with recommendations to address identified issues. The objectives are to highlight the gaps and challenges observed in these facilities and provide practical, actionable solutions for improvement. Throughout the assessment, various findings were made regarding the state of the facilities and their operations. These findings were based on several factors, including the availability, consistency and validity of data, staff capacity and efficiency, access to the national non-health sector tool and adherence to established protocols and guidelines.

Based on these findings, recommendations were developed to address the identified challenges and gaps, with a focus on improving the quality of data generated by the facilities. The recommendations were carefully designed to be realistic, actionable and tailored to the specific needs of each facility. They include strategies for enhancing data collection and reporting processes, strengthening staff training and capacity building, improving infrastructure and equipment and reinforcing adherence to established protocols and guidelines. By implementing these recommendations. State facilities are expected to enhance service delivery and contribute to the overall goal of achieving high-quality data across the state.

The summary of the findings indicates that most data transmission errors occurred between the monthly summary form and the eNNRIMS-DHIS. Although there were also significant

transmission errors from the register to the Monthly Summary Form (MSF), the errors from the summary form to the eNNRIMS-DHIS2 were more prevalent.

4.1 Programmatic Implications of Data Quality Findings on HIV/AIDS Data Systems

4.1.2 HIV Testing Services (HTS) Indicators

- The findings reveal significant discrepancies in HTS reporting, particularly during transmission from Monthly Summary Forms (MSF) to eNNRIMS DHIS2.0, where concurrence rates drop from 80% (Register to MSF) to 49% (MSF to eNNRIMS DHIS2.0).
- Data inconsistency suggests that reporting and disaggregation processes introduce errors during transmission to the eNNNRIMS DHIS2.0 leading to underreporting in national systems.
- The dropping of data concurrence from the 100% Register - MSF level to 47% MSF-eNNRIMS DHIS2.0 level highlights a systemic gap in capturing KP-specific data, which could underestimate testing coverage and linkage to care.
- Data transcription errors during transmission from MSF to eNNRIMS DHIS2.0 will negatively impact programmatic decision-making. Without reliable HTS data, programs face several challenges:
    - Inability to accurately measure testing yield
    - Underestimation of testing coverage among key populations
    - Inaccurate linkage-to-care calculations
    - Suboptimal testing strategy decisions

4.1.3 Prevention Indicators

- Prevention data accuracy declining from 71% concurrence (Register to MSF) to 48% (MSF to eNNRIMS DHIS2.0) suggest data quality issues which may lead to prevention gaps.
- The data accuracy decline could be attributed to non-use of national tools or non-availability of the national tools.
- Despite, NACA has revised Non health sector (NHS)tool in 2022 and distributed to all the 37 states, non-adherence to the standardized NHS tools undermines efforts to monitor and measure program impact.
- Inconsistent data may **divert resources away from high-risk groups**, misaligned and perpetuating HIV transmission

4.1.4 Anti-Retroviral Treatment (ART) Indicators

- Data transcription disparity for KP treatment indicators (KP currently on ART, KP new on treatment) from EMR to National Data Repository (NDR data despite higher concurrence (74–86%) between registers and eNNRIMS DHIS2.0, signals critical interoperability gap.
- The data disconnect suggest delays or omissions in reporting which has implication for treatment programs. It can lead to inaccurate viral suppression calculations, challenge with monitoring patient retention and also compromised measurement of 95-95-95 targets

4.2 Key recommendations based on the NJDQA findings:

1. **Standardize Data Collection Tools**
    - Enforce mandatory use of approved national NHS tools across all states and facilities to improve data consistency.
2. **Strengthen Data Transmission Processes**
    - Implement automated validation checks between registers, MSFs, and eNNRIMS DHIS2.0 to reduce manual entry errors.
    - Introduce real-time data synchronization where possible.
3. **Targeted Training for M&E Staff**
    - Conduct refresher training on data management, focusing on states with high error rates (Lagos, Rivers, Nasarawa, Gombe).
    - Prioritize hands-on eNNRIMS DHIS2.0 2.0 training for data clerks and supervisors.
4. **Improve Data Quality Oversight**
    - Establish routine data quality audits at state and facility levels.
5. **Address Resource Gaps**
    - Ensure consistent supply of reporting forms and job aids to all facilities.
    - Provide devices (tablets/laptops) for digital data entry in remote areas.
6. **Enhance Feedback Mechanisms**
    - Implement monthly performance feedback loops from state to facility levels.
    - Share DQA findings with implementing partners for corrective action.
7. **Strengthen KP-Specific Reporting**
    - Conduct typology-specific training for accurate disaggregated reporting.
8. **Institutionalize Data Use Culture**

- Mandate regular data review meetings at facilities and state levels to inform program decisions.
- Link data quality performance to supervisory visits and incentives.

9. **Leverage Technology**
    - Scale up electronic medical records (EMR) integration with eNNRIMS DHIS2.0 to minimize transcription errors.
    - Explore AI-assisted data validation for outlier detection.
10. **State-Specific Action Plans**
    - Develop tracker and quality improvement plans for underperforming states
    - Prioritize on-site mentoring in Ebonyi, Bauchi and Cross River and other states where system gaps persist.

4.3 Summary of Facility specific Key Findings and Recommendations

Table 10 Summary of Facility specific Key Findings and Recommendations

S/N	States	Facilities	Key Findings	Recommendations
1	Adamawa	• Yola KP OSS	• Transcription error from the register to the summary form (MSF	• Ensure proper data entry, signing, and submission of original MSF copies
2	Bauchi	• Bauchi KP OSS • Misau KP OSS	• The eNNRIMS DHIS2.0 data in the state is aggregated and reported at SACA office, this making it difficult to attribute the contribution of each SDP.	• The SACA to ensure that each OSS key in their data separately
3	Bayelsa	• Yenagoa KP OSS	• The data entered at the data entry point is not reflecting in eNNRIMS DHIS2.0. Additionally, the site is not utilizing the national non-health sector tools.	• The use of the National non-health sector tool to improve data quality and harmonization.
4	Borno	• Maiduguri KP OSS	• Inconsistencies of data pulled out from the eNNRIMS	• IPs Staff should be trained on how to key in data on the

			DHIS2.0platform. While the data on the (MSFs & Registers) tally and are consistent.	eNNRIMS DHIS2.0 according to the thematic area.
5	Cross-River	• Bakassi KP OSS • Ikom KP OSS • Yakur KP OSS • Calabar Munipal KP OSS		
6	Ebonyi	• Hero's Health Community Support Initiative • Equitable Health for Women Empowerment Initiative (EHWEI)	• Inadequate knowledge in the Non-Health Sector Program	• There is a need to re-train the staff on the Non-Health Sector programming and data collection tools for quality and proper documentation.
7	Ekiti	• Ado Ekiti KP OSS	• Documentation gap from MSF to eNNRIMS DHIS2.0, and all data collection tools not properly filled and stored	• Refresher training on basic M&E should be provided to staff.
8	Gombe	• Gombe KP OSS	• Non-usage of the national NHS tools	• Ensure the use of standard national non-health sector tools to improve quality and accuracy of data.
9	Imo	• IMO OSS	• Data discrepancies were identified between the source document and eNNRIMS DHIS2.0	• Reconcile data source by comparing data from the different source documents
10	Kano	• Kano KP OSS • Badawa KP OSS	• Non-usage of the national NHS tools	• Ensure the use of standard national non-health sector tools to improve quality and accuracy of data.
11	Kogi	• Lokoja KP OSS • Dekina KP OSS • Adavi KP OSS	• Data discrepancies were identified between data captured on the register to the data MSF and eNNRIMS DHIS2.0 on HTS. This cut across all the month under review.	• Reconcile data source by comparing data from the different source documents

12	Kwara	• SFH KP OOS	• Incomplete data entry and discrepancies between Register, MSF and eNNRIMS DHIS2.0	• Ensure proper data entry, signing, and submission of MSF at OSS
13	Lagos	• Mushin KP OSS • Lagos Island KP OSS • Lagos Mainland OSS CPHI	• Prevention MSF and register not in use across the SDP	• Ensure the use of standard national non-health sector tools to improve quality and accuracy of data.
14	Nasarawa	• Akwanga KP OSS • CISHAN • Lafia KP OSS • Olive Right to Health Initiative	• Non-usage of the national NHS tools across the site	• Ensure the use of standard national non-health sector tools to improve quality and accuracy of data.
15	Niger	• Minna KP OSS • Suleja KP OSS	• There is a lack of harmonized national non-health sector tools for data collection and reporting, along with data discrepancies identified in the registry compared with to MSF across the facilities.	• Ensure proper data entry, signing, and submission of MSF
16	Ogun	• Abeokuta KP OSS		
17	Osun	• Ede South KP OSS Osogbo	• Non-usage of all the revised NHS tools	• Ensure the use of standard national non-health sector tools to improve quality and accuracy of data.
18	Rivers	• The Initiative for Advancement of Humanity (IAH) • Center for Population Health Initiative (CPHI) • Diadem Consult	• The national non-health sector tools were not available and not in use across the facilities	• Ensure the use of standard national non-health sector tools to improve quality and accuracy of data.
19	Sokoto	• SOKOTO OSS	• Data recorded on registers and MSFs did not match with the data uploaded on eNNRIMS DHIS2.0	• Ensure conducting a review session with SDP staff on harmonizing data from registers, MSFs, and DHIS, as well as Update data on MSF to reflect figures on source documents and

				ensure prompt signing of registers
20	Taraba	• Jalingo KP OSS	•	

4.4 State and Facilities Visited

Table 11 State and facilities visited

N/S	States	Facilities
1	Adamawa	• Yola KP OSS
2	Bauchi	• Bauchi KP OSS • Misau KP OSS
3	Bayelsa	• Yenagoa KP OSS
4	Borno	• Maiduguri KP OSS
5	Cross-River	• Bakassi KP OSS • Ikom KP OSS • Yakur KP OSS • Calabar Munipal KP OSS
6	Ebonyi	• Hero's Health Community Support Initiative • Equitable Health for Women Empowerment Initiative (EHWEI)
7	Ekiti	• Ado Ekiti KP OSS
8	Gombe	• Gombe KP OSS
9	Imo	• IMO OSS
10	Kano	• Kano KP OSS • Badawa KP OSS
11	Kogi	• Lokoja KP OSS • Dekina KP OSS • Adavi KP OSS
12	Kwara	• SFH KP OOS
13	Lagos	• Mushin KP OSS • Lagos Island KP OSS • Lagos Mainland OSS CPHI
14	Nasarawa	• Akwanga KP OSS • CISHAN • Lafia KP OSS • Olive Right to Health Initiative
15	Niger	• Minna KP OSS • Suleja KP OSS
16	Ogun	• Abeokuta KP OSS
17	Osun	• Ede South KP OSS Osogbo
18	Rivers	• The Initiative for Advancement of Humanity (IAH)

		• Center for Population Health Initiative (CPHI) • Diadem Consult
19	Sokoko	• SOKOTO OSS
20	Taraba	• Jalingo KP OSS

Appendix

DATA CONCURRENT RATE ACROSS STATES & SDPS

Table 12 HTS Concurrent rate % between MSF & eNNRIMS DHIS2.0 BY SDPS

HTS Concurrent rate % between MSF & eNNRIMS DHIS2.0 BY SDPS									
States	**SDP Name**	**Number of MSM tested for HIV & received results**	**Number of MSM tested positive**	**Number of FSW tested for HIV & received results**	**Number of FSW tested positive**	**Number of PWID tested for HIV & received results**	**Number of PWID tested positive**	**Number of TG tested for HIV & received results**	**Number of TG tested positive**
Lagos	Lagos Island OSS	0%	0%	0%	0%	0%	0%	N/A	N/A
Lagos	Lagos Mainland OSS CPHI	100%	100%	100%	0%	100%	100%	100%	100%
Lagos	Mushin OSS	100%	100%	100%	100%	100%	100%	N/A	N/A
Adamawa	Yola OSS	100%	105%	100%	100%	100%	98%	N/A	N/A
Borno	Maiduguri KP OSS	100%	94%	100%	100%	96%	105%	0%	0%
Sokoto	SOKOTO OSS	98%	86%	107%	160%	99%	97%	0%	0%
Cross River	Bakassi OSS	100%	100%	100%	100%	100%	100%	N/A	N/A
Cross River	Ikom OSS	100%	100%	100%	100%	100%	0%	N/A	N/A
Cross River	Yakur OSS	81%	100%	94%	100%	100%	0%	N/A	N/A
Cross River	Calabar Munipal OSS	100%	100%	100%	98%	100%	100%	100%	100%
Ebonyi	Ebonyi OSS	109%	102%	103%	98%	101%	93%	107%	94%
Ebonyi	Ebonyi OSS	109%	102%	103%	98%	101%	93%	107%	94%
Ebonyi	Ebonyi OSS	109%	108%	103%	98%	101%	93%	107%	94%
Niger	Minna OSS	111%	98%	100%	99%	100%	94%	N/A	N/A
NIGER	SULEJA OSS	100%	100%	100%	100%	100%	100%	N/A	N/A

EKITI	ADO EKITI KP OSS	101%	102%	100%	100%	98%	98%	100%	103%
Bauchi	Bauchi KP OSS and Misau KP OSS	76%	115%	72%	92%	69%	132%	N/A	N/A
Rivers	The Initiative for Advancement of Humanity (IAH)	100%	100%	N/A	N/A	N/A	N/A	N/A	N/A
Rivers	Center for Population Health Initiatives (CPHI)-DOD	0%	0%	0%	0%	0%	0%	0%	0%
Rivers	Obio-Akpor OSS (Diadem)	N/A	N/A	100%	100%	100%	100%	N/A	N/A
Kogi	Lokoja OSS	100%	100%	100%	100%	100%	100%	100%	N/A
Kogi	Dekina OSS	100%	0%	99%	100%	100%	100%	N/A	N/A
Kogi	Adavi KP OSS	100%	100%	99%	100%	100%	100%	N/A	N/A
Kano	Kano KP OSS (Kano Badawa OSS)	385%	1850%	236%	1030%	302%	0%	0%	0%
Imo	IMO OSS	100%	100%	100%	100%	100%	100%	100%	100%
Osun	Ede South KP OSS Osogbo	92%	95%	101%	101%	107%	58%	100%	100%
Nasarawa	CISHAN	0%	0%	0%	0%	0%	0%	0%	N/A
Nasarawa	Lafia KP OSS	0%	0%	0%	0%	0%	0%	0%	N/A
Nasarawa	Akwanga KP OSS	0%	0%	0%	0%	0%	0%	N/A	N/A
Nasarawa	Olive Right to Initiative ORHI	0%	0%	0%	0%	0%	0%	0%	100%
Gombe	OSS Gombe	103%	90%	80%	111%	97%	100%	129%	92%
Bayelsa	OSS	133%	300%	115%	143%	116%	170%	0%	0%
Ogun	Abeokuta KP OSS	100%	100%	100%	100%	100%	100%	100%	100%
Taraba	OSS	100%	100%	98%	100%	100%	101%	N/A	N/A
Kwara	SFH KP OSS	0%	0%	0%	0%	0%	0%	0%	0%

Table 13 Prevention Concurrent rate % between MSF & eNNRIMS DHIS2.0 BY SDPs

Prevention Concurrent rate % between MSF & eNNRIMS DHIS2.0 BY SDPs						
S/N	**States**	**SDP Name**	**MSM reached with prevention services**	**FSW reached out with prevention services**	**PWID reached with prevention services**	**TG reached with prevention services**
2	**Lagos**	Lagos Island OSS	0%	0%	0%	N/A
3	**Lagos**	Lagos Mainland OSS CPHI	100%	100%	100%	100%
4	**Lagos**	Mushin OSS	0%	0%	0%	N/A
5	**Adamawa**	Yola OSS	100%	100%	100%	N/A
6	**Borno**	Maiduguri KP OSS	100%	100%	100%	N/A
7	**Sokoto**	SOKOTO OSS	100%	100%	100%	N/A
8	**Cross River**	Bakassi OSS	100%	100%	100%	N/A
9	**Cross River**	Ikom OSS	100%	100%	100%	N/A
10	**Cross River**	Yakur OSS	100%	100%	100%	N/A
11	**Cross River**	Calabar Municipal OSS	100%	100%	100%	100%
12	**Ebonyi**	Ebonyi OSS	842%	127%	715%	0%
13	**Ebonyi**	Ebonyi OSS	842%	127%	715%	0%
14	**Ebonyi**	Ebonyi OSS	842%	127%	715%	0%
15	**Niger**	Minna OSS	107%	85%	97%	N/A

16	**NIGER**	SULEJA OSS	100%	100%	100%	N/A
17	**EKITI**	ADO EKITI KP OSS	104%	101%	123%	71%
18	**Bauchi**	Bauchi KP OSS and Misau KP OSS	188%	211%	179%	N/A
19	**Rivers**	The Initiative for Advancement of Humanity (IAH)	0%	N/A	N/A	N/A
20	**Rivers**	Center for Population Health Initiatives (CPHI)-DOD	0%	0%	0%	0%
21	**Rivers**	Obio Akpor OSS (Diadem	N/A	0%	0%	N/A
22	**Kogi**	Lokoja OSS	99%	100%	100%	100%
23	**Kogi**	Dekina OSS	100%	100%	100%	N/A
24	**Kogi**	Adavi KP OSS	100%	100%	100%	N/A
25	**Kano**	Kano KP OSS (Kano Badawa OSS)	300%	130%	338%	0%
26	**Imo**	IMO OSS	100%	100%	100%	100%
27	**Osun**	Ede South KP OSS Osogbo	100%	100%	100%	100%
28	**Nasarawa**	CISHAN	0%	0%	0%	N/A
29	**Nasarawa**	Lafia KP OSS	0%	0%	0%	N/A
30	**Nasarawa**	Akwanga KP OSS	0%	0%	0%	N/A
31	**Nasarawa**	Olive Right to Initiative ORHI	1833%	2474%	1442%	0%
32	**Gombe**	OSS Gombe	1163%	2837%	538%	0%
33	**Bayelsa**	OSS	79%	127%	101%	N/A
34	**Ogun**	Abeokuta KP OSS	100%	102%	118%	100%

35	**Taraba**	OSS	100%	100%	100%	100%
36	**Kwara**	SFH KP OSS	0%	0%	0%	0%

Table 14 Concurrent Rate for Treatment Indicators by SDPS

Concurrent Rate for Treatment Indicators by SDPS

States	SDP Name	Number of MSM currently on ART	Number of MSM virally suppressed	Number of FSW currently on ART	Number of FSW virally suppressed	Number of PWID currently on ART	Number of PWID virally suppressed	Number of TG currently on ART	Number of TG virally suppressed	Total Number of KPs currently on treatment (September)(EMR to NDR)	Total Number of KPs newly enrolled in clinical care(September)(EMR to NDR)
Lagos	Mushin OSS	98%	97%	96%	99%	97%	96%	100%	N/A	100%	283%
Lagos	Lagos Island OSS	0%	0%	0%	0%	0%	0%	N/A	N/A	100%	100%
Lagos	Lagos Mainland OSS CPHI	100%	98%	100%	100%	100%	99%	100%	97%	0%	0%
Adamawa	Yola OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	100%	100%
Borno	Maiduguri KP OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	116%	900%
SOKOTO	SOKOTO OSS	100%	100%	92%	100%	100%	100%	N/A	N/A	91%	103%
Cross River	Bakassi OSS	100%	89%	100%	97%	100%	98%	0%	0%	100%	33%
Cross River	Ikom OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	95%	41%
Cross River	Yakur OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	99%	45%
Cross River	Calabar Munipal OSS	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%

Ebonyi	Ebonyi OSS	100%	97%	100%	76%	100%	90%	100%	76%	103%	256%
Ebonyi	Ebonyi OSS	100%	97%	100%	76%	100%	90%	100%	76%	103%	256%
Ebonyi	Ebonyi OSS	100%	73%	100%	76%	100%	90%	100%	0%	100%	100%
Niger	Minna OSS	100%	100%	100%	100%	100%	100%	100%	100%	178%	89%
NIGER	SULEJA OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	250%	170%
EKITI	ADO EKITI KP OSS	99%	100%	100%	100%	95%	96%	93%	N/A	100%	100%
Bauchi	Bauchi KP OSS and Misau KP OSS	98%	98%	99%	99%	99%	99%	N/A	N/A	92%	99%
Rivers	The Initiative for Advancement of Humanity (IAH)	0%	0%	0%	0%	0%	0%	N/A	N/A	102%	86%
Rivers	Center for Population Health Initiatives (CphI)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Rivers	Diadem Consult	0%	0%	100%	0%	100%	0%	N/A	N/A	98%	100%
Kogi	Lokoja OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	99%	259%
Kogi	Dekina OSS	100%	98%	100%	100%	100%	100%	N/A	N/A	100%	100%
Kogi	Adavi KP OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	103%	319%
Kano	Kano KP OSS (Kano Badawa OSS)	100%	100%	100%	100%	100%	100%	N/A	N/A	117%	654%
IMO	IMO OSS	100%	100%	100%	100%	100%	100%	100%	N/A	100%	100%
Osun	Ede South KP OSS Osogbo	100%	100%	100%	100%	100%	100%	67%	N/A	100%	56%
Nasarawa	CISHAN	0%	0%	0%	0%	0%	0%	N/A	N/A	0%	0%
Nasarawa	Lafia KP OSS	0%	69%	0%	100%	0%	100%	N/A	N/A	100%	100%
Nasarawa	Akwanga KP OSS	100%	100%	100%	100%	100%	100%	N/A	N/A	100%	100%

Nasarawa	Olive Right to Initiative ORHI	0%	53%	0%	100%	0%	100%	0%	N/A	100%	100%
GOMBE	OSS Gombe	0%	94%	0%	97%	0%	74%	0%	50%	10%	165%
Bayelsa	OSS	100%	100%	100%	100%	100%	100%	100%	100%	99%	672%
Ogun	Abeokuta KP OSS	100%	100%	100%	100%	100%	100%	100%	N/A	100%	100%
Taraba State	OSS	100%	99%	100%	100%	63%	100%	N/A	N/A	3367%	102%
Kwara	SFH KP OSS	0%	0%	0%	0%	0%	0%	N/A	N/A	88%	174%