HIV NON-HEALTH SECTOR DATA QUALITY ASSESSMENT

TECHNICAL REPORT

December 2025

Acknowledgement

The 2025 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 second 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 Community Coordination Centres, formally 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. CCC – Community Coordinating Centres
21. SDP - Service Delivery Point
22. IP - Implementing Partner
23. NHS - Non-Health Sector
24. GB-V - Gender-Based Violence (likely)
25. C&S - Care and Support
26. TWG - Technical Working Group
27. CPHI - Center for Population Health Initiative
28. IAH - Initiative for Advancement of Humanity
29. EHWEI - Equitable Health for Women Empowerment Initiative
30. ORHI - Olive Right to Health Initiative

Executive Summary

Background

The National Joint Data Quality Assessment (NJDQA) focused exclusively on community intervention data was conducted in December 2025 by NACA 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 8 states (Anambra, Delta, Ebonyi, Gombe, Kwara, Lagos, Osun, and Rivers) 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 Community Coordination Centres, formally 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-

- Immediately 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 2025 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 coordinating the multi-sectoral response to HIV/AIDS programs in Nigeria. Community-based service data are generated by civil society organizations (CSOs) and other implementers of HIV/AIDS services using well-structured and standardized tools based on globally and nationally approved indicators. These tools are widely accepted by implementers of HIV/AIDS programs across treatment, prevention, care, and support components.

The standardized tools were reviewed and deployed by NACA to the 36+1 states of the federation with technical support from relevant stakeholders in the national HIV/AIDS response. Data generated using these tools are reported monthly on the electronic Nigeria National Response Information Management System (eNNRIMS–DHIS 2.0). The eNNRIMS–DHIS 2.0 platform is customized to collate Non-Health Sector (NHS) community-level aggregate data for national and global reporting.

The quality of data generated from HIV/AIDS programs is critical for effective decision-making and program performance. Accurate and reliable data inform planning, monitoring, and evaluation processes, making Data Quality Assessments (DQAs) an essential component of program management. However, challenges such as missing values, reporting bias, measurement errors, and human errors in data entry and computation continue to affect data quality, raising concerns about data reliability.

The National Joint Data Quality Assessment (NJDQA) is a critical exercise aimed at ensuring the accuracy, completeness, consistency, and reliability of HIV/AIDS program data in Nigeria. In recognition of the importance of effective monitoring and evaluation of HIV/AIDS response interventions, the NJDQA serves as a mechanism for identifying gaps in data collection, management, and reporting systems, while proposing actionable recommendations for improvement.

The 2025 NJDQA was conducted in December 2025, following adjustments necessitated by the United States Government (USG) Stop Work Order, which also resulted in the re-designation of One Stop Shops (OSSs) as Community Coordinating Centers (CCCs).

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 a key component of the HIV/AIDS Monitoring and Evaluation (M&E) framework. Initially launched in 2008, the NJDQA has undergone several refinements to align with global best practices for data verification and validation.

The assessment brings together key stakeholders, including NACA, the Federal Ministry of Health (FMoH), United Nations agencies, USG partners, civil society organizations, and relevant Ministries, Departments, and Agencies (MDAs), to review and strengthen the quality of HIV/AIDS data reported at national and sub-national levels.

Over the years, the NJDQA has contributed significantly to strengthening Nigeria's HIV/AIDS data management systems, improving data integrity, and supporting evidence-based decision-making. The 2025 NJDQA continued this tradition by focusing on community-based programs, with particular emphasis on data quality within Non-Health Sector (NHS) interventions, including HIV testing services, prevention programs, and care and support services for key populations.

1.1.3 Rationale for the 2025 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. Despite ongoing improvements, persistent data quality challenges, particularly within community intervention programs necessitate periodic assessments to identify gaps and implement corrective actions.

The 2025 NJDQA was conducted to:

- Strengthen the monitoring and evaluation (M&E) framework for HIV/AIDS programs.
- Improve confidence in data reported 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 challenges, the NJDQA contributes to improved program outcomes, more efficient resource allocation, and enhanced accountability within Nigeria's HIV/AIDS response.

1.1.4 Goal and Objectives

1.1.4.1 Goal of the 2025 NJDQA Exercise

The primary goal of the 2025 NJDQA was to enhance the quality of HIV/AIDS data used for program review, performance evaluation, planning, and decision-making at both national and sub-national levels.

1.1.4.2 Objectives of the 2025 NJDQA Exercise

The specific objectives of the assessment were to:

- Verify and validate reported data from January to June 2025.
- Assess the technical and infrastructural capacity of service delivery points (SDPs) in data management and reporting.

- 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), Community Coordinating Centers (CCCs), and Implementing Partners (IPs) at sub-national levels.
- Generate action points to address data quality and program management gaps identified during the assessment.
- Train sub-national M&E personnel on the DQA process, methodology, and best practices.

1.1.5 Scope of the 2025 NJDQA Exercise

The 2025 NJDQA focused exclusively on Community intervention HIV/AIDS programs, covering key indicators related to HIV testing, prevention, treatment, and care and support services for key populations (KPs). Eight (8) states were purposively selected based on the following criteria:

- Engagement in key population programming
- History of data quality challenges
- High attrition rates among M&E personnel

Selected states included Anambra, Delta, Osun, Lagos, Rivers, Ebonyi, Gombe, and Kwara. The assessment was conducted at Community Coordinating Centers (CCCs) and Community-Based Organizations (CBOs) across the selected states.

CHAPTER TWO

2.0 METHODOLOGY

2.1 2025 NJDQA Processes

The **2025 National Joint Data Quality Assessment (NJDQA)** adopted a structured and systematic approach to assess the **accuracy, completeness, consistency, and timeliness** of HIV/AIDS program data reported from community-based interventions. The assessment, conducted in December 2025**,** utilized the following core methodological components:

- Stakeholder engagement
- State and site selection
- Data verification and validation
- Capacity building and on-the-spot technical support

2.1.1 Stakeholder Engagement

At the national level, a one-day stakeholder engagement meeting was convened prior to the commencement of the field assessment. The meeting brought together key stakeholders involved in the national HIV/AIDS response to:

- Present and review the NJDQA concept note
- Constitute a technical committee to provide oversight and guidance for the assessment
- Define the scope, methodology, and modalities for the NJDQA exercise

This engagement ensured stakeholder buy-in, alignment with national M&E priorities, and a shared understanding of roles and responsibilities throughout the assessment process.

2.1.2 State and Site Selection

Eight (8) 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 CCCs and CBOs were selected in each state.

List of States selected for the NJDQA

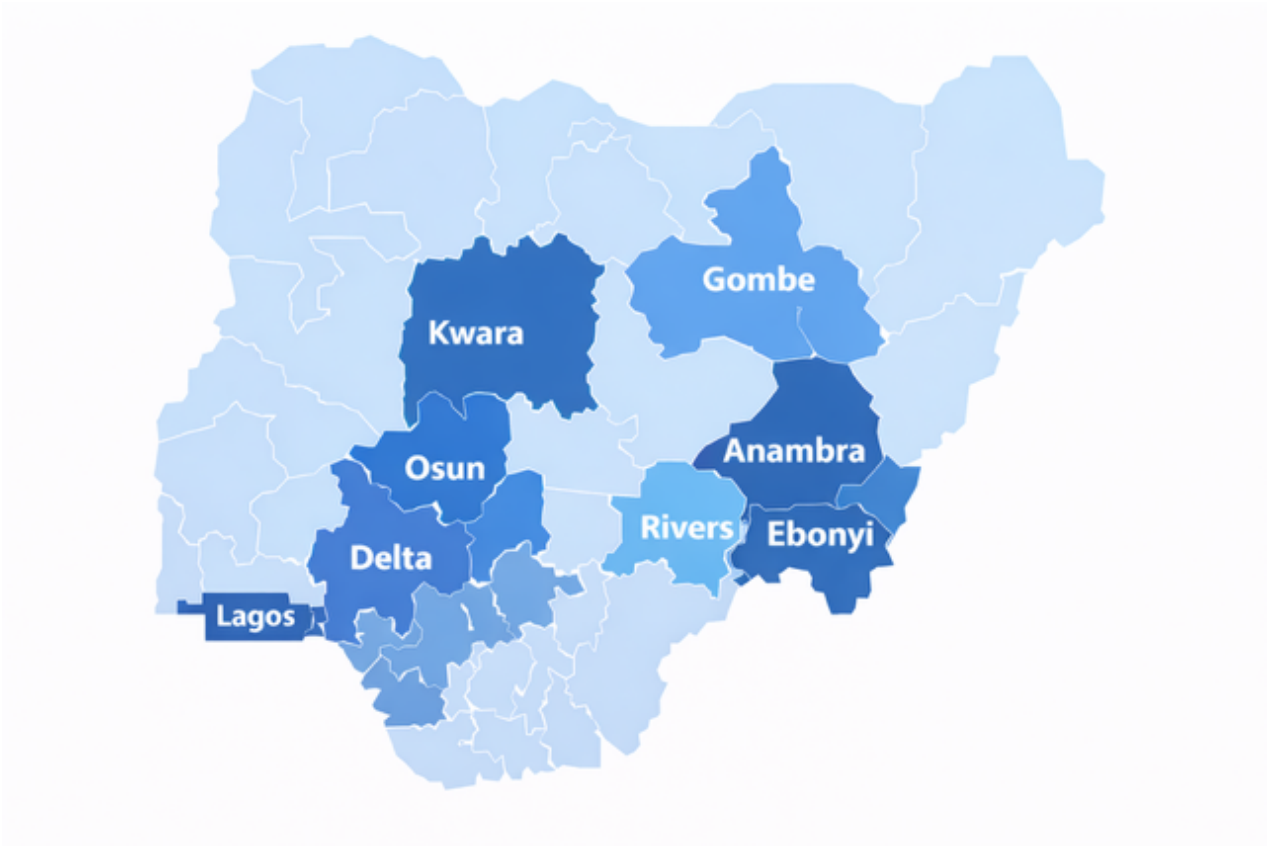

Table 1 List of States selected for the NJDQA

S/N	GEO POLITICAL ZONES	STATES
1	North Central	Kwara
2	North East	Gombe
4	South East	Anambra, and Ebonyi
5	South South	Delta, and Rivers
6	South West	Lagos, 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
PrEP INDICATORS		
No of individuals who received PrEP at least once in the reporting month	Compare MSF/EMR	Compare EMR/NDR
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 2025 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 CCCs 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

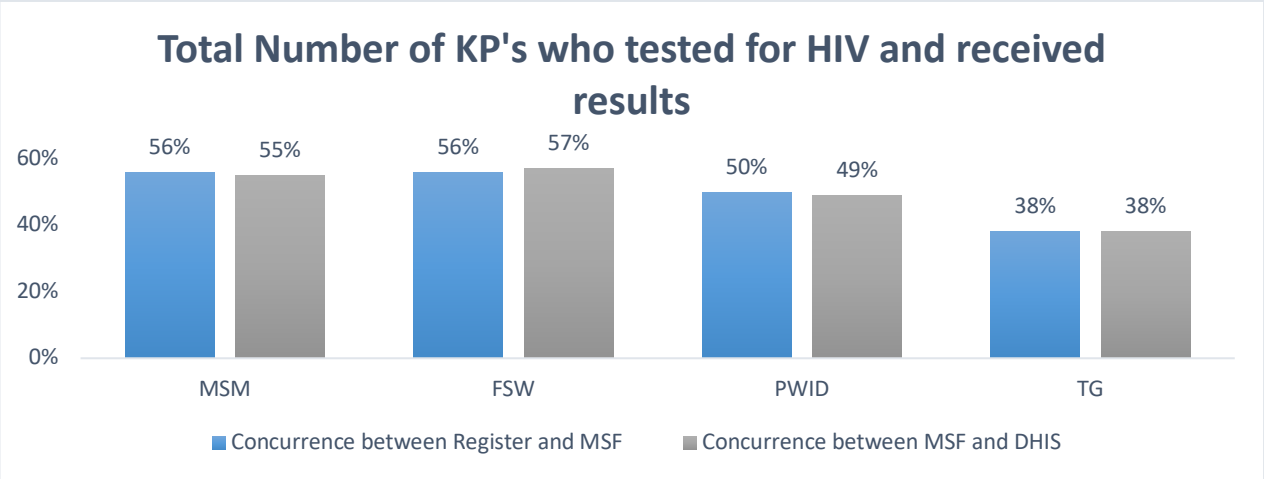

Figure 1 Concurrent rate for KP HTS Data by Typology

Figure 1 shows the concurrence of reported data on Key Populations reached with prevention across reporting levels from registers to Monthly Summary Forms (MSFs) and from MSFs to DHIS from the data quality assessment (DQA), which was conducted in 8 states, assessing 16 Service Delivery Points (SDPs)

Of the 16 SDPs assessed, 9 reported data for MSM, 9 for FSW, 8 reported for PWID, and 6 for TG. The concurrence analysis was therefore conducted based on the SDPs that reported data for each key population group.

The findings show low levels of data concurrence across the reporting cascade, indicating inconsistencies between source registers, MSFs, and DHIS.

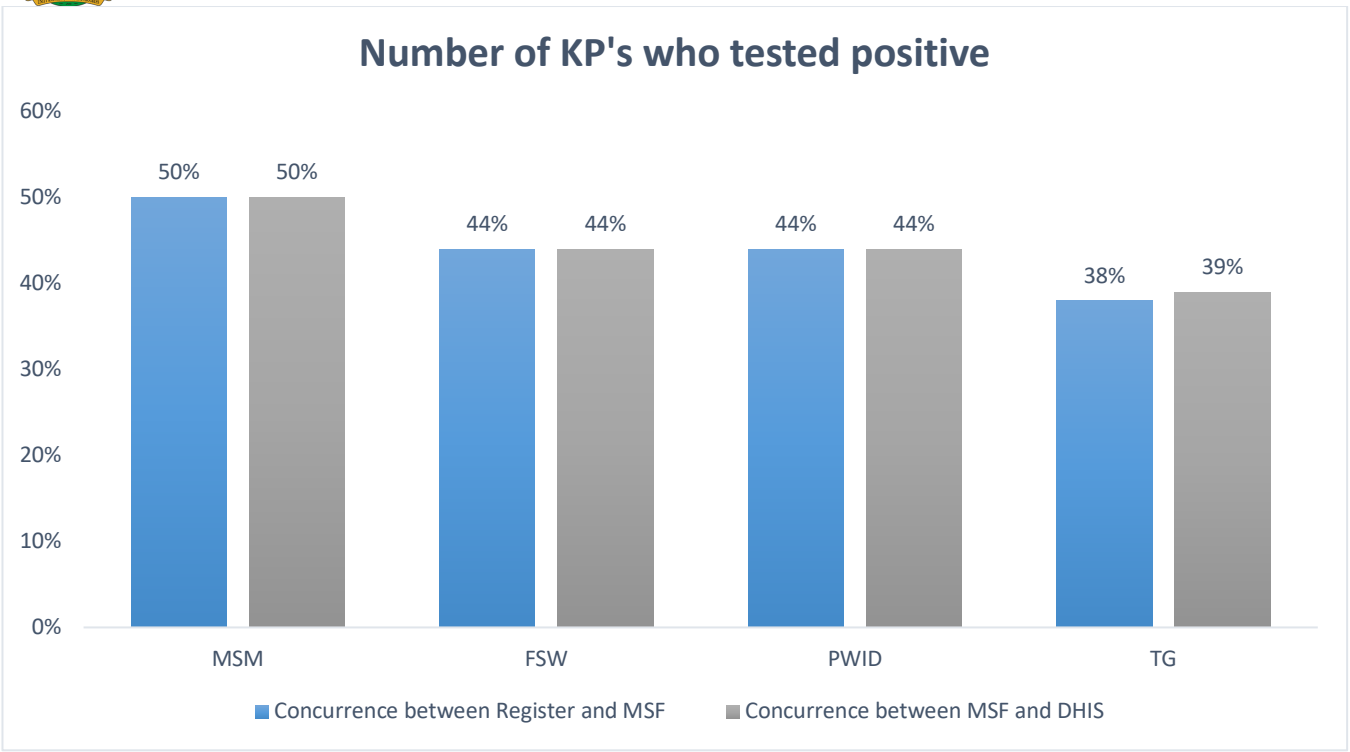

Figure 3 Concurrent Rate for KPs Tested Positive by Typology

Figure 2 shows the concurrence of reported data on Key Populations reached with prevention across reporting levels from registers to Monthly Summary Forms (MSFs) and from MSFs to DHIS from the data quality assessment (DQA), which was conducted in 8 states, assessing 16 Service Delivery Points (SDPs)

Of the 16 SDPs assessed, 8 reported data for MSM, 7 for FSW, 7 reported for PWID, and 6 for TG. The concurrence analysis was therefore conducted based on the SDPs that reported data for each key population group.

The findings show low levels of data concurrence across the reporting cascade, indicating inconsistencies between source registers, MSFs, and DHIS.

3.1.2 Prevention Indicators

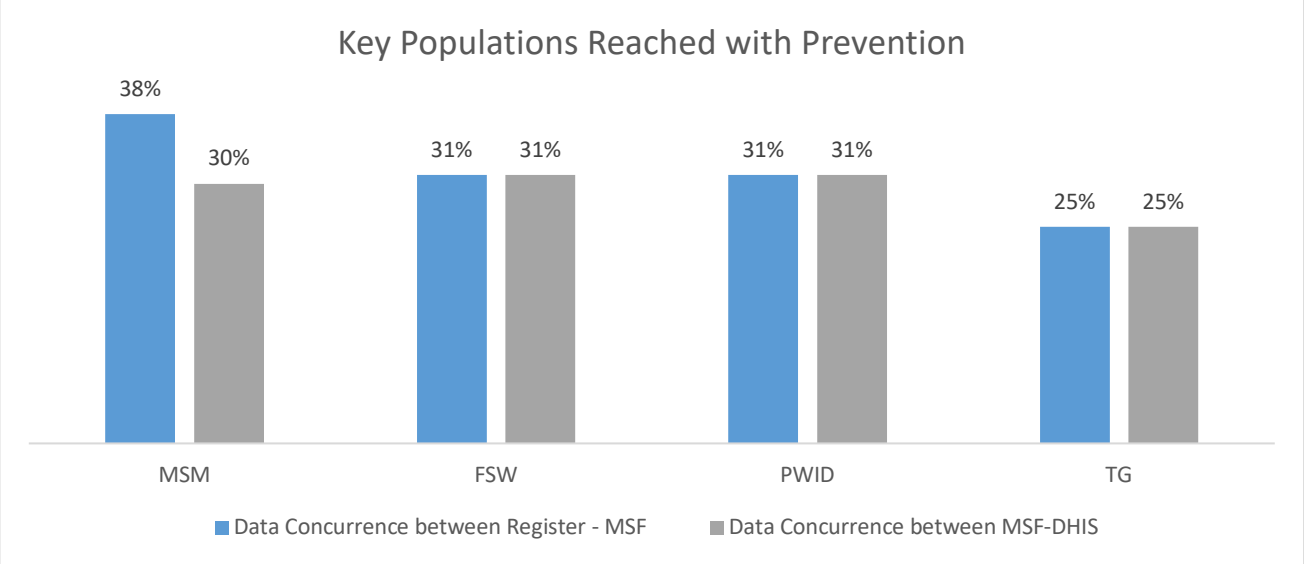

Figure 3 Concurrent Rate for KPs reached with Prevention Services

Fig 3 shows the concurrence of reported data on Key Populations reached with prevention across reporting levels from registers to Monthly Summary Forms (MSFs) and from MSFs to DHIS from the data quality assessment (DQA) which was conducted in 8 states, assessing 16 Service Delivery Points (SDPs)

Of the 16 SDPs assessed, 6 reported data for MSM, 5 for FSW and PWID, and 4 for TG. The concurrence analysis was therefore conducted based on the SDPs that reported data for each key population group.

The findings show low levels of data concurrence across the reporting cascade, indicating inconsistencies between source registers, MSFs, and DHIS.

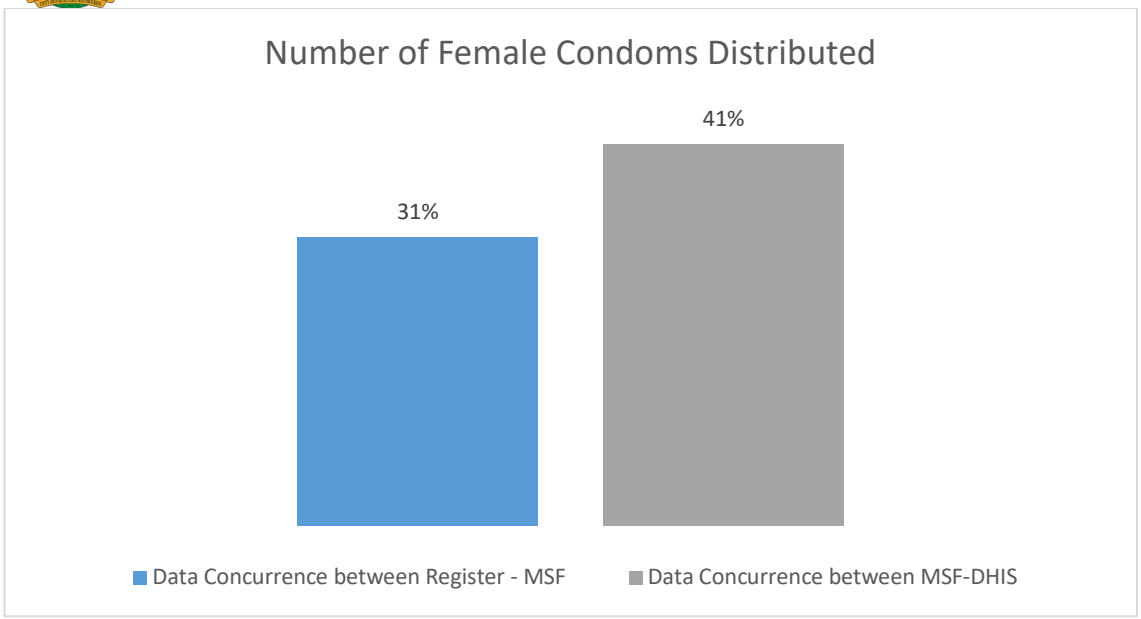

Figure 4 Concurrent Rate for KP Female Condoms Distributed

Fig 4 Shows Data concurrence on number of female condoms distributed across reporting levels across. The exercise compared data reported from registers to the Monthly Summary Forms (MSFs) and from the MSFs to the DHIS from registers to Monthly Summary Forms (MSFs) and from MSFs to DHIS from the data quality assessment (DQA) which was conducted in 8 states, assessing 16 Service Delivery Points (SDPs)

Out of the 16 SDPs assessed, 6 reported data for MSM, 5 for FSW and PWID, and 4 for TG. The analysis was therefore based on the SDPs that reported data for these key population groups.

The results show that 31% of the data matched between the registers and the MSFs, while 41% matched between the MSFs and the DHIS.

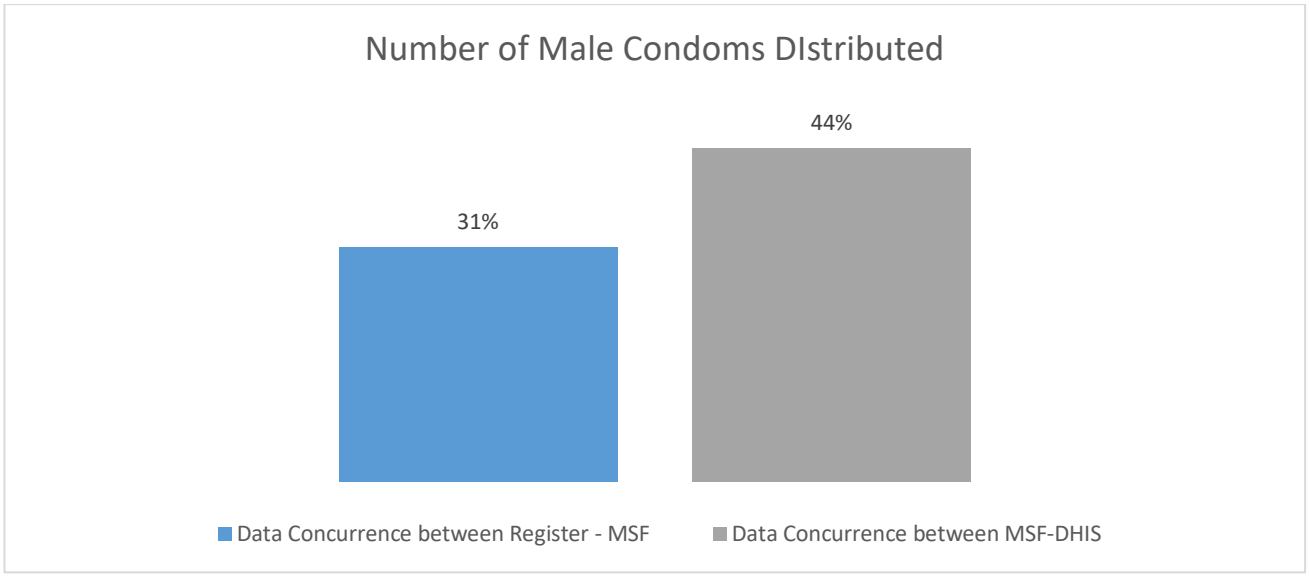

Figure 5 Concurrent Rate for KP Male Condoms Distributed

Fig 5 Shows A data quality assessment was conducted in 8 states, where 16 Service Delivery Points (SDPs) were reviewed to assess the accuracy of data on the number of male condoms distributed across reporting tools. The exercise compared data reported from registers to the Monthly Summary Forms (MSFs) and from the MSFs to the DHIS.

Out of the 16 SDPs assessed, 6 reported data for MSM, 5 for FSW and PWID, and 4 for TG. The analysis was therefore based on the SDPs that reported data for these key population groups.

The findings show that data consistency between the registers and the MSFs was 31%, while data consistency between the MSFs and the DHIS was 44%. This indicates that there are differences in the data reported across the different reporting tools, suggesting possible gaps in data recording, aggregation, and reporting.

3.1.2 PrEP Indicator

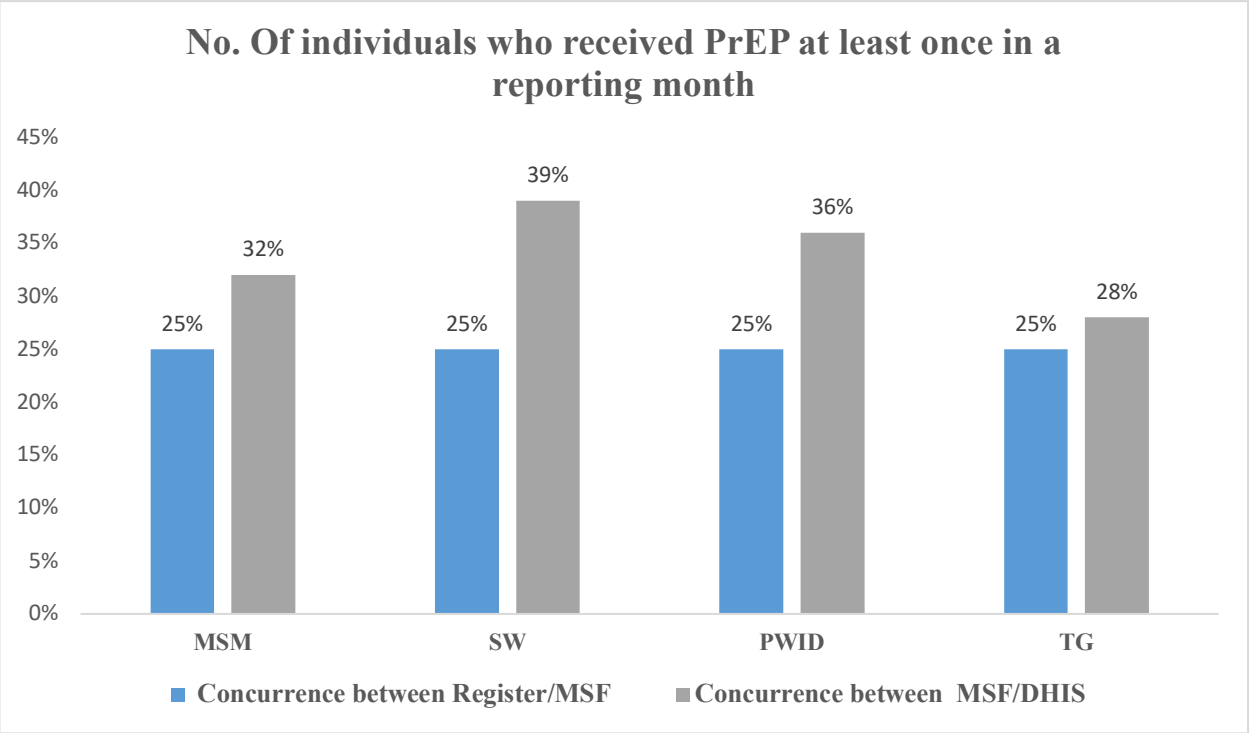

Figure 6 CONCURRENT RATE BETWEEN EMR AND NDR FOR KPs (TREATMENT INDICATORS)

Figure 6 shows concurrence of reported data between Register and MSF for individuals who received PrEP at least once in the reporting month. 25% across all KP groups (MSM, SW, PWID, TG) received, indicating low alignment between source documents and MSF records. Concurrence between MSF and DHIS is relatively higher but still inadequate, ranging from 28% to 39% across KP groups. Of the 16 SDPs assessed, 4 reported for MSM, 5 for FSW, PWID and TG. The

concurrence analysis was therefore conducted based on the SDPs and the reported data for each key population group.

Sex Workers (SW) recorded the highest concurrence (39%), followed by PWID (36%) and MSM (32%), while Transgender (TG) had the lowest concurrence (28%).

In summary, the findings suggest data inconsistencies across reporting tools, highlighting the need to strengthen data documentation, validation, and synchronization between Registers, MSF, and DHIS.

3.2 Data availability by the thematic areas

3.2.1 HTS data availability

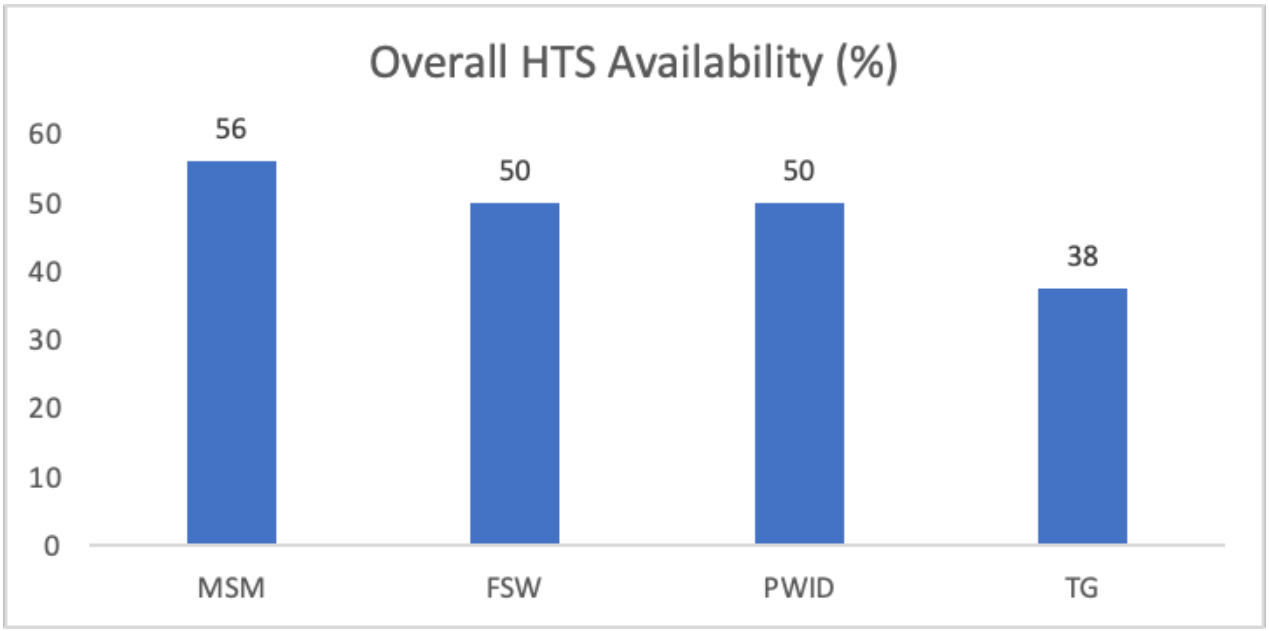

Figure 12 HTS Data Availability

Figure 12 The chart presents the availability of HIV Testing Services (HTS) data across 16 assessed sites for key populations. HTS reporting was highest among men who have sex with men (MSM), with 56% availability; data were reported from 9 sites, while 7 sites did not report. Female sex workers (FSW) and people who inject drugs (PWID) each had 50% availability, with 8 sites reporting and 8 sites not reporting for both groups. Transgender persons (TG) had the lowest data availability at 38%, with only 6 sites reporting and 10 sites not reporting. The sites that did not report HTS data were located in Lagos, Delta, Osun, and Rivers states.

3.2.2 Prevention data availability

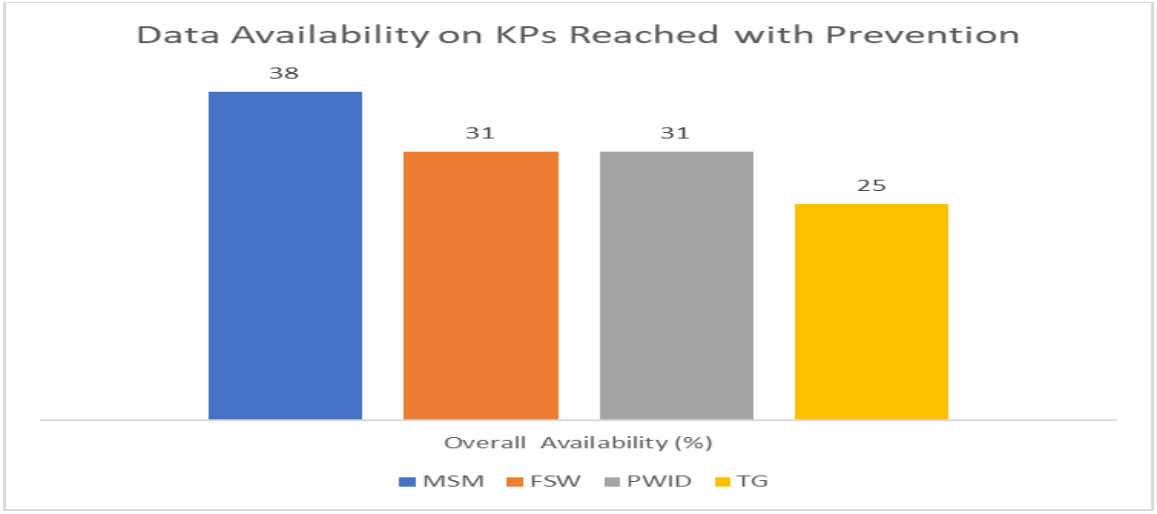

Figure 13 Prevention Data Availability

Figure 13 above shows that a total of 16 Service Delivery Points (SDPs) were assessed on the availability and reporting of data for key population groups. Of the 16 SDPS assessed, 6 reported data on MSM, 5 on FSW, 4 on PWID, and 4 on TG.

The findings highlight challenges in the documentation and reporting of services for these populations across the facilities assessed. These gaps indicate the need to strengthen KP-sensitive service delivery approaches, improve data collection and reporting tools, and build the capacity of SDPs to consistently capture and report information for all key population groups. Strengthening facility-level data management and reporting systems will help ensure that the needs and service outcomes of all KP groups are accurately reflected in program data and inform strategic planning and interventions.

3.2.3 PrEP data availability

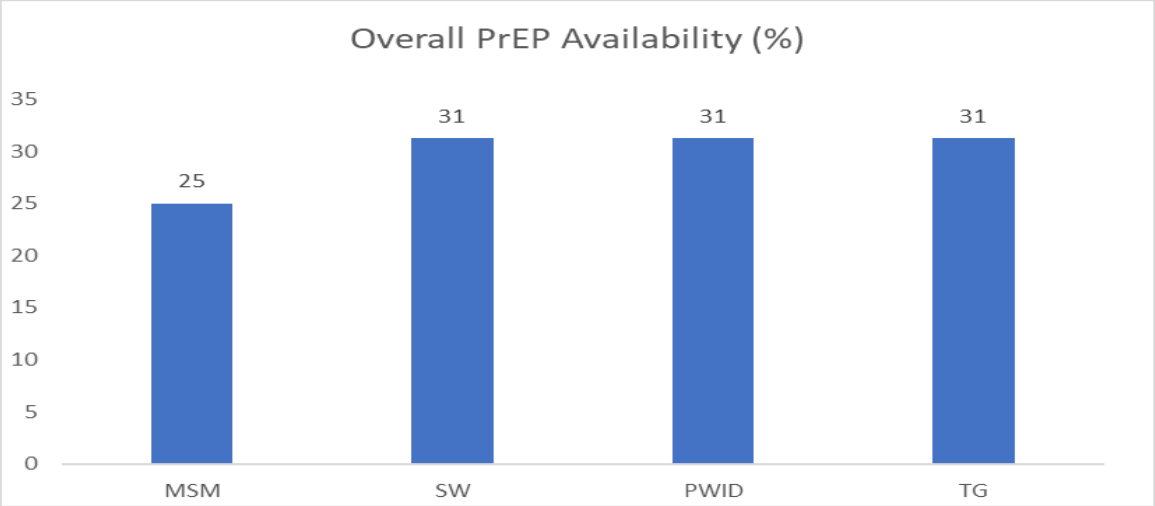

Figure 14 PrEP Data Availability

Figure 14 summarizes the availability of PrEP data across all 16 site.PrEP data is highest among Sex Workers (SW), People Who Inject Drugs (PWID), and Transgender persons (TG), each at 31%. However, Men who have Sex with Men (MSM) have comparatively lower availability at 25%, indicating a potential gap in PrEP service coverage for this population that may require targeted program interventions. Data were reported from 5 sites, while 11 sites did not report. sex workers (SW), Transgender (TG) and people who inject drugs (PWID) each had 31% availability, with 5 sites reporting and 11 sites not reporting for the three (3) groups. Men who Sleep with Men (MSM) had the lowest data availability at 25%, with only 4 sites reporting and 12 sites not reporting. The sites that did not report PrEP data were located in Lagos, Delta, Osun, and Rivers states.

3.2.4 eNNRIMS-DHIS data availability

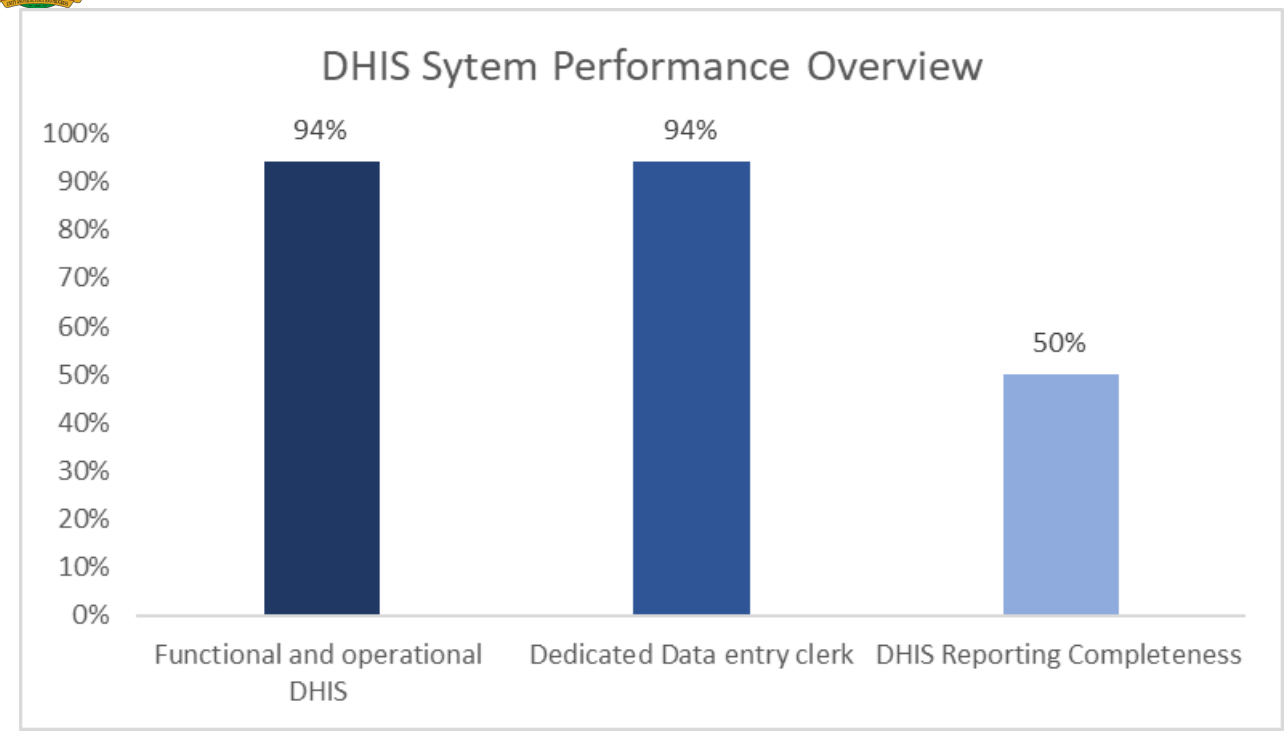

Figure 15 eNNRIMS DHIS 2.0 Data Availability

Figure 15 summarizes the availability of eNNRIMS DHIS2.0 across 16 sites:

- A functional and operational DHIS is available at 94% of sites, indicating that most sites have the system in place.
- A dedicated Data Entry Clerk is present at 94% of sites, supporting efficient data management.
- DHIS reporting completeness has been achieved at 50% of sites.

These findings show that while most sites have functional systems and dedicated personnel, reporting completeness remains low, which may impact the overall quality and reliability of the data.

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	100%	0%	No Issue	0
The service delivery unit has an assigned staff with responsibility for data documentation	100%	0%	No Issue	0
Staff responsible for reviewing periodic reports before submission to the next level	100%	0%	No Issue	0
Process in place to ensure data compilation and reporting is completed if the responsible staff is not available.	100%	0%	No Issue	0
SDPs receive regular feedback on the quality of their submitted reports according to the guidelines	100%	0%	No Issue	0
SDPs receive regular supportive supervisory visits from either State, LGA or National level staff according to the guidelines.	88%	13%	Ebonyi/Delta	2
…If yes, was the last visit within the past three months.	44%	44%	Lagos,Anambra,Osun, Rivers	7

Interpretation

1. The majority of staff have received training on data management.
2. All service delivery units have designated personnel for data documentation
3. All SDPs ensure reports are reviewed before submission, except one in Kogi state
4. A backup process exists for all SDPs to ensure data compilation and reporting during staff absence.
5. All SDPs receive regular feedback on report quality.
6. Supervision is consistent across most SDPs, reinforcing compliance and quality assurance except Ebonyi and Delta.
7. Most SDPs have received recent visits, except for sites in Lagos,Anambra, Osun and Rivers, 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	100%	0%	No Issue	0

SDPs have a copy of written guidelines provided by the National Program/M&E Unit on reporting requirements and deadlines	100%	0%	No Issue	0

Interpretation

1. All 16 SDPs have an up-to-date guidance on indicator definitions,
2. All 16 SDPs have a copy of the written guidelines provided by the National Program/M&E Unit on reporting requirements and deadlines

Table 7 Data-collection and Reporting Forms and Tools

Data-collection and Reporting Forms and Tools	YES	NO	States with issues on the M&E system assessment	No of sites
SDPs consistently making use of the National Program standard reporting forms/tools at all reporting service delivery points	31%	69%	Ebonyi, Gombe, Kwara. Anambra, Osun, Rivers, Delta	11
Clear instruction on how to complete the data collection and reporting forms/tools provided by the National Program/Project.	88%	12%	Anambra, Osun	2
Sufficient stocks of blank data collection and reporting forms at the service site	56%	44%	Ebonyi, Anambra, Osun, Rivers	7

Interpretation

1. A significant proportion of SDPs (about 69%) do not consistently use standard national reporting tools, particularly in Ebonyi, Osun, Rivers, Delta, Anambra, Gombe, and Kwara
2. Anambra and Osun do not have clear instructions on how to complete the data collection and reporting forms/tools provided by the National program.
3. About 44% of the SDPs 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%		0
SDPs maintains an adequate archive of program documents (i.e. clean, dry, with sufficient space, shelves, filing system etc.)	96%	6%	River State	1

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 except Rivers that has issues with one site.

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	88%	13%	Lagos, Osun	2
Analysed data/results presented/disseminated to other information system stakeholders promptly.	88%	13%	Osun	2

Interpretation

1. Most SDPs visibly display service charts/tables except for 2 SDPs in Lagos and Osun.
2. Timely data dissemination is mostly achieved, but Osun 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, accuracy, and validity of data, staff capacity and efficiency, timely access to the national community tools 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.

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, with an average concurrent rate of 47% between the register-to-monthly summary forms and the monthly summary forms-to-DHIS.
- Data inconsistencies suggest that reporting and disaggregation processes introduce errors during transmission to the monthly summary forms and the eNNRIMS 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 31% concurrence (Register to MSF) to 29% (MSF to eNNRIMS DHIS2.0) reveals data quality issues, which may lead to prevention gaps.
- The data accuracy decline could be attributed to the non-use of national tools or non-availability of the national community tools.
- Despite the revision of the community tools in 2022 by NACA and distribution to all the 36+1 states, non-adherence to the standardized community tools undermines efforts to monitor and measure program impact.
- Inconsistent data may **divert resources away from high-risk groups**, misaligning and perpetuating HIV transmission

4.1.3 PrEP Indicators

- The summary of the findings revealed an average of 33.75% data transmission errors for PrEP 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) at 25%, the errors from the summary form to the eNNRIMS-DHIS were more prevalent.
- The restriction in USG funding during the review period limited PrEP provision to pregnant women, breastfeeding mothers, and survivors of assault, which affected PrEP reporting.

Due to unreliable PrEP data, program faced some challenges :

- Reduced access for the general population. This likely contributed to decreased PrEP uptake and coverage, increased vulnerability to HIV infection among other most at-risk populations.
- Inaccurate or incomplete data makes it difficult to determine whether PrEP targets are being achieved.

4.2 Key recommendations based on the 2025 NJDQA findings:

1. **Standardize Data Collection Tools**
    - Provision of national tools at a timely rate, either by the National or State.
    - Enforce mandatory use of approved national community tools across all states and service delivery points (SDP) 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.
    - Enhance real-time data synchronization where possible.
3. **Targeted Training for M&E Staff**
    - Conduct regular refresher training on data management, focusing on states with high error rates (Lagos, Rivers, Osun, and Delta).
    - Prioritize hands-on eNNRIMS DHIS2.0 training for data clerks and supervisors.
4. **Improve Data Quality Processes**
    - Strengthen routine data quality audits at the state and SDP.
    - Strengthen routine data quality through DQA, on-site visit, data verification, and mentoring visit.
5. **Address Resource Gaps**
    - Ensure consistent supply of reporting tools and job aids to all SDPs.
    - Provide devices (tablets/laptops) for digital data entry in remote areas.
    - Need for Alternative Funding or Program Adjustments through exploration of alternative funding sources, partnerships, or resource reallocation to restore PrEP access to the general population.
6. **Enhance Feedback Mechanisms**
    - Implement monthly performance feedback loops from the National to the State as well as SDPs.
    - Share DQA findings with implementing partners for corrective action.
7. **Strengthen KP-Specific Reporting**
    - Support States in conducting continuous data abstractions of KP specific data.
8. **Institutionalize Data Use Culture**
    - Mandate regular data review meetings at SDP 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 Lagos, Osun, Rivers and Delta and other states where system gaps persist.

4.3 Summary of SDP specific Key Findings and Recommendations

Table 10 Summary of SDP specific Key Findings and Recommendations

S/N	State	SDP	Key Findings	Recommendations
1	**Anambra**	OSS AHNi	• Strong engagement with KP networks. • Inconsistent documentation across CBOs. • Some staff need refresher training on national tools. • Coordination with OSS functional but not standardized.	• Conduct refresher training on national KP tools and indicators. • Standardize documentation across sites. • Introduce monthly internal DQAs. • Strengthen commodity documentation and supervision.

				• ANSACA and AHNi to conduct routine supervision.
2	**Delta**	OSS Oshimili South; Ika South OSS	• National KP tools are not in use due to the USG stop-work order. • eNNRIMS DHIS reporting disrupted; no typology disaggregation. • Most KP services suspended; only ART refills ongoing. • KP clients are reluctant to use referral facilities due to stigma. • CBOs were identified, but service continuity was affected by funding gaps. • Capacity gaps in eNNRIMS reporting and national tools.	• SACA to advocate for restoration of KP services. • Train staff on national tools and eNNRIMS reporting. • Strengthen coordination among SACA, IPs, and CBOs. • Implement stigma-reduction interventions at referral facilities. • Improve data validation and supervision.
3	**Ebonyi**	Ebonyi OSS (ECEWS)	• National eNNRIMS community tools not in use. • Under-reporting of HTS data by KP typology. • CBOs lack access to eNNRIMS DHIS. • Registers not summarized monthly.	• Strengthen state data governance and oversight. • Ensure availability of national reporting tools. • Conduct refresher training on eNNRIMS tools. • Harmonize AGYW reporting pathways.

			• Weak oversight from SACA.	• Register CBOs on DHIS organizational units.
4	**Gombe**	OSS	• Errors in HTS MSF data summation (Jan, Mar, May). • Under-reporting for FSW, PWID, TG; over-reporting for MSM. • Similar discrepancies were observed in prevention data.	• Correct MSF records to reflect accurate data on eNNRIMS DHIS. • Strengthen routine data validation.
5	**Kwara**	Kwara OSS	• SFH registers are used instead of national tools. • High reporting rate on DHIS. Data is consistent between registers and MSF but inconsistent with DHIS. • No GBV data reported across typologies. • Functional M&E system with trained staff.	• Ensure immediate adoption of national tools. • Conduct data audit to resolve discrepancies. • Implement standardized data cleaning protocols. • Provide refresher training on eNNRIMS DHIS reporting. • Strengthen routine data quality assurance.

6	**Lagos**	Mushin CSCC; Isolo CSCC; CPHI	• eNNRIMS DHIS is not used due to the US stop-work order. KP data not disaggregated by typology. • Prevention tools not in use. OSS sites functions mainly as coordination centers. • No psychosocial support or GBV interventions.	• Provide DHIS access rights to LIPs. • Address reporting disruptions from the stop-work order. • Strengthen monitoring and oversight by LSACA. • Improve follow-up on data discrepancies.
7	**Osun**	CSCC; CHGHI; A-AIHD; COSWOHI	• eNNRIMS DHIS is not used due to stop-work order. • KP data not disaggregated by typology. • Prevention registers not in use. • Limited DHIS access for HTS reporting. • CSCC mainly functions as a coordination center.	• Provide DHIS access to implementing partners. • Address reporting disruptions due to stop-work order. • Strengthen monitoring by OSACA. • Improve documentation and reporting practices.
8	**Rivers**	CPHI; Initiative for Advancement for Humanity; Diadem Consult	• National community HTS and prevention tools are not in use. • Reporting by typology stopped Feb–Jun 2026. • Weak oversight from SACA. • M&E capacity gaps among staff. • Data records domiciled with Diadem; limited verification.	• Strengthen state data governance and oversight. • Ensure the availability of national tools. • Conduct refresher training on eNNRIMS reporting. • Improve documentation and verification of partner data.

4.4 State and SDPs Visited

Table 11 State and SDPs visited

N/S	STATES	SDP
1	Anambra	• OSS AHNi
2	Delta	• OSS Oshimili South • Ika South OSS
3	Ebonyi	• Ebonyi OSS (ECEWS)
4	Gombe	• OSS
5	Kwara	• Kwara OSS
6	Lagos	• Mushin CSCC • Isolo CSCC • Centre for Population Health Initiatives (CPHI)
7	Osun	• Community Service Coordination Centre • CHGHI • A-AIHD • COSWOHI
8	Rivers	• Centre for Population Health Initiative • Initiative for Advancement for Humanity • Diaden Consult

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								
State	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	Mushin CSCC	100%	100%	100%	0%	0%	0%	0%	0%
Lagos	Isolo CSCC	100%	0%	100%	0%	100%	0%	100%	100%
Lagos	Centre for Population Health Initiatives (CPHI)	0%	0%	0%	0%	0%	0%	0%	0%
Ebonyi	Ebonyi OSS (ECEWS)	105%	107%	104%	100%	107%	108%	109%	100%
DELTA	OSS Oshimili South	0%	0%	0%	0%	0%	0%	0%	0%
Delta	Ika South OSS	0%	0%	0%	0%	0%	0%	0%	0%

Anambra	OSS AHNi	86%	100%	95%	101%	82%	100%	102%	120%
Kwara	Kwara OSS	100%	100%	100%	100%	100%	93%	100%	100%
Osun	Community Service Coordination Centre	0%	0%	0%	0%	0%	0%	0%	0%
Osun	CHGHI	0%	0%	0%	0%	100%	100%	0%	0%
Osun	A-AIHD	100%	100%	0%	0%	0%	0%	100%	100%
Osun	COSWOHI	0%	0%	100%	100%	0%	0%	0%	0%
Rivers	Centre For Population Health Initiative	100%	100%	100%	100%	100%	100%	0%	0%
Rivers	Initiative for Advancement for Humanity	100%	100%	0%	0%	0%	0%	0%	0%
Rivers	Diaden Consult	0%	0%	100%	100%	100%	100%	0%	0%
Gombe	OSS	95%	100%	111%	100%	101%	100%	100%	100%

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

HTS Concurrent rate % between MSF & eNNRIMS DHIS2.0 BY SDPS					
State	**SDP Name**	**MSM reached with prevention services**	**FSW reached with prevention services**	**PWID reached with prevention services**	**TG reached with prevention services**
Lagos	Mushin CSCC	0%	0%	0%	0%
Lagos	Isolo CSCC	0%	0%	0%	0%
Lagos	Centre for Population Health Initiatives (CPHI)	0%	0%	0%	0%
Ebonyi	Ebonyi OSS (ECEWS)	100%	100%	100%	100%
DELTA	OSS Oshimili South	0%	0%	0%	0%
Delta	Ika South OSS	0%	0%	0%	0%
Anambra	OSS AHNi	84%	93%	98%	105%
Kwara	Kwara OSS	100%	100%	100%	100%
Osun	Community Service Coordination Centre	0%	0%	0%	0%

Osun	CHGHI	0%	0%	0%	0%
Osun	A-AIHD	0%	0%	0%	0%
Osun	COSWOHI	0%	0%	0%	0%
Rivers	Centre For Population Health Initiative	100%	100%	100%	0%
Rivers	Initiative for Advancement for Humanity	0%	0%	0%	0%
Rivers	Diaden Consult	0%	0%	0%	0%
Gombe	OSS	95%	100%	101%	101%

Table 14 Concurrent Rate for PrEP Indicators by SDPS

PrEP Concurrent rate % between MSF & eNNRIMS DHIS2.0 BY SDPS					
State	**SDP Name**	**No of MSM who received PrEP**	**No of SW who received PrEP**	**No of PWID who received PrEP**	**No of TG who received PrEP**
Lagos	Mushin CSCC	0%	0%	0%	0%
Lagos	Isolo CSCC	0%	0%	0%	0%
Lagos	Centre for Population Health Initiatives (CPHI)	0%	0%	0%	0%
Ebonyi	Ebonyi OSS (ECEWS)	100%	100%	100%	100%
DELTA	OSS Oshimili South	0%	0%	0%	0%
Delta	Ika South OSS	0%	0%	0%	0%
Anambra	OSS AHNi	257%	264%	288%	186%
Kwara	Kwara OSS	115%	236%	118%	109%
Osun	Community Service Coordination Centre	0%	0%	0%	0%
Osun	CHGHI	0%	0%	0%	0%
Osun	A-AIHD	0%	0%	0%	0%
Osun	COSWOHI	0%	0%	0%	0%
Rivers	Centre For Population Health Initiative	0%	0%	0%	0%
Rivers	Initiative for Advancement for Humanity	0%	0%	0%	0%
Rivers	Diaden Consult	0%	0%	0%	0%
Gombe	OSS	41%	31%	78%	47%