

Monitoring and Evaluation

Standard Operating Procedures (SOP)



The ACTION Project

May 2005

Abbreviations

ACTION	AIDS Care and Treatment in Nigeria
ARV	Antiretroviral
CDC	Centers for Disease Control and Prevention
GHAIN	Global HIV/AIDS Initiative in Nigeria
IHV-N	Institute of Human Virology-Nigeria
IHV-UMD	Institute of Human Virology-University of Maryland
FHI	Family Health International
GON	Government of Nigeria
M&E	Monitoring and Evaluation
NACA	National Action Committee on AIDS
NASCP	National AIDS STD Control Program
PEPFAR	President's Emergency Plan for AIDS Relief
PMM	Patient Management and Monitoring
PME	Programme Monitoring and Evaluation
PMTCT	Prevention of mother-to-child transmission
POS	Point of service
OI	Opportunistic infections
STI	Sexually-transmitted infections
TB	Tuberculosis

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1. Introduction

This document is the standard operation procedures (SOP) for the AIDS Care and Treatment in Nigeria (ACTION) project. It describes the overall purpose and processes of monitoring and evaluation (M&E) in the context of providing treatment, care, and management of HIV/AIDS at health facilities in Nigeria. They guide M&E officers in providing qualitative and efficient service in HIV-treatment centers and in evaluating performance, thereby serving as a quality assurance tool for management. SOPs are intended for M&E Focal persons, M&E officers, Health facility managers, and Quality assurance staff.

1.1. Objectives of the SOPs for M&E

The primary objective of the SOPs for M&E is to provide information on procedures for safe, efficient and qualitative overall service for improved patient's management and monitoring (PMM) as well as programme monitoring and evaluation (PME).

Specific objectives are to:

- Provide M&E staff with operational information for effective monitoring
- Ensure that M&E procedures are performed consistently to maintain quality
- Ensure that procedures comply with health facility standards and national guidelines
- Serve as training documents for new M&E staff and to build capacity for existing staff
- Serve as a quality assurance tool for management to evaluate service delivery, impact of interventions and reinforce performance in accordance with health facility standards and national guidelines

1.2. Roles and responsibilities of ACTION M&E

The M&E unit within the facility is headed by a Focal person and assisted by an M&E officer. One full-time data entry personnel and two part-time data entry personnel are also employed as part of the M&E team.

The functions of the M&E unit generally are to:

1. Strengthen the Monitoring and Evaluation systems and plans for IHVN program at the site.
2. Ensure the Confidentiality and security of the PMM forms.
3. Monitor the data flow of PMM forms from Program Enrollment, Initial Clinic Evaluation, Follow-up Clinic Evaluation, Laboratory Order and Result, Pharmacy Order and Medication Adherence Assessment.
4. Ensure accurate recording of patient data and timely submission of reports to the IHVN Office through the project coordinator.

1.3. Roles and responsibilities of M&E staff:

Responsibilities	Activities	Responsible persons
Ensure enough supply of forms	Request for PMM forms from PMM officer at GHAIN when achieving a 50% stock-out	M&E officer
Ensure security of PMM forms	Securely lock PMM forms in cabinet	M&E Officer
Provide PMM forms to clinics	Collect PMM forms from M&E office and deliver to clinics on regular days	M&E officer
Retrieve PMM forms from service units	Retrieve clinical forms from the various clinics (adult ARV, pediatrics, PMTCT) to M&E office for data entry and storage. Ensure lab forms are returned by <u>Day 2</u> (two days after the clinic day) to M&E and client folders. Ensure pharmacy forms are returned to M&E office on the same day. Ensure adherence forms are returned to M&E office on the same day.	Health recorder, Data entry clerks
Store data	File forms according to the month of registration in the file cabinets in the M&E office	Health recorder
Enter data	Enter data from all clinic, lab, and pharmacy by Day 4.	Data entry clerk/assistant
Clean data	Provide feed back from data error log book to respective persons by Day 5. Clean data and compile indicators by Day 6.	M&E officer
Feedback	Write report and feedback to ARV coordinator by day 7	M&E officer

2. Collection of information

2.1 PMM Forms

PMM forms are data collection tools designed to monitor and evaluate the HIV treatment program at the designated health facilities across the country

2.1.1. Purpose of PMM forms

The PMM forms serve dual functions. First it serves as a tool for the collection of key indicators for program monitoring and evaluation. Second it ensures the collection of key data elements for patient management and monitoring. More specifically, the purpose of the PMM forms is to:

- Standardize data collection and monitoring procedures
- Record information about ART program coverage and uptake at a health facility
- Track the number of patients seeking ARVs and/or receiving supporting services
- Produce clinically valuable information and evidence based reports for care- providers and scaling-up activities
- Provide program monitoring information to all levels to identify progress and challenges and improve ART services
- Document the extent to which HIV services are being utilized

2.1.2. Identification system

A PMM Identification system consists of 3 parts. The first 3-letters denote the State. The second 3-numbers denote the facilities while the last 5-digit numbers represent a serial patient identification. Once a patient presents at the ARV clinic, the enrollment process begins with the assignment of a serial ID number. This number is assigned sequentially from the program ID log (**Appendix 1**) kept at the ARV Clinic. The PMM ID and date of enrollment visit is written on the patient's registration hand card. The patient is asked to bring this card with them to every subsequent visit. The same PMM ID is used at each visit. If patient arrives without their registration hand card that displays their PMM ID, the nurse or records clerk checks the program ID log for **ALL** identifying information that links that individual i.e. name and date of birth and verifies the link before the number is referenced for that patient. If linkage is impossible at that visit, a new PMM ID is assigned for use at that visit, but the correct PMM ID is reassigned as soon as the missing number is resolved. All attempts should be made before assigning new ID. Below is an example of the Identification system.

STATE	FACILITY	SERIAL PATIENT NUMBER
<input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/>	<input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 25px; border: 1px solid black;" type="text"/>

2.1.3. Types of forms

Below are a list of and a description of the 9 PMM forms used for ACTION M&E:

1. Personal History Form
2. Adult Initial Clinical Evaluation Form
3. Adult Follow-up Clinical Encounter Form
4. Paediatric Initial Clinical Evaluation Form
5. Paediatric Follow-up Clinical Encounter Form
6. Laboratory Order and Result Form
7. Pharmacy Order Form
8. Medication Adherence Assessment Form
9. Contact Tracking and Termination Form

Table 1. Type of Forms and Description

Forms	Description
Personal History Form	Completed only at enrollment. Patient's name, date of enrollment, age, gender, address and contacts' address is collected on the enrollment form for all patients. Additional information on marital status, educational level, employment status, and number of children is collected from adult patients only as well as a documentation of service point of entry.
Initial Clinical Evaluation Form (Adult)	Initial Clinical Evaluation documents Medical history, Treatment history, Current symptoms, Physical examination, WHO HIV staging, Treatment plan, Clinical course, Pregnancy history/PMTCT, Adverse events/side effects, and TB prophylaxis/treatment. This is completed at the initial clinical visit by the physicians and clinic staff
Follow-up Evaluation Form (Adult)	Completed at each follow-up visits to track the patients' progress. Patients' medical history, physical examination, HIV assessments, ART history and treatment plan is collected on the follow-up clinical evaluation form.
Paediatric Initial Clinical Evaluation Form	Paediatric Initial Evaluation documents Medical history, Treatment history, Current symptoms, Physical examination, WHO HIV staging, Treatment plan, Clinical course, Pregnancy history/PMTCT, Adverse events/side effects, TB prophylaxis/treatment It is completed at the initial clinical visit.
Paediatric Follow-up Evaluation Form	Follow-up Paediatric Clinical Evaluation documents Medical History, illness since last visit, current symptoms; ARV side effects, Physical examination, WHO HIV staging, and it track patient's progress. This form is completed at follow-up clinical visit
Laboratory Form	Completed for all patients at enrollment and as necessary at follow-up. All ordered ARV related laboratory tests and any additional tests are listed on the laboratory form. Patients' name, sex, date of birth, date and time tests are ordered are collected on the laboratory form. All laboratory forms are initiated during clinical evaluation and completed at the laboratory.
Pharmacy Form	Completed for patients that are ART eligible at enrollment or follow-up. To whom ARV medication should be dispensed is noted on the pharmacy form. Pharmacy form is also completed for patients that receive prescription for opportunistic infections. All pharmacy forms are initiated during clinical evaluation and completed at the pharmacy.
Medication Adherence Assessment Form	Completed when adherence counseling is recommended to ART eligible patients at enrollment or follow-up. ART eligible patients are placed in adherence support group to get the necessary adherence counseling and support for ART.
Program Termination	Completed after a patient enrolled in the PEPFAR HIV Care program notifies their physician that they wish to terminate their HIV care. This form is also completed if a patient misses all their follow-up visits or does not pick up their prescribed HIV medication for over a three month period. Program termination form is completed only after multiple attempts have been made

Forms	Description
	to contact the patient. Patient's name, dates of attempts made to contact the patient and reason for exiting the program are collected on the program termination form.

2.1.4 Form Inventory and supply

Our partner GHAIN will be responsible for form printing and distribution. A request must be made to the PMM officer at GHAIN when the inventory dips below 50% of stock out **(See Appendix 7 for GHAIN contact)**

2.2 Form instructions

PMM form instruction provides a step by step direction for health providers (clinician, nurse, lab technician, pharmacist, health administrative, etc) in completing the PMM forms.

All forms consist of 3 general sections

1. Header (patient's personal information) - header section must be filled to ensure that patient's data can be maintained and retrieved whenever it's necessary.
2. Main Body (patient's relevant health assessment data) - main body section must be filled with the best effort so that the patient's progress can be well monitored and evaluated
3. Footer (information of when and who fills the forms). Date is always in dd/mm/yyyy format.

Step by step instruction to complete the PMM form

1. Personal History Form Instruction

This form must be completed in the very beginning, to enroll the patient in PEPFAR program.

No. 1 – 6 is mandatory and must be filled with the best effort and clarity

- | | |
|-------------------------------|---|
| 1. Visit Date | Enter the date of visit when the patient first enrolls into the PEPFAR program; visit date starts with 2 digits day, followed by 2 digits month and 4 digits year (dd/mm/yyyy).
Note: this is not always the same date that patient first registered at the hospital/facility. |
| 2. Patient Name | Enter patient's surname and other names if any. |
| 3. Hospital (Unit) No. | Enter patient's designated hospital number.
Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility. |
| 4. ID | State: Enter the state abbreviation in the state boxes.
Facility No: Enter the designated facility number.
Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program |
| 5. Sex | Tick the check box for patient's gender. |
| 6. Age | Enter the patient's age. If the patient is not yet 5 years old, enter the months in the space provided. |
| 7. Date of Birth | If known, enter the patient's date of birth. Starting with 2 digits date, 2 digits month, and 4 digits year of birth. |

No. 8 – 16 are filled for ADULT and PAEDIATRIC patients

- | | |
|--|--|
| 8. Where does the patient live? | Enter the information where the patient resides . |
| 9. Contact Person / Next of Kin | Enter the patients' contact person's name and address.
Note: preferably a person who can make decision for the patient. |
| 10. Marital Status | Tick the patient's marital status. Tick N/A for paediatric patient.
Widowed: the husband/wife has deceased.
Divorced: legally separated.
Married: legally married.
Separated: does not live together as husband and wife but not legally separated. |
| 11. Educational Level | Tick patient's educational level. If Other is ticked, specify details in the provided space. Tick N/A for paediatric patient. |
| 12. Preferred Language | Indicate language patient prefers to communicate in. |

1. Personal History Form Instruction

13. Patient's Job Status	Enter patient's job status. If Other is ticked, specify details in the provided space. Tick N/A for paediatric patient.
14. How long would it take you to arrive at the hospital?	Indicate the length of time (approximate hours and minutes) it took for the patient to arrive the hospital from home.
15 a. How many dependents are at home?	Enter the number of people financially dependent on the patient; include extended family, such as sister, nephew, grandmother, etc., if they are financially depending.
15 b. How many of them are under 18 years old?	Enter the number of people under 18 years old of the number that patient provided in 15 a .
16. Service entry into program	Tick patients' service point of entry into the PEPFAR program.
No. 17 – 22 is filled for PAEDIATRIC patient only.	
17. With whom does child live?	Enter the name and the relationship of the person whom the child lives with.
18 a. Is the mother of child live?	Indicate if the mother of the child is still alive. If the mother is alive, enter her name in the space provided. If the mother does not live with the child, then provide the mother's address.
18 b. Is the father of child live?	Indicate if the father of the child is still alive. If the father is alive, enter his name in the space provided. If the father does not live with the child, then provide the father's address.
19. Child's parents/ caregivers are:	Indicate whether the child's parents/caregivers are married and living together.
20. Job/occupation status of child's parents/ caregivers:	Indicate child's mother/father/caregiver's occupation based on the Job Codes provided. If code 1 is chosen, specify the type of employment in the space provided.
21. Educational level of child's parents/caregiver:	Indicate child's mother/father/caregiver's educational level based on the Educational Codes provided. If code 7 is chosen, specify the type of education in the space provided.
22. How many siblings does the child have?	Indicate the number of siblings the child has, not necessarily those that live in the same house.

2. Adult Initial Clinical Evaluation Form Instruction

No 1 – 7 is mandatory and must be filled with the best effort and clarity

- | | |
|---|---|
| 1. Visit Date | Enter the date of visit when the patient first enrolls into the PEPFAR program; visit date starts with 2 digits day, followed by 2 digits month and 4 digits year (dd/mm/yyyy).
Note: this is not always the same date that patient first registered at the hospital/facility. |
| 2. ID | State: Enter the state abbreviation in the state boxes.
Facility No: Enter the designated facility number.
Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program |
| 3. Hospital (Unit) No. | Enter patient's designated hospital number.
Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility. |
| 4. Patient Name | Enter patient's surname and other names if any. |
| 5. Sex | Tick the check box for patient's gender. |
| 6. Date of Birth | If known, enter the patient's date of birth. Starting with 2 digit date, 2 digit month, and 4 digit year of birth. |
| 7. Age | Enter the patient's age. If the patient is not yet 5 years old, enter the months in the space provided. |
| 8. Presenting complaint | Enter patient's reason for this visit. |
| 9. Symptom review | Tick Y if the symptom(s) occur and tick N if it does not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks. |
| 10. Additional comments | Indicate any additional comments on the patient's symptom review. |
| 11. Past medical problems | Indicate patient's past medical problems if any. |
| 12. Family history | Indicate patient's family medical history. |
| 13. Hospitalization | Indicate if patient has ever been hospitalized, for what reasons and for how long. |
| 14. Drug allergies | Enter patient's drug allergies if any. |
| 15. Have you ever received treatment for an illness by a native doctor/traditional healer? | Tick Y if patient has received treatment, tick N if has never. |
| 16 a. Last menstrual period | Enter the first day of the last normal menstrual period. Skip to no. 17 if the patient is male. |

2. Adult Initial Clinical Evaluation Form Instruction

16 b. Currently pregnant	Tick Y if the patient is pregnant, N if not, Uncertain if the patient is not sure. Skip to no. 17 if N or Uncertain is ticked.
16 c. Gestational age	Enter the gestational age (age of pregnancy) to the last completed week.
16 d. Expected date of delivery	Enter the expected date of delivery, if known.
17. Latest CD4	Enter the latest CD4, if available. Enter the date of the latest CD4 count using dd/mm/yyyy format. Tick which method was used for the last CD4 count. Note: GON patients more likely to have CD4 count available.
18. Lowest CD4	Enter patient's lowest CD4 result if available along with the date of the test result. Tick lab records seen if the clinician sees the lab result.
19. Latest VL	Enter the latest viral load, if available. Enter the date of the latest viral load using dd/mm/yyyy format. Tick which method was used for the last CD4 count.
20. Previous ARV exposure (probe)	Indicate the type of ARV exposure that patient ever had in the past and specify it in the space provided. Tick None if patient has never had one.
21. Current medications (probe and specify)	Tick patient's current medications and specify the medications in the space provided. If patient is not under medication, tick None .
22. Adherence	<p data-bbox="230 1192 537 1255">a. Participating in an adherence program</p> <p data-bbox="230 1371 472 1465">b. Treatment was interrupted (unintentional)</p> <p data-bbox="230 1497 586 1560">c. Treatment was stopped (intentional)</p>
23. Past or current ARV side effects	Tick any side effects that occur. If no side effect occurs, tick None . If side effect is not listed here, tick Other and specify it in the space provided.
24. Physical exam	<p data-bbox="634 1738 1263 1770">Temp: Indicate patient's body temperature in Celsius.</p> <p data-bbox="634 1770 938 1801">BP: Indicate patient's BP.</p> <p data-bbox="634 1801 1003 1833">Pulse: Indicate patient's pulse.</p> <p data-bbox="634 1833 1133 1864">Weight: Enter patient's weight in kilogram.</p> <p data-bbox="634 1864 1149 1896">Height: Enter patient's height in centimeter.</p> <p data-bbox="634 1896 1438 1944">If any, indicate significant findings on physical exam. If none found, tick NSF. If the finding is not listed, indicate it in the space provided.</p>

2. Adult Initial Clinical Evaluation Form Instruction

25. Assessment	Indicate clinician's assessment.
26. WHO staging criteria	Tick any of the symptoms/illnesses listed if ever occurred to patient.
27. WHO stage	Indicate WHO stage based on WHO staging criteria ticked.
28 a. Plan	Indicates the treatment plan until patient's next visit.
28 b. Plan (specify orders on requisition)	Tick the chosen plan and specify it in the space provided.
29. Enroll in	Indicate the status of patient enrollment at the end of the current clinical evaluation.
30. ARV therapy plan	Indicate the ARV therapy plan. If the Change Treatment or Stop ARV Therapy is ticked, enter the code number from Reason Codes for why the option is chosen.
31 a. Regimen	Tick the regimen that the patient is currently in.
31 b. Drugs in regimen	Indicate the specific drugs in the regimen.
32. Patient has disclosed status to	Indicate to whom patient has disclosed his/her HIV/AIDS status. If the patient has not disclosed it to anybody, tick No One option. If other is chosen, specify the person.
33. HIV status can be discussed with	Indicate to whom HIV status of patient can be discussed with (preferably a person who can make decision for the patient in case of emergency).
34 a. Patient has received care for HIV/AIDS from	If patient has ever received care for HIV/AIDS, choose from the options listed.
34 b. Specify facility name	Enter the facility name where the patient has received treatment mentioned in no. 34 a.
35. Is the patient a member of a support group	Tick Y if patient is a member of a support group, otherwise tick N
36. Additional notes	Enter any important additional notes related with patient's evaluation.
37. When is patient's next appointment?	Tick patient's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician signature	Clinician who provides initial evaluation signs in the space provided.
Print name	Enter the full name of the clinician.

3. Follow-up Clinical Encounter Form Instruction

No. 1 – 6 is mandatory and must be filled with the best effort and clear.

1. Visit Date	Enter the date of the follow-up visit; start with 2 digits day, 2 digits month and 4 digits year.
2. ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program
3. Hospital (Unit) No.	Enter patient's designated hospital number. Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility.
4. Patient Name	Enter patient's surname and other names if any.
5. Last CD4 count	Enter patient's last CD4 count, if known.
6. Last VL	Enter patient's last Viral Load, if known.
7 a. Current ART regimen	Enter the date patient started using current ART regimen.
7 b. Regimen	Enter drugs in regimen patient is currently using.
7 c. Regimen is	Tick whether patient's regimen is in 1st line , 2nd line or Salvage .
Medical History	
8. Symptom review	Tick Y if the symptom(s) occur and tick N if not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.
9. Illnesses since last visit	Indicate any illnesses since patient's last visit. If none, skip to no 10.
10. Hospitalization since last visit	Indicate if patient has been hospitalized since last visit, for what reason and for how long. If none, skip to no. 11.
11. Since your last visit, have you received treatment for an illness by a native doctor or traditional healer?	Tick Y for yes, N for no.
12 a. Last menstrual period	Enter the first day of the last normal menstrual period. Note: Skip to no. 13 if patient is Male.
12 b. Currently pregnant	Tick the correct option. If N or Uncertain is ticked, continue to no. 13.
12 c. Gestational age	Enter the gestational age (age of pregnancy) to the last completed week.
12 d. Expected date of delivery	Indicate expected date of delivery if known.

3. Follow-up Clinical Encounter Form Instruction

13. Current medication	Tick patient's current medications and specify them. If there is no current medication tick None .
14. Past or current ARV side effects	Tick any ARV side effects that have occurred since last visit, or are occurring now. If no side effect, tick None . If the side-effects occurred are not listed, tick Other and specify the side effect.
15 a. Participating in an adherence program:	Tick Y or N to indicate whether patient is participating in an adherence program. Indicate whether patient ever missed medication in the last 3 days or during last week. If patient ever missed medications, enter code from Reason Codes for why patient missed medications.
15 b. Treatment was interrupted (unintentional)	Indicate whether treatment was interrupted unintentionally. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days treatment was interrupted. Enter code from Reason Codes for why treatment was interrupted.
15 c. Treatment was stopped (intentionally)	Indicate whether the treatment was interrupted intentionally. Enter the date of the first day the treatment was interrupted intentionally. In the box provided, enter how many days the treatment stopped. Enter code from Reason Code for why treatment was interrupted intentionally.
16. Physical exam	Temp: Indicate patient's body temperature in Celsius. BP: Indicate patient's BP. Pulse: Indicate patient's pulse. Weight: Enter patient's weight in kilogram. Height: Enter patient's height in centimeter If any, indicate significant findings on physical exam. If none found, tick NSF . If the finding is not listed, indicate it in the space provided.
17. Assessment	Indicate clinician's assessment
18. WHO staging criteria	Tick any of the symptoms/illnesses listed if ever occurred to patient.
19. WHO stage	Indicate WHO stage based on WHO staging criteria ticked.
20 a. Plan	Clinician indicates the treatment plan until patient's next visit.
20 b. Plan (specify orders on requisition)	Tick the chosen plan and specify it in the space provided.
21. ARV therapy plan	Indicate the ARV therapy plan. If the Change Treatment or Stop ARV Therapy is ticked, enter the code number from Reason Codes for why the option is chosen.
22. Regimen	Tick the regimen that the patient is currently in.
23. Additional notes	Enter any important additional notes related with patient's evaluation.

3. Follow-up Clinical Encounter Form Instruction

24. When is patient's next appointment?	Tick patient's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician signature	Clinician who provides initial evaluation signs in the space provided.
Print name	Enter the full name of the clinician.

4. Paediatric Initial Clinical Evaluation Form

No 1 – 6 is mandatory and must be filled with the best effort and clear

1. Visit Date	Enter the date of visit when the patient is evaluated for the first time by clinician in PEPFAR program; start with 2 digit day, followed by 2 digit month and 4 digit year. Note: this is not always the same date that patient first registered at the hospital/facility.
2. ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program
3. Hospital (Unit) No.	Enter child's designated hospital number. Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility.
4. Patient Name	Enter patient's surname and other names if any.
5. Sex	Tick the check box for patient's gender.
6. Date of Birth	If known, enter the patient's date of birth. Start with 2 digit day, 2 digit month, and 4 digit year of birth.
7. Age	Enter the patient's age. If the patient is not yet 5 years old, enter the months in the space provided.
8. Presenting complaint	Enter patient's reason for this visit.
9. Symptom review	Tick Y if the symptom(s) occur and tick N if symptom(s) did not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.
10. Additional comments	Indicate any additional comments on the patient's symptom review.
11 a. Developmental Assessment: please check the most advanced milestone	Clinician ticks child's most advanced milestone
11 b. Has the patient lost developmental milestones?	Indicate whether child has lost any developmental milestones
11 c. Is the child in school?	Indicate whether child is in school. If yes, provide the name of the school. If not, skip to no. 12.
11 d. School performance	(1) Indicate in which class/grade the child is in. (2) Indicate whether child's performance in class is satisfactory.
12 a. Past medical history	Enter child's past medical history, including any hospitalization and surgery. Indicate the reason and the period of time of hospitalization and surgery.

4. Paediatric Initial Clinical Evaluation Form

12 b. Past drug history/allergies	Indicate child's past drug history and allergies.
12 c. Immunization	Tick immunizations from the list that have been given to the child.
13. Family history	Indicate child's family medical history.
14 a. Patient has received previous care for HIV/AIDS from	If child has ever received previous care for HIV/AIDS, indicate where the care was received. If none received, tick None and skip to no. 15.
14 b. Specify facility name	Specify the facility name where the child received previous care for HIV/AIDS from.
15. Has the child ever received treatment for an illness by a native doctor/traditional healer/alternative health provider?	Indicate yes or no.
16 a. Mode of transmission	Indicate mode of transmission to the child. If other is ticked, specify details in the space provided.
16 b. Booked for ANC	Indicate if child's mother was booked at the antenatal clinic. If YES indicate the gestational age (weeks) at the time of booking.
16 c. Gestational age at birth	Indicate mother's age of pregnancy when the child was born.
16 d. Duration of membrane rupture	Indicate the duration of membrane rupture in hours and minutes.
16 e. Mode of delivery	Indicate whether mode of delivery was vaginal , elective Cesarean or non-elective Cesarean .
16 f. Birthweight	Indicate child's birthweight.
16 g. Duration of breast feeding	If child was breast fed, indicate the duration of breast feeding. Tick None if child was not breast fed.
16 h. Was any mixed feeding done?	Indicate whether there was any mixed feeding done for the child.
17. Latest CD4	Enter the latest CD4, if available. Enter the date of the latest CD4 count. Tick which method was used for the last CD4 count. Note: GON patients more likely to have CD4 count available.
18 a. Latest VL	Enter the latest viral load, if available. Enter the date of the latest viral load count using dd/mm/yyyy format. Tick which method was used for the last CD4 count.
18 b. Lowest CD4	Enter patient's lowest CD4 result if available along with the date of the test result. Tick lab records seen if the clinician sees the lab result.

4. Paediatric Initial Clinical Evaluation Form

19 a. Previous ARV exposure other than PMTCT	If child has ARV exposure other than PMTCT, tick Treatment , indicate for how many months the treatment and specify ARV.
19 b. Previous ARV exposure through PMTCT	Indicate child's previous ARV exposure through PMTCT, if any. Otherwise tick None . If Other is ticked, specify the drugs.
20. Current medications	Indicate child's current medication and specify it in the space provided. If child is not under any medications, tick None and continue to no. 21.
Complete no. 21 – 23 only if child has past history of ARV treatment. If none, skip to no. 24.	
21. Treatment was interrupted (by patient/caregiver)	Indicate whether treatment was interrupted by patient/caregiver. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days the interruption lasted. Enter code from Reason Code for why medication was interrupted.
22. Treatment was interrupted (by clinician)	Indicate whether treatment was interrupted by clinician. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days the interruption lasted. Enter code from Reason Code for why medication was interrupted.
23. ARV side effects	Tick any side effects that occur. If no side effect occurs, tick None . If side effect is not listed here, tick Other and specify it in the space provided.
24. Physical exam	<p> Temp: Indicate child's body temperature in Celsius. BP: Indicate child's BP. Pulse: Indicate child's pulse. Weight: Enter child's weight in kilogram. Height: Enter child's height in centimeter. Head circumference: Enter child's head circumference in centimeter. MUAC: Enter child's MUAC in centimeter. Weight for height: Indicate whether child's weight for height is normal, under or over. If any, indicate significant findings on physical exam. If none found, tick NSF. If the finding is not listed, indicate it in the space provided. </p>
25. Assessment	Indicate clinician's assessment.
26. WHO staging criteria	Tick any of the symptoms/illnesses listed if ever occurred to child.
27. WHO stage	Indicate WHO stage based on WHO staging criteria ticked.
28 a. Plan	Clinician indicates the treatment plan until child's next visit.
28 b. Plan (order on specific requisition form)	Tick the chosen plan and specify it in the space provided.
29. Enroll in	Indicate where you plan to enroll the patient

4. Paediatric Initial Clinical Evaluation Form

30. ART plan (if applicable)	Indicate ARV therapy plan for child. If Change Treatment or Stop ART is ticked, enter the code number from Reason Codes for why the option is chosen.
31. Regimen (if applicable)	Tick the regimen that the patient is currently in and specify it.
32 a. Child's status known to:	Indicate the person(s) who know child's HIV/AIDS status.
32 b. Is child aware of his/her diagnosis by name?	Indicate whether child is aware that his/her illness is HIV/AIDS. If child's development (e.g. 2 months old baby) does not allow him/her to understand, tick N/A . If Y is ticked skip to no. 33.
32 c. Is child aware that he/she has chronic illness, but not by name?	If child is aware that he/she has chronic illness, but does not understand that it is HIV/AIDS, tick Y . Otherwise, tick N .
33. HIV status can be discussed with	Indicate to whom HIV status of child can be discussed with (preferably a person who can make decision for the child in case of emergency).
34. Is the patient's caregiver a member of a support group	Tick Y if patient's caregiver is a member of a support group, otherwise tick N
35. Additional comments	Enter any important additional comments related with child's evaluation.
37. When is patient's next appointment?	Tick child's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician Name	Enter full name of clinician who provides child's initial evaluation.
Signature	Clinician who provides initial evaluation signs in the space provided.
Consultant Name	Enter the full name of the consultant clinician.

5. Paediatric Follow-up Clinical Encounter Form Instruction

No. 1 – 8 is mandatory and must be filled with the best effort and clear.

1. Visit Date	Enter the date of follow-up visit; start with 2 digit day, 2 digit month and 4 digit year.
2. Child Name	Enter child's surname and other names if any.
3. ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program
4. Hospital (Unit) No.	Enter child's designated hospital number. Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility.
5 a. Last CD4 count	Enter child's last CD4 count and the date of the test result, if known.
5 b. Last CD4%	Enter child's last CD4% and the date of the test result, if known.
6. Last VL	Enter child's last Viral Load and the date of the test result, if known.
7 a. Current ART regimen	Enter the date of the child started using current ART regimen.
7 b. Regimen	Enter drugs in regimen the child is currently using.
7 c. Regimen is	Tick whether child child regimen is in 1st line , 2nd line or Salvage .
8. Age	Enter the child's age. If the child is not yet 5 years old, enter the months in the space provided.
9. Presenting complaint	Enter the reason for this visit.
10. Symptom review	Tick Y if the symptom(s) occur and tick N if not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.
11 a. Developmental milestones attained since last visit	Tick developmental milestones that child has attained since last visit.
11 b. Has the child lost developmental milestones since last visit?	Indicate whether child has lost any developmental milestones since last visit. If yes, indicate in the space provided.
12. Illnesses since last visit	Indicate any illnesses since child's last visit. If none, skip to no 13.
13. Hospitalization since last visit (include duration, indication and treatment)	Indicate if child has been hospitalized since last visit; include duration, indication and treatment.

5. Paediatric Follow-up Clinical Encounter Form Instruction

<p>14. Since last visit, has the child received treatment for an illness by a native doctor/traditional healer/alternative health provider?</p>	<p>Indicate yes or no.</p>
<p>15. Current medications (probe and specify)</p>	<p>Tick child's current medications and specify the medications in the space provided. If child is not under medication, tick None. If Other is ticked, specify the medications.</p>
<p>16. Possible ARV side effects (either presently or since last visit)</p>	<p>Tick any side effects that have occurred since last visit or are occurring presently. If no side effect occurs, tick None. If side effect is not listed here, tick Other and specify it in the space provided.</p>
<p>17. Adherence since last visit</p>	<p>Tick N/A if child is not participating in adherence program.</p>
<p>a. Treatment was interrupted (by patient/caregiver)</p>	<p>Indicate whether treatment was interrupted by patient/caregiver. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days the interruption. Enter code from Reason Code for why medication was interrupted.</p>
<p>b. Treatment was interrupted (by clinician)</p>	<p>Indicate whether treatment was interrupted by clinician. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days the interruption. Enter code from Reason Code for why medication was interrupted.</p>
<p>18. Physical exam</p>	<p>Temp: Indicate child's body temperature in Celsius. BP: Indicate child's BP. Pulse: Indicate child's pulse. Weight: Enter child's weight in kilogram. Height: Enter child's height in centimeter. Head circumference: Enter child's head circumference in centimeter MUAC: Enter child's MUAC in centimeter Weight for height: Indicate whether child's weight for height is normal, under or over. If any, indicate significant findings on physical exam. If none found, tick NSF. If the finding is not listed, indicate it in the space provided.</p>
<p>19. Assessment</p>	<p>Indicate clinician's assessment.</p>
<p>20. Change in WHO stage since last visit?</p>	<p>Indicate whether WHO stage has changed since last visit.</p>
<p>21 a. WHO staging criteria</p>	<p>Tick any of the symptoms/illnesses listed if ever occurred to child.</p>
<p>21 b. WHO stage</p>	<p>Indicate WHO stage based on WHO staging criteria ticked.</p>
<p>22 a. Plan</p>	<p>Clinician indicates the treatment plan until child's next visit.</p>
<p>22 b. Plan (specify orders on requisition)</p>	<p>Tick the chosen plan and specify it in the space provided.</p>

5. Paediatric Follow-up Clinical Encounter Form Instruction

23 a. ART plan (if applicable)	Indicate ARV therapy plan for child. If Change Treatment or Stop ART is ticked, enter the code number from Reason Codes for why the option is chosen.
23 b. Regimen (if applicable)	Tick the regimen that the patient is currently in and specify it.
24. Additional comments	Enter any important additional comments related with child's evaluation.
25. When is patient's next appointment?	Tick child's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician Name	Enter full name of clinician who provides child's initial evaluation.
Signature	Clinician who provides initial evaluation signs in the space provided.
Consultant Name	Enter the full name of the consultant clinician.

6. Laboratory Order and Result Form Instruction

Collection Date	Enter the date of sample collection; starting with 2 digit day, 2 digit month, and 4 digit year. Must be filled.
Patient Name	Enter patient's surname and other names if any. Must be filled.
ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program. Must be filled.
Hospital (Unit) No.	Enter patient's designated hospital number. Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility. Must be filled
Facility Name	Enter facility name where the patient is currently registered and is being treated. Must be filled.
Lab Registration No	Enter the registration no. of labs where tests are run. Must be filled.
Sex	Tick patient's gender. Must be filled.
Age	Enter age of the patient. For paediatric patient, if less than 5 years, enter the age in months. Must be filled.
Lab form consists of 4 sections, which are Immunology/Virology, Hematology, Chemistry, and Microbiology. Each part goes to the designated lab. Each section has 2 columns, which are Orders and Result. The name of tests provided is listed in the Order column. Clinician ticks the test he/she wants to order for the patient. The person who runs the tests records the results of the ordered tests in the Result column. Result column has been equipped with units.	
Ordered by	Clinician who orders the tests enters his/her name and signature in the space provided. Enter the date the tests were ordered. Must be filled.
Reported by	The person who runs the tests (can be lab technician or lab scientist) enter his/her name and signature in the space provided. Enter the date of the test results reported. Must be filled.
Checked by	Lab scientist enters his/her name and signature in the space provided after checking the test results. Enter the date of the results checked. Must be filled.

7. Pharmacy Order Form Instruction

Date	Enter the date of drug prescribed; starting with 2 digit day, 2 digit month, and 4 digit year. Must be filled
Patient Name	Enter patient's surname and other names if any. Must be filled
ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program. Must be filled
Facility Name	Enter facility name where the patient is currently registered and is being treated. Must be filled
Hospital (Unit) No.	Enter patient's designated hospital number. Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility. Must be filled
Pharmacy Registration No	Enter registration no. of the pharmacy where drugs are dispensed. Must be filled
Do Not Dispense ARV's to Patient; Hold for Adherence Staff Pickup	Clinician ticks this if the drugs will be picked up by adherence staff.
Medication provided by	Clinician ticks whether the drugs are provided by GON, PEPFAR or other program. If Other is ticked, enter the name of the program that provides the drugs.
<p>The main body of this form consists of 2 sections, which are ARV Medication and OI Prophylaxis. Each section has 7 columns, i.e. Medications, Strength, Actual Dose, Frequency, Quantity Prescribed, and Quantity Dispensed. Following are the instructions how to fill each column for both sections.</p>	
Name of Medications	The names of medications in ARV Medications are already listed. However, in OI Prophylaxis, for Other TB Meds and Other option, clinician needs to enter the name of the medications he/she wants to prescribe in the space provided.
Strength	Tick the strength of the selected medication. Mg/ml strength is used only for paediatric patients. Note: Pay careful attention to Didanosine strength; 250 mg and 400 mg options can be used if the medication prescribed is Videx EC.
Actual Dose	Enter the actual dose in the space provided. This is used only for paediatric patients.
Frequency	This column is used to determine the frequency of taking medications per day. Clinician ticks the selected frequency. The notes beside the frequency (i.e. <60 kg or if on rifampicin) should be taken into consideration when selecting frequency for patient.

7. Pharmacy Order Form Instruction

Duration	Indicate how many days/weeks/months the prescription will be filled for.
Quantity Prescribed	Clinician enters the quantity of each medication prescribed.
Quantity Dispensed	Pharmacist enters the quantity of each medication dispensed.
Ordered by	Clinician enters his/her name and signature in the space provided. Enter the date of prescription is issued. Must be filled.
Counseled by	Adherence Counselor enters his/her name and signature in the space provided. Enter the date when the patient counsel with Adherence Counselor about the medications.
Dispensed by	Pharmacist enters his/her name and signature in the space provided. Enter the date when the medications are dispensed. Must be filled.
Picked up by	The person who picks up the medications enters his/her name and signature in the space provided. Enter the date of pick up. Must be filled.

8. Medication Adherence Assessment Form

Date	Enter the date of adherence counseling; start with 2 digits day, 2 digits month, and 4 digits year. Must be filled
Patient Name	Enter patient's surname and other names if any. Must be filled.
Facility Name	Enter facility name where the patient is currently registered and is being treated. Must be filled.
ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program. Must be filled.
Hospital No.	Enter patient's designated hospital number. Notes: Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility. Must be filled.
1 a. List all current ARV medications and doses missed.	Enter the name of medication, dosage and frequency in the column provided. Indicate how many doses were missed yesterday, 2 days ago and 3 days ago.
1 b. List all current TB and OI medications and doses missed.	Enter the name of medication, dosage and frequency in the column provided. Indicate how many doses were missed yesterday, 2 days ago and 3 days ago.
2. Many of your medications need to be taken on a schedule, such as "12 hourly" for ARV meds or "once daily" for TB meds. How closely did you follow your specific schedule over the last three days?	Indicate how closely patient adheres to his/her medications taking schedule.
3. What do/did you do to help you remember to take/give medications, i.e. to be adherent?	Indicate what kind of tool or regular event that patient uses to remind him/herself take his/her medications.
4. Sometimes one forgets to take their pills in certain circumstance. Did you/your child skip or miss any of your/his/her medications?	Indicate for each time listed in 4a – 4e whether patient misses or skips his/her medications. If the time patient misses or skips his/her medications, is not listed here, indicate the time in 4f and specify it.

8. Medication Adherence Assessment Form

<p>5. Taking medications everyday can be difficult. What were the most common reason(s) for not taking or missing your medications during the last visit?</p>	<p>Tick Not applicable/did not miss taking any of medications if patient never missed his/her medications since the last visit. Tick the check box in the Check all that apply column for patient's reasons for missed or delayed medications. From all reasons that are checked, rank top 3 reasons. If the most common reasons are not listed, record them in Other and specify them in the space provided.</p>
<p>6 a. What issues or barriers need to be addressed for you to become more adherent? Specify.</p>	<p>Check issues or barriers that apply. If the issues or barriers are not listed, record them in the blank lines provided.</p>
<p>6 b. Any other issues?</p>	<p>Record any other issues that patient presents.</p>
<p>7. If adherent, continue current treatment strategy as is.</p>	<p>If patient adheres, tick Y. Otherwise tick N.</p>
<p>8 a. If not adherent, have adherence team re-evaluate patient's situation.</p>	<p>Tick Y if patient does not adhere to his/her medication schedule and adherence team will re-evaluate patient's situation. Adherence counselor should the next step with regards to patient's re-evaluation in the space provided. Otherwise tick N.</p>
<p>8 b. Suggest the following reminders to help you /your child to take your/his/her medications, i.e., to be adherent.</p>	<p>Adherence Counselor tick reminders listed that he/she suggests for patient.</p>
<p>Adherence Counselor Name</p>	<p>Enter Adherence Counselor's full name.</p>
<p>Adherence Counselor Signature</p>	<p>Adherence Counselor signs in the space provided.</p>
<p>Date</p>	<p>Enter the date of counseling.</p>

9. Contact Tracking and Termination Form Instruction

This form is filled when the first attempt to contact is started.

ID	State: Enter the state abbreviation in the state boxes. Facility No: Enter the designated facility number. Serial Enrolment No: Enter the patient's assigned serial number when he/she first enrolled into PEPFAR program. Must be filled
Patient Name	Enter patient's surname and other names if any. Must be filled
Hospital No.	Enter patient's designated hospital number. Notes: Note: in most cases, this is the patient's identifying number given when the patient first registered at the hospital/facility. Must be filled
1. Patient Contact Address/Ph. Number	Enter patient's contact address and phone number as complete as possible.
2 a. Guardian Name	For paediatric patient. Enter child's guardian name.
2 b. Guardian Contact Address / Ph. Number	For paediatric patient Enter guardian's address and phone number as complete and clear as possible.
3 a. Date of Missed Scheduled Appointment	Enter the date of missed scheduled appointment.
3 b. Date of Last Actual Contact	Enter the date of the last time health provider staff or adherence counselor had actual contact with patient.
4. Attempt to Contact	Provide information of attempts to contact patient. Record the date of contact and who attempted the contact. Indicate mode of communication when attempt to contact was made. Indicate whether the guardian, CHEW or Peer Supporter was contacted.
Signature of Contact Tracer	Contact Tracer signs in the space provided after last attempted contact made.
Date	Enter the date of last attempted contact.
5. Patient Care Terminated	Indicate whether patient's care is terminated.
6. Reason for exit from program	Indicate whether patient's reason for exiting the program is (a) Lost to Follow Up, (b) Dropped Out of Care or (c) Death . If (b) is ticked, specify the specific reason. If (c) is ticked, indicate the date of death and tick the cause of death and specify it.
Date of Termination	Enter the date of termination.
Clinician Name	Enter full name of clinician.

9. Contact Tracking and Termination Form Instruction

Signature	Clinician signs in the space provided.
Consultant Name	Enter the full name of the consultant clinician.
Consultant Signature	Enter consultant's signature in the space provided.

2.3. Training log book

2.3.1. Purpose of the training log book

The training log (**Appendix 4**) serves multiple purposes but mainly, it serves as a collection tool to provide key training indicators. It provides a total account of personnel trained in HIV care at each facility within the different thematic groups. Proper accounting of personnel trained in different thematic areas helps to inform capacity building strategy within and across facilities.

2.3.2. Types of training

There are two different types of training in the context of the ACTION project

Table 2. Types of Training and Description

Training Type	Description
Centralized Training	A centralized training is one organized by ACTION only or jointly by ACTION and GHAIN. Centralized training is organized by thematic group and provides a forum where common knowledge is shared by HIV care personnel from different facilities. Number of personnel trained at centralized trainings is compiled by the ACTION PROJECT training coordinator and submitted to the M&E division of IHV Nigeria at the end of each month.
Facility Training	Facility training is any training that occurs at the facility. Facility training can be organized by either IHV Nigeria ACTION staff or the facility administration. A facility training can be a formally organized training or on the job training. Number of personnel trained at facility trainings are recorded in the training log book and reported on a monthly basis to the M&E division of IHV Nigeria.

2.3.4. Types of training log book

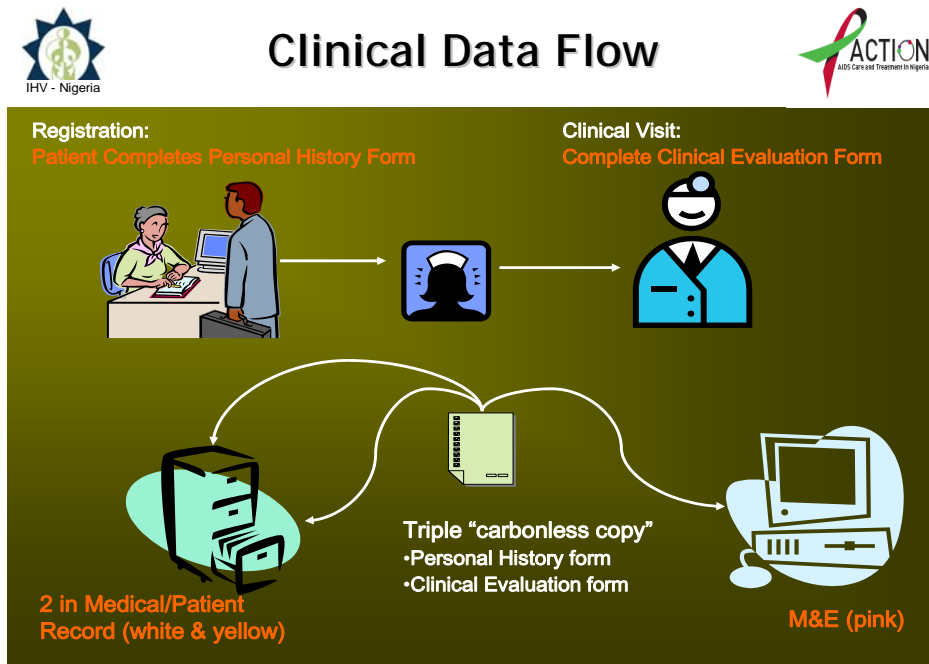
For the purposes of reporting training program indicators and capacity building for HIV care and treatment in the ACTION project, there are six main types of training log books. Each of these log books is placed in the different thematic group location and filled out by a designated officer from each group. They are:

1. PMTCT Training Log
2. Adult Clinical ARV Training Log
3. Paediatric Clinical ARV Training Log
4. Laboratory Training Log
5. M&E Training Log
6. Adherence Training Log

Examples of program indicators reported from information collected from training logs.

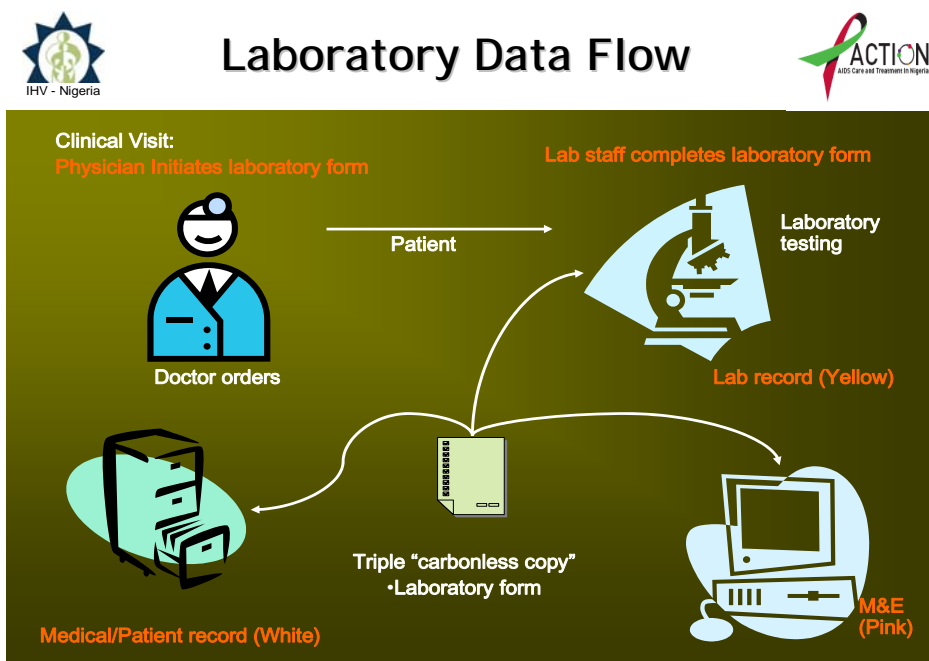
Type of Training log	Reporting program indicator
PMTCT Training log	Number of health workers newly trained or retrained in PMTCT services
Clinical ARV Training Log	Number of health workers trained in providing ART treatment Number of individuals trained to provide general HIV-related palliative care
Laboratory Training Log	Number of individuals trained in providing lab-related activities (CD4 test and other HIV related tests) Number of individuals trained in blood safety
M&E Training Log	Number of individuals trained in strategic information (M&E, surveillance, and HMIS)
Adherence Training Log	Number of individuals trained in ARV adherence

3. M&E activities at each service units



When a patient presents at the clinic the Personal History form is filled. The patient is then directed to a clinician who does an initial clinical evaluation using the Initial Clinical Evaluation Form. The first two copies of the forms for each of the patients are kept in the Medical/Patient Record in the clinic, while the pink copy is collected by data entry clerk/ program officer from the M&E unit. The data on this pink copy is

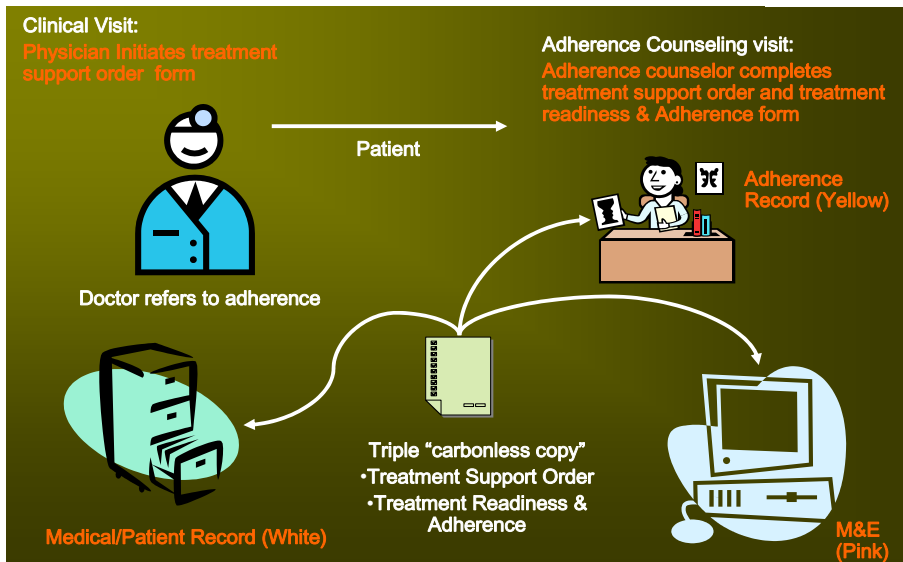
captured electronically with the computer based automated system and the hard copy is kept in a secure filing cabinet in the M&E office.



At a clinic visit the clinician orders for lab tests by filling the lab order form, selecting the specific tests to be performed. This form, along with the patient's specimen is sent to the lab. Once the tests are done, a designated lab staff records the test results in to the lab form. The white copy of this form is sent to the medical/patient records. The yellow copy is securely filed away in the laboratory filing cabinet, while the

pink copy is collected by data entry clerk/ program officer from the M&E unit. The data on this pink copy is captured electronically with the computer based automated system and the hard copy is kept in a secure filing cabinet in the M&E office.

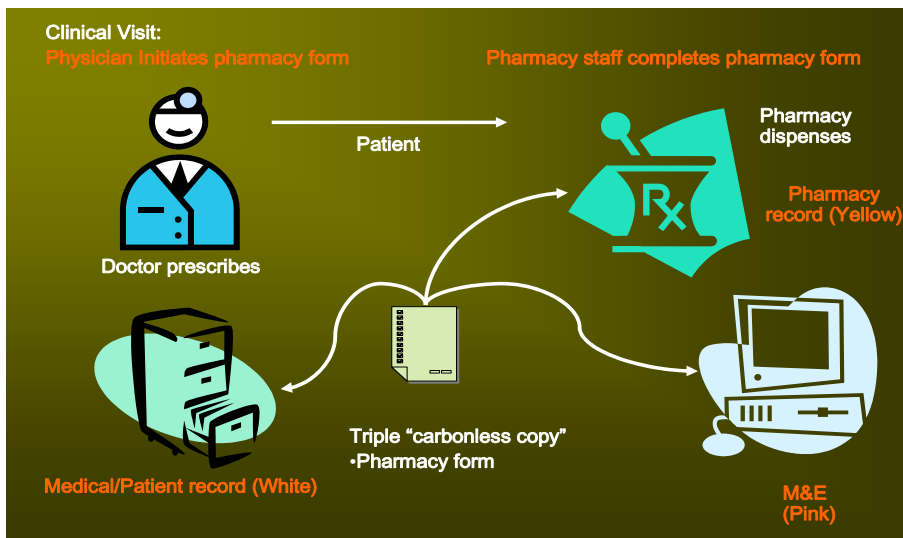
Adherence/Treatment Support Data Flow



At a clinic visit the clinician initiates a medical adherence assessment form. The patient goes to the adherence counseling office with this form. While interacting with the patient, the Adherence counselor completes the medical adherence assessment form. The white copy of this form is sent to the medical/patient records. The yellow copy is securely filed away in the Adherence office filing cabinet, while the pink copy is collected by

data entry clerk/ program officer from the M&E unit. The data on this pink copy is captured electronically with the computer based automated system and the hard copy is kept in a secure filing cabinet in the M&E office.

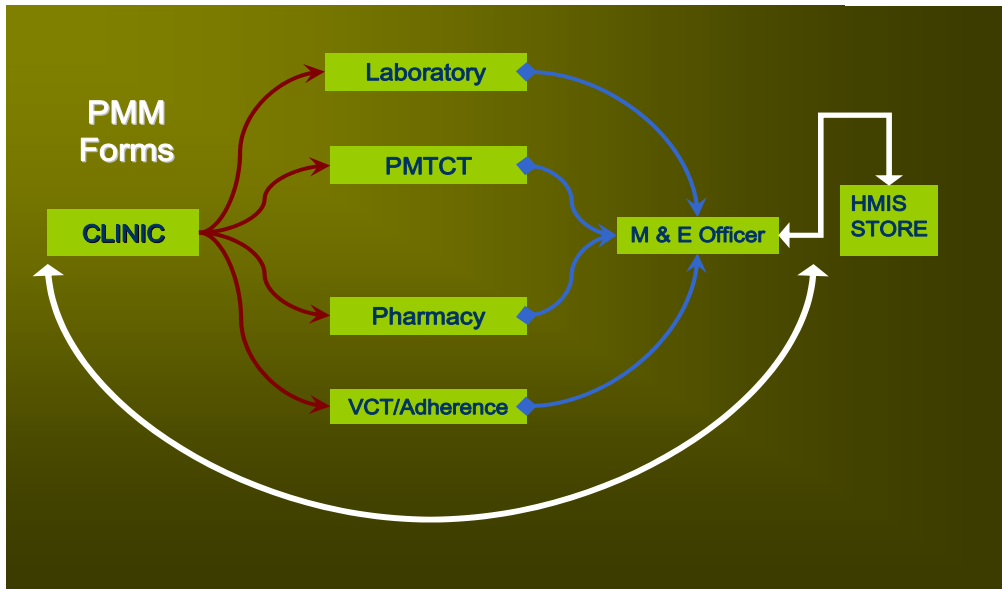
Pharmacy Data Flow



At a clinic visit the clinician initiates a Pharmacy order form specifying the dosage and quantity of drugs to be dispensed. The patient goes to the pharmacy with this form. The Pharmacist fills in the quantity dispensed and appends signature before dispensing the drugs. The patient/caregiver also appends signature on the form before collecting the drugs. The white copy of this form is sent to the medical/patient records. The yellow

copy is securely filed away in the Pharmacy filing cabinet, while the pink copy is collected by data entry clerk/ program officer from the M&E unit. The data on this pink copy is captured electronically with the computer based automated system and the hard copy is kept in a secure filing cabinet in the M&E office.

Overall On-Site Data Flow



Data that is generated every clinic day from the Clinic, Lab, Pharmacy, Adherence office and PMTCT centre is captured on the pink copy of the PMM forms. This pink copy is collected by data entry clerk/ program officer from the M&E unit. The data on this pink copy

is captured electronically with the computer based automated system. The hard copy is securely filed away in a filing cabinet in the M&E office.

4. Management of information

4.1. Form Storage

All ART-PMM forms are in triplicates (White, yellow and pink).

At the completion of each of the clinical evaluation, lab investigations, or drug dispensation:

1. The white form is placed in the patient's folder
2. Yellow form is retained by the unit that is kept at the unit that completed the order or provided service
3. Pink form is sent to M&E office for data entry and record keeping

Note: All the PMM forms should be locked up in the cabinet.

4.2. Quality management

Clinical record is collected using paper-based and computer-based systems. Microsoft Access is used as the database program, and tested before implemented. It is also equipped with date of data entry and technician's initial. Paper-based record is entered into database everyday by data entry technician at the point-of-service. In-country technicians are trained by the IHV-Nigeria M&E staffs. As an additional quality assurance measure, IHV-Baltimore M&E staffs who have thorough knowledge of the Standard Operating Procedures organize several onsite visits. The onsite visits are to ensure that in-country technician are following the standard procedures. Additionally, contact number is provided in the database for software operation and questions. Data entry technician should follow the data quality control procedure outlined below to ensure the integrity of all data entered.

Prior to data entry

1. Check that the minimum dataset are completed
2. Check that boxes are properly checked
3. Check that values and comments are eligible and clear
4. Check that numbers mostly dates, age, test results, and other values are valid
5. Check that all answers are consistent for example a male cannot be pregnant
6. Investigate all unclear data with relevant staff before data entry
7. Correct all error prior to data entry
8. Document all data errors and corrected changes made in the data log book

After data entry

1. Check data quality regularly using the data entry checks in place
2. Rectify any identified errors
3. Document any changes made in the database in a data log book
4. Identify common sources of error using the data log book
5. Ensure proper and consistent daily data back-up
6. Train and retrain personnel making common data collection errors to improve data quality

Errors made on data collection forms are recorded in the data error log book by the data entry clerk (**Appendix 5**). Errors can occur at both the data collection and data entry phase. Types of data collection errors are listed below:

- Wrong form- using the wrong PMM form to collect data i.e., a physician using an initial clinical evaluation form instead of follow-up clinical evaluation form
- Routing errors – i.e., when a person filling out a form, places the number in the wrong part or wrong order.
- Consistency errors – i.e., when two or more responses on the same form are contradictory. For example, when the birth date and age are inconsistent.
- Transposition – i.e., “39” is entered instead as “93”. This is typically a typing mistake.
- Range errors – When a number lies outside the range of probable or possible values.

Types of data entry errors are listed below:

- Copying errors – i.e., “1” is entered as “7”.
- Coding errors – Inserting the wrong code. i.e., A physician selects “1” which represents Yes, but the coder copies 2 (which represents “No”) instead.
- Misinterpretation errors – misreading or misunderstanding what is written, and then entering what is the presumed response (instead of verifying information).

The date, patient/hospital id, type of error, personnel responsible, whether or not the personnel has been notified and whether or not error has been corrected must be recorded in the data entry error log book. Data error log book enables data entry personnel to see the common types of errors being made and identify personnel making errors consistently. This will inform the need for training or retraining of personnel on the proper use of the PMM forms.

4.3. Automated System

Futures Group, under the consortium of our partner GHAIN is responsible for developing and providing training & support for the computer-based system that will be used for data capture at the health facility. Initially this system is used for data capture by the data entry clerks. The system will eventually be developed to produce CDC indicator reports on a monthly basis (Appendix 6). Not all fields will be entered. Only key critical data elements will be entered.

The data entry clerk at the POS will have user level access to the system, while the systems support staff from IHV-Nigeria will have administrative level access to the system. If the system develops any fault, IHV-Nigeria In-country M&E staff should be contacted immediately for further directive. No external systems support person should be brought in to work on the system without due permission from IHV-Nigeria M&E department.

No part of the data set in the backend MS Access database may be used for research or any other purpose without the permission of IHV-Nigeria M&E director. The use of the data set in the electronic database without due permission will be taken as a breach of the patients’ right to confidentiality.

4.4. Confidentiality and security

Much of the information collected by health facilities about patients is confidential. Any efforts to monitor and evaluate clinical care programs must above all else respect this confidentiality. It is important to ensure that the monitoring system does not increase the risk that an individual patient’s name or health status will be revealed.

Confidentiality- The M&E staff must maintain patients’ confidentiality by ensuring that:

- Patient’s personal identifiers is only present on first copy of program forms
- All other patients’ medical information is identified by numbers not names
- Review of clinical records containing the names of patients should be restricted to the healthcare providers of the patients concerned

Security-The M&E staff must maintain the security of both hard copies and electronic data by ensuring that:

- Both hard and electronic copies of all PMM forms are stored under fire-safe and secured filing cabinets
- All databases are password protected or protected by firewalls

5. Reporting of information

5.1. Facility level Data Reporting

5.1.1. Developing aggregated data from patient level data

M&E officers collect the M&E copies of all completed PMM forms, edit, collate and enter the data into the electronic database. M&E officers generate report from the aggregate data every month. The M&E officer at each point of service is required to transfer raw data to IHV-Nigeria (IHVN) monthly for quality assurance purposes.

5.1.2. Reporting of data to site coordinator

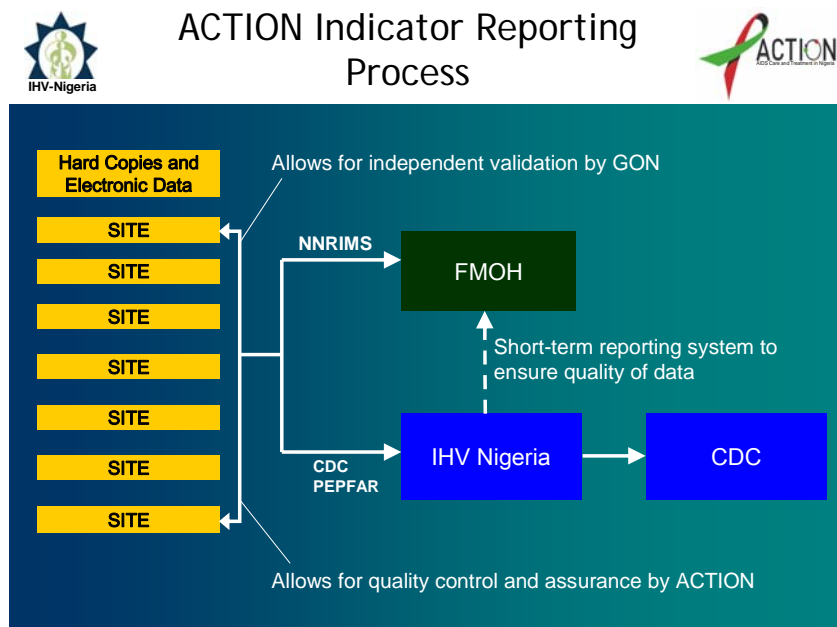
On the 30th or 31st of each month (the end of each month), the site M&E officer sends the draft monthly reporting for review by site ART coordinator and ACTION; this is a procedure to ensure data's completeness and quality. ACTION will assist with data discrepancy, completeness, and troubleshooting if needed. On the 7th of subsequent month the site M&E officer will generate the final monthly reporting indicators from the database. This final report is forwarded to IHVN.

5.2. National level Data Reporting

5.2.1. Description of key data reporting to IP and GON

The final monthly reporting indicators are forwarded from IHVN to IHV-Baltimore for review. The process from data compilation at the point of service to data aggregation and indicator reporting at the IHVN takes 7-10 working days (maximum of 14 work days). If the report is approved by IHV-Baltimore, on the 10th day of the completion month, the site ART Coordinator should send a hard

copy of the NNRIMS indicators to the Federal Ministry of Health. A hardcopy of the CDC and PEPFAR indicator reports should be also mailed or faxed to the IHV Nigeria Office in Abuja to include the ACTION Project Director and M&E Director. ART coordinator has the option of additionally sending the summary forms electronically. FMOH M&E unit NASCP and the IHVN M&E unit will acknowledge receipt or non-receipt of the reports as soon as they receive them.



Appendix 2: PMM Forms

(See PMM forms in excel format. The forms will be put together with the main document in pdf format)

Appendix 3: Example of PMM Form Instruction

(See example PMM form instructions in excel format. The forms will be put together with the main document in pdf format)

Appendix 6: Manual for PMM Automated System

(Waiting for file from M&E IHVN)

Appendix 7: Important contact information

Name	Role	Phone (Nigeria)	Email
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