**Report of TA visit To Tse-Agberagba Primary Health Center for DQA and Folder Audit**

**Introduction**

The team met with the Officer-in-Charge (OIC) of the facility, Mr Gabriel Tyoade, to whom they introduced themselves and informed him of the purpose of the visit. He warmly welcomed the team and gave them the visitors’ book to sign. Thereafter, the team proceeded to the ART unit where they met with various service providers, APIN Ad hoc staff and facility volunteers.

**Observations on DQA**

The DQA exercise went smoothly with data concurrency in most thematic areas, except in TB\_ART department.

Firstly, the Central TB Treatment register was not sighted. The TB volunteer explained that the Local Government TB focal person picked it and has not returned it.

Secondly, TB\_ART was underreported by 1. Reported figure is 0 while validated figure is 1 (male 30-34). This was confirmed using the TB presumptive register.

Similarly, TX\_TB was over reported by 1. Reported figure is 2 while validated figure is 1 (male 30-34).

**Observations on Folder Audit**

1. AHD folders audited were found to be in proper order. Two (2) AHD clients were identified for the period under review.
2. There is agreement between entries in the folder and EMR updates especially in terms of drug pickup dates, numbers of drugs dispensed, sex of client, Viral load and Blood Pressure.
3. It was noted that when additional care cards are added to a client folder, the complete information on the old care card are not transferred to the new care card.

**Solutions Proffered**

1. The team encouraged the TB volunteer to make efforts to retrieve the TB treatment register and return it to the facility as soon as possible.
2. The M&E Assistant was advised to strengthen documentation and reporting, especially in the TB area.
3. Data entry clerks were advised to ensure they completely transfer all the information on the old care card unto the new one whenever the old care card is used up.

**Conclusion**

The facility appears to be properly organized, as evidenced by the quality of documentation and concurrency between the folders and EMR. The Officer-in-Charge was briefed on the findings and he promised to give more support to the ART unit in order to ensure quality client care, documentation and reporting.