IRB Research approval number: ####
This approval will elapse on: dd/mm/yyyy

Title of the research: Completion of 6-month Isoniazid preventive treatment among Under Six Child contacts of adults with smear positive pulmonary Tuberculosis in Lagos, Nigeria

Name(s) and affiliation(s) of researcher(s) of applicant(s):

This study is being conducted **by Dr Adepoju Victor Abiola** of the Jhpiego Nigeria (an affiliate of John Hopkins University, Nigeria (PI, Nigeria)

Sponsor(s) of research: **NA**

Information About the Research(purpose, procedure, duration etc)

My name is Adepoju Victor Abiola. We will like to take your consent on behalf of your under-six children who was placed on INH in this health facility. We are planning to extract the child information on INH history from the register. The data will not contain your child name, age or any other means of identification when the data is eventually analysed and published

Possible Risks
We do not expect that you are at risk of any bad things happening to you by participating in this interview. You may feel uncomfortable answering some questions. You are not required to answer any question that you do not want to. In addition, you can refuse to participate in the research study at any time.

Possible Benefits
Being in this study will not directly benefit you. If you have child INH was not completed, we will ask healthcare workers to follow up with you and restart the medications if still eligible.

Voluntary Participation
You are free to decide if you want to be in this research or not. You do not have to answer any questions as we rely only on information available in register. If you agree to participate and then you change your mind, you are free to withdraw your consent and discontinue your participation at any time. If you decide not to participate, your decision will not get you in trouble with your employer.

Confidentiality
We will not share any of the information from the register with anybody outside of our evaluation team. We will protect information about your child and your participation in this research study to the best of our ability. We will not use your child's name in any reports. We will produce a report and possibly briefers with focus on key themes, as relevant. Depending on the findings we may share lessons learned and findings in peer reviewed journal and conferences All identifying information will be removed before the data is shared. All documents about this discussion will be destroyed after 3 years.

Payment

You will not receive any payment for your participation in this study

If You Have a Questions About the Study
If you have any questions about the evaluation, call Adepoju victor on 08166317148

Your rights as a Participant
This research has been is a retrospective cohort review and no human subject is involved hence no ethical approval was necessary in this context. However, permission was received from the Lagos State Ministry of Health through the TB Control program.

Eligibility Criteria:

1. Is your child les tan 6 years ? Yes__ No__

2. Is this participant eligible to participate in this study? Yes__No__

Does the candidate consent to participate in this study? Yes__No__

Do you have any questions? Do you want a copy of this form? Yes__No__

Statement of person obtaining informed consent:

I have fully explained this research to _____the mother of the child_____ and have given sufficient information, including about risks and benefits, to make an informed decision.
DATE: _____August 20, 2022_____ SIGNATURE: __VAA_____
NAME: _____Adepoju Victor_____
Statement of person giving consent:
I have read the description of the research or have had it translated into language I understand. I have also talked it over with the doctor to my satisfaction. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.
DATE: _____August 20,2022_____ SIGNATURE: _ADI_____
NAME: ADI_____
WITNESS' SIGNATURE (if applicable): __EE_____
WITNESS' NAME (if applicable): ___EE_____

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.