**Intensive Adherence Counselling form**

|  |  |  |  |
| --- | --- | --- | --- |
| **A: PATIENT INFORMATION** | | | |
| Client’s Name: |  | Patient ART No : |  |
| Name of Health Facility: |  | Sex: |  |
| Client Phone No: |  | Date of birth/Age: |  |
| Current place of residence (village/parish) |  | Date of last VL sample collection: |  |
| Current ART Regimen: |  | Viral load result prior to IAC (copies/ml): |  |
| Name & Contact of Treatment supporter |  | IAC start Date: |  |
| **B: ADHERENCE ASSESSMENT: (***Adherence levels of the Client should**be assessed every IAC session. The Client should be encouraged to bring all medications with him/her on every appointment date*) | | | |
| 1. **Pill Count:**    1. Adherence = Number of pills swallowed in one month X 100   Total Number of pills supposed to be swallowed in one month   1. **Missed doses/month**    1. 1xdaily dosing: <2doses=G, 2-4 doses=F, >4 doses=P    2. 2xdaily dosing: <3 doses=G, 4-8 doses=F, >8 doses=P   **Adherence scores**: **Good (G)** if >95; **Fair (F)** if 85–94% ; **Poor (P)** if <85% | | | |

**CONSENT FOR PHONE IAC:**

Client agrees to discuss sensitive information about their HIV viral load and adherence to ART in a phone conversation.

**YES** **NO**

| **C: ASSESSMENT OF ADHERENCE BARRIERS:** (*Assessment of client adherence practices should be done every visit since behavior is not static*) | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Issue** | **If N, document key issue/specify** | | | | | | | |
| **Y/N** | **1st IAC** | **Y/N** | **2nd IAC** | **y/N** | **3rd IAC** | **y/N** | **4th IAC** |
| **Adherence related issues (5Rs)** | | | | | | | | |
| Is client taking the Right prescribed ARV regimen? |  |  |  |  |  |  |  |  |
| Is client taking the Right dose of the prescribed ARV regimen?*(****If child, refer to child dozing chart****)* |  |  |  |  |  |  |  |  |
| Is client taking the prescribed ARV regimen the Right way? (e.g. route, food) |  |  |  |  |  |  |  |  |
| Is client taking the prescribed ARV regimen at the right time? |  |  |  |  |  |  |  |  |
| Is client taking the prescribed ARV regimen in the Right frequency? |  |  |  |  |  |  |  |  |
| Is client keeping the drugs as prescribed? |  |  |  |  |  |  |  |  |
| **Other medical related issues** | | | | | | | | |
| Is client taking other medications besides ARVs? (eg. Anti-TB’s)  If yes, list them |  |  |  |  |  |  |  |  |
| Client has any Side effects? |  |  |  |  |  |  |  |  |
| Is client pregnant or breastfeeding? |  |  |  |  |  |  |  |  |
| **Psychosocial Issues** | | | | | | | | |
| Is client knowledgeable about ART? |  |  |  |  |  |  |  |  |
| Has the client disclosed HIV status? If child/adolescent is he/she disclosed to? |  |  |  |  |  |  |  |  |
| Any physical, sexual, emotional abuse currently occurring? |  |  |  |  |  |  |  |  |
| Is client using Alcohol or other drugs eg. Tobacco, Shisha, Marijuana, e.t.c? |  |  |  |  |  |  |  |  |
| Does client have any mental health related problems? |  |  |  |  |  |  |  |  |
| Client’s emotional status ( eg. Anger, shock, denial, anxiety, acceptance, coping, e.t.c )? |  |  |  |  |  |  |  |  |
| Client experiencing any form of Stigma and discrimination? |  |  |  |  |  |  |  |  |
| Client has socio-economic issues problems? |  |  |  |  |  |  |  |  |

**D: FIRST IAC SESSION**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adherence Assessment score (Percentage and code): \_\_\_\_\_\_\_

**Barriers, strategies and actions**

|  |  |  |
| --- | --- | --- |
| Barriers | Strategies (what client is going to do to deal with the barriers) | Action Plan (how and when-within 1 month) |
| 1. | 1. | 1. |

Next IAC Appointment Date: ----------------------------------------------------------

Name of Counselor/Health Worker: ---------------------------------------------- Signature ------------------------

**E: SECOND IAC SESSION**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adherence Assessment score (Percentage and code): \_\_\_\_\_\_

**Review of 1st IAC Action points**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Barriers, strategies and actions**

|  |  |  |
| --- | --- | --- |
| Barriers | Strategies (what client is going to do to deal with the barriers) | Action Plan (how and when-within 1 month) |
|  |  | 1. |

Next IAC Appointment Date: ----------------------------------------------------------

Name of Counselor/Health Worker: -------------------------------------------- Signature --------------------------

**F: THIRD IAC SESSION**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adherence Assessment score (Percentage and code): \_\_\_\_\_\_\_

**Review of 2nd IAC Actions**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Barriers, strategies and actions**

|  |  |  |
| --- | --- | --- |
| Barriers | Strategies (what client is going to do to deal with the barriers) | Action Plan (how and when-within 1 month) |
|  |  | 1. |

**IAC SESSIONS OUTCOMES:**

**(*Tick the appropriate box*)**

**Client ready for 2nd VL test**

**Client not ready for 2nd VL test**

**ACTION TO BE TAKEN**

1. Appointment for 2nd VL made : Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If client is not ready for 2 VL test, continue with IAC
3. Client referred for further support. Specify **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Counselor/Health Worker: ------------------------------------------- Signature --------------------------

**Key Messages**

* IAC sessions must be documented using approved MOH tools.
* A review of those documents helps you monitor the IAC coverage and the quality of the IAC sessions.