

Administer at each follow up visit if patient on ARV, TB or OI Medications.

Patient Name

Facility Name

ID - -
State Facility No Serial Enrollment No

Hospital No

Sex F M

Age years If < 5 years months

1. I have questions about the medications you (or your child) took over the last three days. Most people have to take many pills every day for their diseases. We are trying to understand your medication adherence habits, so please share with us your routine in taking your meds.

1a. List all current ARV medications and doses missed.

ARV Med Name, Dosage, Frequency	Yesterday	2 days ago	3 days ago
1)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed
2)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed
3)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed
4)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed

1b. List all current TB and OI medications and doses missed.

TB and OI Med Name, Dosage, Frequency	Yesterday	2 days ago	3 days ago
1)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed
2)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed
3)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed
4)	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed	<input type="text"/> Doses Missed

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?

- Never Most of the time
 Some of the time All of the time
 About half of the time

3. What do/did you do to help you remember to take/give medications, i.e., to be adherent?

Sometimes one forgets to take their pills in certain circumstances. Did you/your child skip or miss any of your/his/her medications:

- 4a. In the mornings?** Y N **4b. In the evenings?** Y N
4c. On market days? Y N **4d. On the weekends?** Y N
4e. When traveling? Y N **4f. Others (specify)** _____

Patient Name

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5. Taking medications every day can be difficult. What were the most common reason(s) for not taking or missing your medications during the last visit?

Not applicable/ did not miss taking any of my medications.

Possible Reasons for Missed or Delayed Medications	Check all that apply	Rank top 3 reasons
Forgot	<input type="radio"/>	<input type="checkbox"/>
Fell asleep / slept through dose	<input type="radio"/>	<input type="checkbox"/>
Change in routine / away from home	<input type="radio"/>	<input type="checkbox"/>
Busy / working / at school	<input type="radio"/>	<input type="checkbox"/>
Got pregnant	<input type="radio"/>	<input type="checkbox"/>
Patient moved	<input type="radio"/>	<input type="checkbox"/>
Ran out of medications	<input type="radio"/>	<input type="checkbox"/>
Pharmacy or dispensary did not have any medicines	<input type="radio"/>	<input type="checkbox"/>
Not able to pay	<input type="radio"/>	<input type="checkbox"/>
Felt well	<input type="radio"/>	<input type="checkbox"/>
Felt sick / bad (for example, nausea or vomiting)	<input type="radio"/>	<input type="checkbox"/>
Felt overwhelmed / depressed	<input type="radio"/>	<input type="checkbox"/>
Did not understand how to take medications	<input type="radio"/>	<input type="checkbox"/>
Did not want others to know	<input type="radio"/>	<input type="checkbox"/>
Too many pills	<input type="radio"/>	<input type="checkbox"/>
Did not want to take medications	<input type="radio"/>	<input type="checkbox"/>
Afraid of / affected by drug side effects	<input type="radio"/>	<input type="checkbox"/>
Other (specify) _____	<input type="radio"/>	<input type="checkbox"/>
Other (specify) _____	<input type="radio"/>	<input type="checkbox"/>
Other (specify) _____	<input type="radio"/>	<input type="checkbox"/>
Children specific:		
Refuses to take medications	<input type="radio"/>	<input type="checkbox"/>
Spits medications out	<input type="radio"/>	<input type="checkbox"/>
Vomits medications	<input type="radio"/>	<input type="checkbox"/>
Did not understand how to give medications	<input type="radio"/>	<input type="checkbox"/>
Caregiver did not want to give medications	<input type="radio"/>	<input type="checkbox"/>
Caregiver moved	<input type="radio"/>	<input type="checkbox"/>
Change in caregiver	<input type="radio"/>	<input type="checkbox"/>

6a. What issues or barriers need to be addressed for you to become more adherent? Specify.

Patient/Caregiver - Related	Check	Health Team - Related	Check	Environment - Related	Check
Commitment	<input type="radio"/>	Trust and confidence	<input type="radio"/>	More family support	<input type="radio"/>
Health beliefs	<input type="radio"/>	Poor communication	<input type="radio"/>	More PLWHA support	<input type="radio"/>
HIV knowledge	<input type="radio"/>	Poor patient education	<input type="radio"/>	Address stigma	<input type="radio"/>
Disclosure of status	<input type="radio"/>	Adherence team support	<input type="radio"/>	School	<input type="radio"/>
Health of patient	<input type="radio"/>	Provider support	<input type="radio"/>	Improve job skills	<input type="radio"/>
Lifestyle	<input type="radio"/>	Cultural / religious sensitivity	<input type="radio"/>	Need a job	<input type="radio"/>
Away from home	<input type="radio"/>	Drug supply	<input type="radio"/>	Transport to clinic	<input type="radio"/>
Work / study	<input type="radio"/>		<input type="radio"/>	Food availability	<input type="radio"/>
Depression	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>
Alcohol / substance use	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>
Cost	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>
Support group	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>

6b. Any other issues (in patient's own words): _____

7. If adherent, continue current treatment strategy as is. Y N

8a. If not adherent, have adherence team re-evaluate patient's situation. Y N

Next Step: _____

8b. Suggest the following reminders to help you /your child to take your / their medications, i.e., to be adherent.

- None needed
- Use pillbox
- Use alarm or text-messaging
- Time pill taking with daily routine (i.e., prayers, eating, radio program)
Specify: _____
- Go to adherence counseling sessions
- Praise child
- Make medications more palatable (add flavor to medications)
- Use Treatment Partner (an HIV+ peer, friend or family member);
Who: _____
- WOT, specify: _____
- DOT, specify: _____
- Other: _____

Adherence Counselor Name

Adherence Counselor Signature

Date (dd/mm/yyyy)