Informed Consent Form

Title: Refill of Antiretroviral medicines (ARVs) at Community Pharmacies

Sponsors: Strengthening Integrated Delivery of HIV/AIDS Services Delivery (SIDHAS) project with funding from PEPFAR through US Agency for International Development (USAID)

Background and Purpose of the Intervention: Some of the hospitals providing antiretroviral treatment (ART) in the project are overburdened due to high patients’ load and inadequate pharmacy personnel for timely provision of quality pharmaceutical services. These have resulted in increased waiting time; and inadequate duration of pharmacist-patient interaction during service provision which has the potential to adversely affect the quality of pharmaceutical care provided to patients. This intervention is aimed to decongest ART sites with excessive patients load while ensuring that the patients are not alienated from standard clinical and laboratory services; and consequently improve patient satisfaction with ART services. Note that the antiretroviral medicines will remain FREE.

What You Will Be Asked to Do?
You are eligible to participate in this intervention if you are:
- Stable on 1st line ART regimen for at least one year from high volume ART sites with inadequate pharmacy personnel,
- Have no opportunistic infections
- Assessed to have good medication adherence
- Be willing to be devolved to a Community Pharmacy of their choice.
- Ready to pay BIMONTHLY fee of One thousand Naira (N1, 000=) to Community Pharmacy; being the administrative charge for the service.
- ART drugs will remain FREE at the Community Pharmacy.
- Sign the Informed consent form for ART refill at CP program

After signing the inform consent form, you will be receiving your bimonthly ARV medicines’ refills at the Community Pharmacy of your choice and return to the hospital every six months for clinical and laboratory assessment or as necessary. You will remain the patient of the hospital with the Community Pharmacy acting as a satellite pharmacy for you to receive your medicines without the long queues at the hospital. The ARV medicines are received from the hospital and your information still be retained in the hospital.

Risks and Discomforts: We do not foresee any risks or discomfort from your participation in this intervention.

Benefits of the Intervention to You:
Some of the benefits to you include improved convenience of your refills and satisfaction due to decreased waiting time to get your medicines. There will also be improvement in the duration of interaction with your pharmacist during service provision which can improve drug therapy monitoring, medication adherence and consequently the quality of pharmaceutical care provided to you.
**Voluntary Participation:** Your participation is completely voluntary and you may choose to stop participating at any time. Your decision not to participate will not influence the treatment or services you are currently receiving or nature of the ongoing relationship with you either now, or in the future.

**Withdrawal from the Intervention:** You can stop participating at any time, for any reason, if you so decide. If you decide to stop participating, you will still be eligible to receive the treatment or services in the hospital. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the hospital, community pharmacy or any other group associated with this project. Note that the Community Pharmacist has the right to stop providing pharmaceutical services to you and will send you back to the hospital if you continue to breach any part of this agreement or due to persistent non-adherence. However, you are not required to stop abruptly on your own or by the Community Pharmacist but follow the procedure for a smooth transition back to the hospital aimed at ensuring transparency and accountability.

**Confidentiality:** All information you supply during the program will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of any form. Your data will be safely stored in a locked facility and only relevant staff will have access to this information. Confidentiality will be provided to the fullest extent possible.

**Questions about the Intervention?** If you have questions about the intervention in general or about your role in the program, please feel free to contact us either by telephone at _______________ or by e-mail ______________________________. If you have any questions about this process, or about your rights as a participant, please contact _________________________________.

**Legal Rights and Signatures:**
I, ________________________________, consent to participate in the **Refill of Antiretroviral medicines (ARVs) in the Community Pharmacy program** conducted by SIDHAS project. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

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**Name of Hospital:**
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Witnessed by Hospital Staff

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