

Baseline behavioral (BEH) CRF [Visit 2]

Note: Information in italics is for the interviewer and will not be read aloud to the participant. All response options should be read aloud to the participant unless shown in italics.

<i>INTERVIEWER READS:</i> The following are some questions related to your sexual and reproductive health, and your relationship with any sexual partners.		
1.	How many partners have you had in the last 6 months?	# Partners: <input type="text"/> <input type="text"/>
2.	Do you currently have a main partner? By main partner, I mean someone you have sex with on a regular basis who you consider to be your primary partner.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No → skip to Q9
3.	How old is your main partner?	<input type="text"/> <input type="text"/> years old <input type="checkbox"/> age unknown, <i>estimated age:</i> _____
4.	How long have you and your main partner been in a relationship? [If you have been in a relationship for less than one year, how many months have you been together?]	<input type="text"/> <input type="text"/> specify years or <input type="text"/> <input type="text"/> specify months
5.	When it comes to making decisions about your health care, who has the final say? Is it...	<input type="checkbox"/> ₁ You <input type="checkbox"/> ₂ Your main partner <input type="checkbox"/> ₃ You and your main partner, together <input type="checkbox"/> ₄ Someone else <input type="checkbox"/> ₅ Other, <i>specify:</i> _____
6.	Do you believe your main partner has or had sexual partners other than you in the last six months?	<input type="checkbox"/> ₁ Yes, I know so <input type="checkbox"/> ₂ Yes, I believe so <input type="checkbox"/> ₃ No <input type="checkbox"/> ₄ Don't know
7.	Are you or your main partner currently using a method for HIV prevention?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No → skip to Q9
8.	What method(s) are you and your main partner using?	Yes No
	a. Male condom	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	b. Female condom	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	c. Oral PrEP	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	d. Male circumcision	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	e. Viral suppression through ART	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	f. Injectable CAB-LA	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	g. DPV vaginal ring	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
	h. Other, specify	<input type="checkbox"/> ₁ <input type="checkbox"/> ₂
9.	In the past 30 days, have you used vaginal lubricant (for any reason)?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No
10.	In the past 30 days, have you had vaginal sex?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No → skip to Q13
11.	I know that you are counseled to use condoms when you have vaginal sex, but I also know that this isn't always possible. In the past 30 days, how often did you use a male or female condom during vaginal sex?	<input type="checkbox"/> ₁ Every time <input type="checkbox"/> ₂ Almost every time <input type="checkbox"/> ₃ Occasionally <input type="checkbox"/> ₄ Very infrequently <input type="checkbox"/> ₅ Never → skip to Q13

12.	During the last time you had vaginal sex, was a male or female condom used?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No <input type="checkbox"/> ₃ Don't know
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13.	When making choices about HIV prevention, who do you speak with to help you make the decision? <i>(Mark all that apply)</i>	<input type="checkbox"/> ₁ No one, it is your decision <input type="checkbox"/> ₂ Clinic staff (doctor, nurse, counselor, etc.) <input type="checkbox"/> ₃ Your mother <input type="checkbox"/> ₄ Your sibling/s <input type="checkbox"/> ₅ Your partner <input type="checkbox"/> ₆ Friend/s <input type="checkbox"/> ₇ Other <i>(Specify: _____)</i>
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INTERVIEWER READS: Now, I would like to talk about pregnancy and family planning. Family planning refers to the various methods that a couple can use to delay or avoid pregnancy.

14.	Have you ever been pregnant? [This includes if you are currently pregnant or have given birth, had an abortion or a miscarriage.] 14a. How many times have you been pregnant?	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No → skip to Q16 # Pregnancies: <input type="text"/> <input type="text"/>
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15.	How many live births have resulted from these pregnancies?	# Live births: <input type="text"/> <input type="text"/>
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16.	Which of the following methods for family planning have you ever used ? Please answer based on your experiences with ALL your partners, both past and present. Have you ever used... <i>(insert response option, mark all that apply)</i>	<input type="checkbox"/> ₁ Oral pills <input type="checkbox"/> ₂ Injectable (or shot) <input type="checkbox"/> ₃ Implant <input type="checkbox"/> ₄ Male condoms <input type="checkbox"/> ₅ Female condoms <input type="checkbox"/> ₆ IUD <input type="checkbox"/> ₇ Emergency contraception <input type="checkbox"/> ₈ Female sterilization (tubal ligation/hysterectomy) <input type="checkbox"/> ₉ Natural methods (rhythm, fertility awareness, calendar) <input type="checkbox"/> ₁₀ None → skip to Q18 <input type="checkbox"/> ₁₁ Other: Is there any other method you have used for family planning? <i>(Specify: _____)</i>
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17.	Which of these methods have you used in the past 30 days?	<p><i>[Only read aloud response options that were chosen in the previous question]</i></p> <input type="checkbox"/> 1 Oral pills <input type="checkbox"/> 2 Injectable (or shot) <input type="checkbox"/> 3 Implant <input type="checkbox"/> 4 Male condoms <input type="checkbox"/> 5 Female condoms <input type="checkbox"/> 6 IUD <input type="checkbox"/> 7 Emergency contraception <input type="checkbox"/> 8 Female sterilization (tubal ligation/hysterectomy) <input type="checkbox"/> 9 Natural methods (rhythm, fertility awareness, calendar) <input type="checkbox"/> 10 None <input type="checkbox"/> 11 <i>Other: Is there any other method you have used for family planning? (Specify: _____)</i>
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INTERVIEWER READS: The next questions are about products or items you may have inserted into your vagina for health reasons, cleanliness, menstrual control or for pleasure. Even if you might change how you use these products while you are in the study, I would like to know how often you have used them in the past three months.

18.	In the last three months, how often have you inserted anything into your vagina to... <i>(Show Response Card 6)</i>	Daily	Almost every day	Weekly	Monthly	Never
	a. Control menses	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	b. Treat infection	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	c. Tighten or dry the vagina for sex	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	d. Clean the vagina	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	e. <i>Other, specify: _____</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	18ai-ei. <i>If participant indicates that they have inserted a product into their vagina, ask: What products or items did you use:</i>	a. _____ b. _____ c. _____ d. _____ e. _____				

19.	How comfortable are you with inserting something in your vagina in general? <i>(Show Response Card 7)</i>	<input type="checkbox"/> 1 Very comfortable <input type="checkbox"/> 2 Somewhat comfortable <input type="checkbox"/> 3 Somewhat uncomfortable <input type="checkbox"/> 4 Very uncomfortable
20.	How comfortable are you with inserting something in your vagina with your fingers? <i>(Show Response Card 7)</i>	<input type="checkbox"/> 1 Very comfortable <input type="checkbox"/> 2 Somewhat comfortable <input type="checkbox"/> 3 Somewhat uncomfortable <input type="checkbox"/> 4 Very uncomfortable

END OF CRF

CRF Completed By: _____ (initials)

CRF Completion Date: ___ / ___ / _____ (dd/mm/yyyy)