





Follow-up behavioral and acceptability (FU3) CRF [Visit 4, 8]

Information in italics is for the interviewer and will not be read aloud to the participant.

<p>INTERVIEWER READS: The following questions ask you about your opinions and experiences with the vaginal ring you used <u>over the past two weeks</u>. Your honest opinions are very important in making sure we have the best information possible for developing HIV prevention products that will be liked and can be easily used by people like you.</p>									
<p>Overall Product Acceptability</p>									
<p>1. On a scale of 1 to 10, how much did you like or dislike using the vaginal ring <u>in the past two weeks</u>, where 1 means extremely disliked and 10 means extremely well liked? <i>(Show Response Card 11)</i></p>									
									
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
¹ Extremely disliked ² Very disliked					⁹ Very well liked ¹⁰ Extremely well liked				
<p>2. Please rate how easy or difficult it was for you to use the ring (have it inserted in your vagina) <u>in the past two weeks</u>, from 1-10, with 1 being extremely difficult and 10 being extremely easy. <i>(Show Response Card 12)</i></p>									
									
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
¹ Extremely difficult ² Very difficult					⁹ Very easy ¹⁰ Extremely easy				
<p>3. On a scale of 1 to 10, how worried were you about using the vaginal ring <u>in the past two weeks</u>, where 1 means extremely worried and 10 means not at all worried? <i>(Show Response Card 13)</i></p>									
									
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
¹ Extremely worried ² Very worried					⁹ Not worried ¹⁰ Not at all worried				
<p>4. On a scale of 1 to 10, how excited were you when using the vaginal ring <u>in the past two weeks</u>, where 1 means not at all excited and 10 means extremely excited? <i>(Show Response Card 14)</i></p>									
									
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
¹ Not at all excited ² Not excited					⁹ Very excited ¹⁰ Extremely excited				
<p>5. How often were you aware of the feeling of this vaginal ring during your normal daily activities?</p>						<input type="checkbox"/> 1 Most of the time <input type="checkbox"/> 2 Sometimes <input type="checkbox"/> 3 Never			

<p>6. Since the last visit, did you notice any of the following changes in your vagina? <i>(Mark all that apply)</i></p>	<p><input type="checkbox"/> ₁ More wetness than normal <input type="checkbox"/> ₂ More dryness than normal <input type="checkbox"/> ₃ More itchiness than normal <input type="checkbox"/> ₄ More soreness than normal <input type="checkbox"/> ₅ Other, <i>specify:</i> _____ <input type="checkbox"/> ₆ No noticeable changes</p>
<p>Expulsion and Removal</p>	
<p>7. Has the vaginal ring been removed or come out since your last study visit? <i>Check all that apply</i></p>	<p><input type="checkbox"/> ₁ Yes, the ring was removed intentionally <input type="checkbox"/> ₂ Yes, the ring came out unintentionally or accidentally <input type="checkbox"/> ₃ No, the ring has not come out, either accidentally or intentionally → skip to Q10</p>
<p>8. <i>[If Q7= 1]</i> Why was the vaginal ring removed? <i>Check all that apply</i></p>	<p><input type="checkbox"/> ₁ <i>It was uncomfortable</i> <input type="checkbox"/> ₂ <i>It felt like it was falling out</i> <input type="checkbox"/> ₃ <i>I wanted to show my partner/ my partner wanted to see it</i> <input type="checkbox"/> ₄ <i>My partner asked me not to wear it</i> <input type="checkbox"/> ₅ <i>I wanted to clean it</i> <input type="checkbox"/> ₆ <i>I was menstruating</i> <input type="checkbox"/> ₇ <i>I wanted to have sex without it</i> <input type="checkbox"/> ₈ <i>I was sick (e.g. diarrhea) and worried that it would be expelled</i> <input type="checkbox"/> ₉ <i>Other (specify):</i> _____</p>
<p>9. <i>[If Q7 = 2]</i> Do you know what caused the ring to come out? <i>[Probes: when did this happen? What were you doing when this happened?]</i></p>	<p>Describe: _____ _____</p>
<p>Burden</p>	
<p>10. Since your last visit, how often did your use of the vaginal ring interfere with any of your regular daily activities?</p>	<p><input type="checkbox"/> ₁ Most of the time <input type="checkbox"/> ₂ Sometimes <input type="checkbox"/> ₃ Never → skip to Q12 <input type="checkbox"/> ₄ Ring not used → skip to Q12</p>
<p>11. Which daily activities were disrupted by ring use?</p>	<p>_____</p>
<p>Ring Use During Sex and Vaginal Practices</p>	
<p>INTERVIEWER READS: I know you were counseled to abstain from sex during the first 14 days (2 weeks) of product use, and I know sometimes sex doesn't only happen when we plan it. I'm going to ask some questions about what you did in two weeks, and it is important that we know what really happened – even if it is not what you were instructed to do. This will help us understand the results we get from this study. Your answers to these questions will not change your involvement in this study.</p>	
<p>12. What kinds of sex did you have during the last two weeks? <i>(Select all that apply)</i></p>	<p><input type="checkbox"/> ₁ Oral <input type="checkbox"/> ₂ Vaginal <input type="checkbox"/> ₃ Anal <input type="checkbox"/> ₄ Digital <input type="checkbox"/> ₅ None <input type="checkbox"/> ₆ Other, <i>specify:</i> _____ <input type="checkbox"/> ₇ Only non-receptive sex</p>

13. Did using the ring affect...	Yes	No
a. How often you had any type of sex?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
b. Your overall desire to have sex?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
14. [If 12 = "None", skip to 15] Overall, how did you feel about the ring being present during sex?	<input type="checkbox"/> ₁ Liked it <input type="checkbox"/> ₂ Did not like it <input type="checkbox"/> ₃ No opinion <input type="checkbox"/> ₄ N/A, I always removed the ring during sex	
15. Have you inserted anything other than the vaginal ring into your vagina in the last two weeks? This could include things like medications, tampons, lubricants, and cleansers.	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₂ No → skip to Q17	
16. What else did you insert into your vagina in the last two weeks? (Read list and select each that apply)	<input type="checkbox"/> ₁ Condom (male or female) <input type="checkbox"/> ₂ Tampons <input type="checkbox"/> ₃ Lubricants <input type="checkbox"/> ₄ Douches <input type="checkbox"/> ₅ Sex toys <input type="checkbox"/> ₆ Water (alone or with soap) <input type="checkbox"/> ₇ Vaginal medications <input type="checkbox"/> ₈ Vaginal moisturizers <input type="checkbox"/> ₉ Vaginal products, to make the vagina dry or tight <input type="checkbox"/> ₁₀ Materials such as paper, cloth, sponges or cotton wool <input type="checkbox"/> ₁₁ Other, specify: _____	
Satisfaction		
17. Please rate on a scale of 1-10 how satisfied you are, overall , with using the vaginal ring, where 1 means extremely dissatisfied and 10 means extremely satisfied. (Show Response Card 15)		
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">1</div> <div style="text-align: center;">2</div> <div style="text-align: center;">3</div> <div style="text-align: center;">4</div> <div style="text-align: center;">5</div> <div style="text-align: center;">6</div> <div style="text-align: center;">7</div> <div style="text-align: center;">8</div> <div style="text-align: center;">9</div> <div style="text-align: center;">10</div> </div>		
<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
<input type="checkbox"/> ₇	<input type="checkbox"/> ₈	<input type="checkbox"/> ₉
<input type="checkbox"/> ₁₀		
¹ Extremely dissatisfied		⁹ Very satisfied
² Very dissatisfied		¹⁰ Extremely satisfied

END OF CRF

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