CRF
Completion Guidelines
Protocol #: MTN-025 (HOPE)
V2.1 (5 July 2018)

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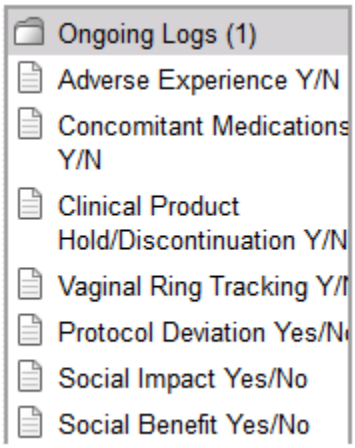
Completion Guidelines for Standard CRFs

The following instructions are study-specific data completion instructions intended to assist site staff when completing Case Report Forms (CRFs) for MTN-025 (HOPE). (Detailed guidance on general data collection, entry, navigation and general use of Medidata Rave is provided in the Medidata Rave Electronic Data Capture (EDC) Training Manual, which is posted on the MTN-025 Atlas web page: https://atlas.scharp.org/cpas/project/MTN/025/begin.view?)

General Guidelines – Medidata Rave eCRFs (electronic CRF completion)

- The Participant ID is automatically assigned by Rave as a 9-digit field, starting with the 3-digit site number followed by a randomly assigned 6-digit participant number.
- All data entered in the eCRF should correspond accurately with the source documents/paper CRFs.
- Complete all required fields on the screens. Please ensure all entries are in English and are accurate, consistent, complete and medically logical.
- Ensure there are no missing data in the eCRF. Where requested to 'specify' for an item, ensure that a specific entry is made.
    - Visit dates should be complete and chronological according to the protocol.
    - All date fields are entered as Day/Month/Year (dd/mmm/yyyy) (e.g., 06 DEC 2015).
- Drop-down menus are available for many fields. Use these menus, when available, to select the appropriate response.
- Avoid using abbreviations and symbols wherever possible. Do not use special characters or hit the Return key in text fields.
- If a scheduled visit was missed, do not enter data on any of the eCRF pages for the visit. Use the Missed Visit eCRF instead.
- Log (or repeating) forms have been provided. Log forms allow you to enter multiple items on one form, and to switch between portrait and log formats for ease of viewing or data entry. The following are log forms for this study: Adverse Experiences, Concomitant Medications, Clinical Product Hold/Discontinuation, Vaginal Ring Tracking, Protocol Deviations, Social Impact, and Social Benefit.



- If corrections are needed: By clicking the "pencil" icon, a new screen will open. You can then correct the value and give the reason for the change.

- In case of an incorrect data entry, a system query will fire. System queries will close automatically after saving the form if the data point is entered or corrected. However, answering a system query prior to updating the data point field will make the query change into a manual query that will need to be closed by the data management team.
- Data changes can be reviewed in the audit trail. If data is modified inadvertently, the change is also saved in the audit trail.
- The Investigator of Record (IoR) will sign all pages after the patient's data has been reviewed, no further changes or additions to the eCRFs are necessary and the casebook status is frozen. The SCHARP Clinical Data Manager(s) will provide directions for the timing of when the Investigator should perform the final review and sign the eCRF pages.

Add Event

- The **Add Event** drop-down menu can add select forms and visits to a participant's casebook.
- The following folders can be added to a participant's casebook:
    - Interim Visits (see section on "Interim Visits" on how to add interim visits to a participant's casebook
- The following forms can be added and will be added to the corresponding participant's folder as designated by the particular month/visit (for example, the Pharmacy Ring Dispensation Enrollment will dynamically add the Pharmacy Ring Dispensation within the V2 – Enrollment folder):
    - Pharmacy Ring Dispensation (Enrollment, Month 1, Month 2, Month 3, Month 6, and Month 9).
    - Pregnancy Outcome (Month 1, Month 2 Month 3, Month 6, Month 9, Month 12, Month 13)
        - This should be used only in the event that there is more than 1 pregnancy outcome. (The first pregnancy outcome should be filled out by selecting the Pregnancy Outcome form within the "Additional Study Procedures" form).

Interim Visits

- Should unscheduled assessments be required for a non-routine visit or procedure, add the visit by clicking on the **Add Event** button. Select "Interim Visit".
- Select the assessments that were performed. The selected forms will be populated automatically within the applicable Interim Visit folder.
- Enter the visit date as the earliest date visit procedures performed at the visit began.

Auto-population of Medidata Rave Forms

- Medidata Rave will dynamically add forms to a participant's casebook based on specified responses. For example, if the question on the Ring Adherence Y/N CRF, "Since the participant's last study visit, has she ever used a vaginal ring?" is marked 'yes', the Ring Adherence form will be added to the existing visit folder.
- Selecting as needed forms within the Additional Study Procedures during regularly scheduled visits, and the Interim Study Procedures during interim visits, will dynamically add these forms to the applicable study visit.

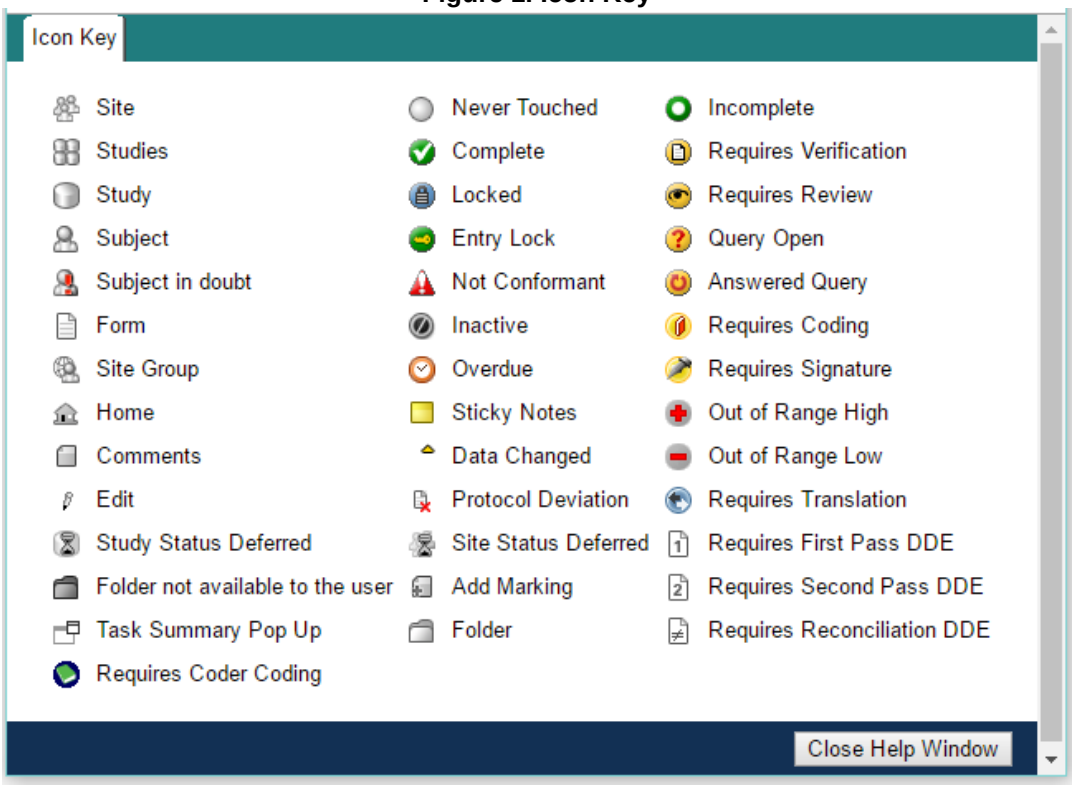
Dynamic Search List Functionality

- Dynamic searchlist functionality is used to look up Adverse Experiences data *(AE log line, start date, and term, e.g. "#001 05JAN2015-FEVER")* or Baseline Medical History data to correspond to a Concomitant Medication entry.
- For Example:
  - An AE of '*FEVER*' started on 05JAN2015 and is reported on the Adverse Experiences eCRF
  - On the Concomitant Medications form, if a listed medication was used for this AE, a dynamic searchlist can be used to select the applicable AE record from the dropdown list.
  - The dynamic search list for 'AE log line, start date, and term' shows records entered on the AE form
  - Your selection can be manually deleted if entered in error
    - **Note:** If the original data (e.g., AE term and/or start date, MH term) changed or the log line was inactivated, the previous selection becomes non conformant. You will need to correct the item by re-selecting from the search list to correspond with the latest data.

Icon Key

Within Rave, an Icon Key is available. The key contains a description and picture of the commonly used icons. To access the Icon Key, click on the Icon Key hyperlink. The Icon Key will open in a separate pop-up window. Below is a screen shot of the Icon Key.

Figure 1. Icon Key

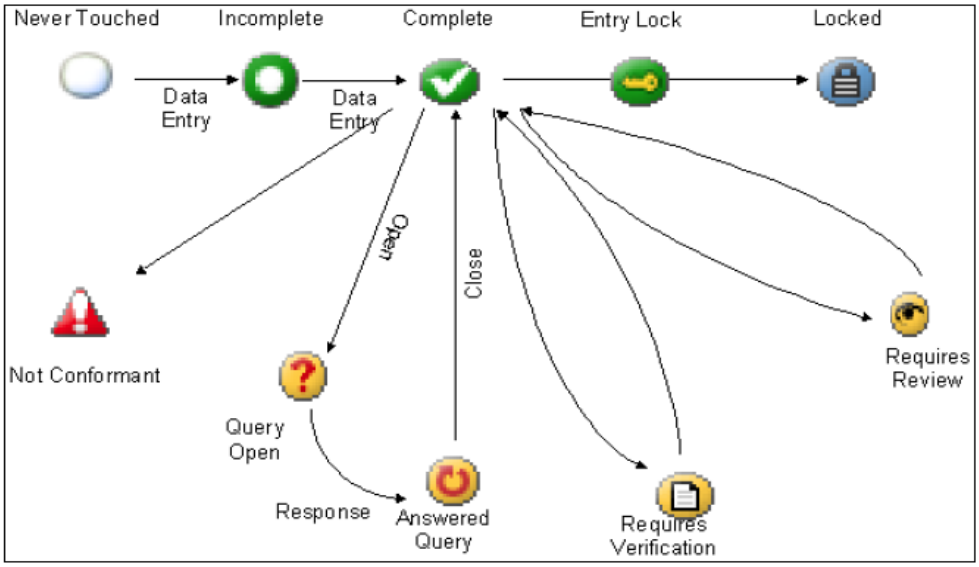


Icon Progressions

The life cycle of folders, forms, fields, etc., follows a logical progression starting with never touched and moving toward complete and locked. Graphical icons are used throughout Rave to visually denote status.

The following figure illustrates the status represented by each icon, and the progression of icons through the life cycle.

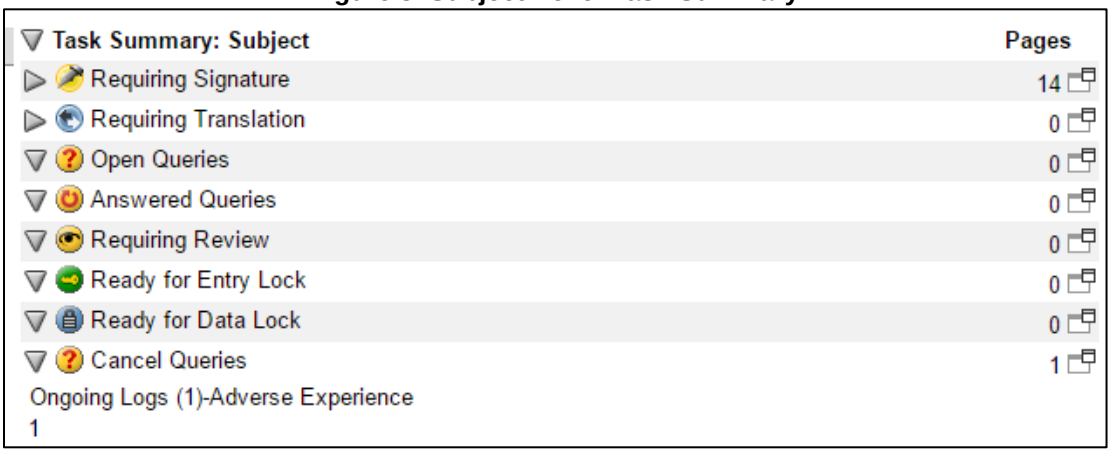
Figure 2. Icon Progression



Task Summary

- The Task Summary Listing displays all pending tasks for a study. At the Site level, it displays the number of participants within the site that contain the selected item (e.g., 5 subjects within the site have forms requiring review). In the expanded view, if a subject name is clicked, that subject's homepage is displayed.
- At the Subject (participant) level, the Task Summary displays the number of pages/forms for the subject that contain the selected item (e.g., 3 forms within the subject have data points that require review). In the expanded task summary view, if a form name is clicked that form is displayed.

Figure 3. Subject-Level Task Summary



General Guidelines – Paper CRF Completion

When completing a paper CRF, refer to detailed instructions on data collection pertaining to the specific form and fields on that form in this document.

Based on Good Clinical Practices (GCPs), the following guidelines should be used for completing paper CRFs:

- Use a black or dark blue medium ballpoint pen. Do not use any other type of writing tool.
- Press firmly when recording data or writing comments.
- Print all data and comments legibly by hand. Entries that cannot be read may result in incorrect data entry.
- Do not use cursive/script handwriting, as it can be difficult to read.
- Write numbers as large as possible on the line specified.
- Record data on the front of CRFs only.
- If the lines provided for written responses are not long enough, continue in another blank area of the form (within the page margins).
- Mark only one answer except when given the instruction “Mark/Select all that apply.”
- A response is required for every item unless instructed otherwise by a skip pattern, as noted in the CCGs.
- **Never** use correction fluid (“white-out”) or correction tape on CRFs.

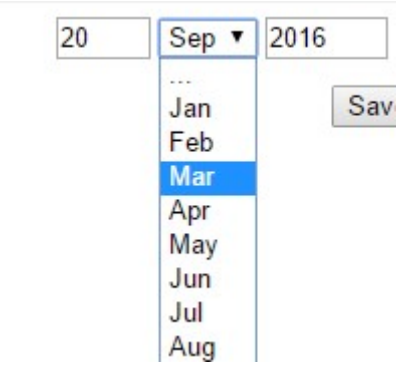
How to Record Dates - Electronic and/or Paper

Dates are entered using the “dd MMM yyyy” format, where “dd” represents the two-digit day, “MMM” represents the three-letter abbreviation of the month (in capital letters), and “yyyy” represents the four digits of the year.

The month field must be entered with the three-letter abbreviation *in English*. Abbreviations are shown below. In the study database, these abbreviations will be selected from a drop-down list in the month field.

Month	Abbreviation	Month	Abbreviation
January	**JAN**	July	**JUL**
February	**FEB**	August	**AUG**
March	**MAR**	September	**SEP**
April	**APR**	October	**OCT**
May	**MAY**	November	**NOV**
June	**JUN**	December	**DEC**

For example, September 20, 2016 is recorded as:



How to Record Time - Electronic and/or Paper

Time is recorded on CRFs using the 24-hour clock (00:00-23:59), in which hours are designated from 0–23. For example, in the 24-hour clock 2:25 p.m. translates to 14:25 (2 p.m. = 14), which would be recorded as follows:

Midnight is recorded as 00:00, not 24:00.

The following chart shows equivalencies between the 12- and 24-hour clocks:

12-hour clock (a.m.)	24-hour clock	12-hour clock (p.m.)	24-hour clock
Midnight	00:00	Noon	12:00
1:00 a.m.	01:00	1:00 p.m.	13:00
2:00 a.m.	02:00	2:00 p.m.	14:00
3:00 a.m.	03:00	3:00 p.m.	15:00
4:00 a.m.	04:00	4:00 p.m.	16:00
5:00 a.m.	05:00	5:00 p.m.	17:00
6:00 a.m.	06:00	6:00 p.m.	18:00
7:00 a.m.	07:00	7:00 p.m.	19:00
8:00 a.m.	08:00	8:00 p.m.	20:00
9:00 a.m.	09:00	9:00 p.m.	21:00
10:00 a.m.	10:00	10:00 p.m.	22:00
11:00 a.m.	11:00	11:00 p.m.	23:00

How to Record Numbers (non-dates)

When recording numbers, please enter the whole number without leading zeros. Instead of '00', this should be recorded as '0'. 3 should be recorded as 3, not '03' and so on.

Data Corrections and Additions - Electronic and/or Paper

Sometimes, data on a CRF (paper or electronic) may need to be changed, clarified, or amended. There are many reasons why data may need to be changed, such as in response to a query or as a result of site review.

If the electronic CRF is source, it is sufficient to make data updates in the study database itself. If a paper CRF is completed, it is important to make changes to the original CRF first, then enter the updated data into the study database.

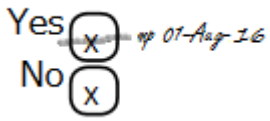
Note for paper CRFs: Never write over an entry once it is recorded. Use the standards outlined in the following paragraphs when changing, clarifying, or amending data.

Whenever an entry on a paper CRF is changed, do the following:

- draw a single horizontal line through the incorrect entry (do not obscure the entry or make it un-readable with multiple cross-outs),
- place the correct or clarified answer near the box, and

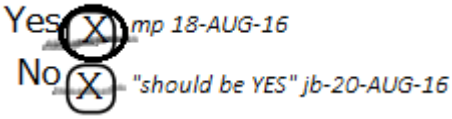
If an **X** is marked in the wrong response box, correct it by doing the following:

- draw a single horizontal line through the incorrectly marked box,
- mark the correct box, and
- initial and date the correction as shown below:



If the correct answer has previously been crossed out, do the following:

- circle the correct item,
- write an explanation in the white space near the item, and
- initial and date all corrections as shown below:



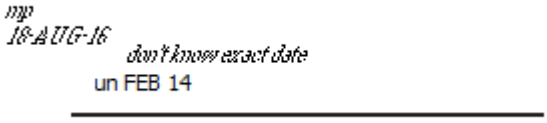
The standards above must ***always*** be followed whenever a paper CRF is changed, clarified, or amended.

How to Handle Missing and Unknown Data

If the answer to an item is not known, is not available, or if the participant refuses to answer for a required item:

- On paper CRFs: draw a single horizontal line through the applicable item and initial and date the item for which the data is unknown. It is helpful to write “don’t know,” “refuses to answer,” “UNK” (unknown), “N/A” (not applicable), or “REF” (refused) near the fields.

  For example, when recording a date, if the exact day is not known, write “un” to designate the “dd” (or date) and write “don’t know” next to the response, as shown below. Initials and date are required for any data item that is refused, missing, unknown, or not applicable, regardless of whether it is marked as such during the initial paper form completion, or as an update to the form.



- On eCRFs: enter “UN” or select the “UNK” option from the drop-down list of the applicable field for which the data is missing/unknown.

A skip pattern, as noted in the CCGs, is the **only** valid reason to leave a response blank.

ADMINISTRATIVE FORMS

Participant Identifier

Purpose:
The Participant Identifier page within Medidata Rave will generate each participant's Pre-screening number/HOPE PTID. This page is the first form completed within Medidata Rave for each participant.

General Instructions:
Complete this form for every MTN-020/ASPIRE participant who was enrolled at your site.

<table>
<tr><th>Field</th><th>Instructions</th></tr>
<tr><td>Participant ID</td><td>To add a participant to the study database, select the "Add Subject" link on the MTN-025 site-specific home page. The Participant Identifier page will appear. This is the first page that should be completed for each participant.

No data entry is required by the site on this form. Click the "Save" button at the bottom of the form. A pop-up box will appear to indicate that a participant has been added to the database and the home page for the participant's file will appear. The link to refer back to the Participant Identifier page is located at the top of each participant's home page. The participant ID will appear on each eCRF generated in Medidata Rave. The participant ID should be written at the top of each paper CRF completed for a participant.

Note that the participant ID generated within Medidata Rave will be assigned as the Pre-screening number for former MTN-020 participants and will be retained as the participant's HOPE ID should she screen for MTN-025. Additionally, a participant will retain her HOPE PTID should she participate in the MTN-025 main study upon completion of participation in the HOPE Decliner population.

The first three digits of each participant ID will comprise of the Rave site ID. Therefore, each participant ID will begin with the site ID. A list of Rave site IDs is provided in the table below:
<table>
<tr><th>CRS Name</th><th>DAIDS ID</th><th>Rave Site ID</th></tr>
<tr><td>Blantyre, Malawi</td><td>30301</td><td>760</td></tr>
<tr><td>Cape Town - Emavundleni</td><td>30346</td><td>779</td></tr>
<tr><td>Durban - Botha's Hill</td><td>31445</td><td>789</td></tr>
<tr><td>Durban - Chatsworth</td><td>30302</td><td>761</td></tr>
<tr><td>Durban - eThekwini</td><td>31422</td><td>785</td></tr>
<tr><td>Durban - Isipingo</td><td>31635</td><td>803</td></tr>
<tr><td>Durban - Verulam</td><td>31663</td><td>548</td></tr>
<tr><td>Harare - Seke South</td><td>30294</td><td>754</td></tr>
<tr><td>Harare - Spilhaus</td><td>30314</td><td>771</td></tr>
<tr><td>WRHI</td><td>31639</td><td>805</td></tr>
<tr><td>Lilongwe, Malawi</td><td>12001</td><td>720</td></tr>
<tr><td>Makerere University, Uganda (MU-JHU)</td><td>30293</td><td>753</td></tr>
<tr><td>Durban - Tongaat</td><td>31662</td><td>807</td></tr>
<tr><td>Zengeza Clinic, Chitungwiza, Zimbabwe</td><td>30320</td><td>774</td></tr>
</table>
</td></tr>
</table>

Pre-Screening Outcome

Purpose:
This form is used to document Pre-Screening process information for each ASPIRE participant, including information on whether the ASPIRE participant was contacted and screened for HOPE.

General Instructions:
Complete this form for each MTN-020/ASPIRE participant at your site.

Field	Instructions
What was this prior participant's ASPIRE PTID?	Provide the 9 digit ASPIRE participant ID (PTID) for each prior ASPIRE participant. Note that hyphens should not be included when entering in Medidata Rave.
Was the participant contacted to participate in HOPE?	Indicate whether the former ASPIRE participant was contacted to participate in the HOPE study. If "yes" is selected, skip the item "Why was the participant not contacted for HOPE" and complete the item "Did the participant conduct a screening visit for HOPE?".
Why was the participant not contacted to participate in HOPE?	Mark the correct response or select the reason from the drop-down menu. Mark/select 'participant was permanently discontinued from study product during ASPIRE' if the participant was permanently discontinued from study product due to any clinical reason other than HIV seroconversion. Mark/select 'participant did not provide permission to be contacted for future studies' if the participant indicated that she did not wish to be contacted for future studies while participating in MTN-020. If the participant was not contacted to participate in HOPE for a reason not specified, mark or select "Other" and specify the reason in the text field space provided. **Upon completion of this item, end the form and leave the remaining items on the form blank.**
Did the participant conduct a screening visit for HOPE?	Mark/select 'Yes' if the ASPIRE participant attended a Screening Visit as part of MTN-025 or as part of the Decliner Population. Mark/select 'No' if the participant did not sign a screening informed consent form for MTN-025 or for the Decliner Population. End the form by leaving the remaining items on the form blank.

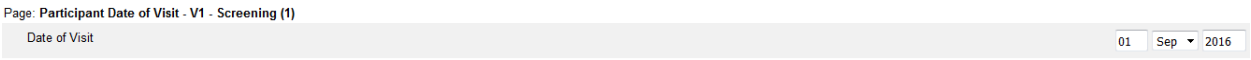
Field	Instructions
Did the participant conduct a screening visit as part of the…?	If the participant conducted a screening visit for HOPE, select whether the participant completed a screening visit as part of the Decliner Population or with the MTN-025 main study. Based on the response to this item, the appropriate visit folder will dynamically appear within the participant's electronic file. For example, if 'Decliner Population' is selected for this item, the Decliner Population Screening/Enrollment visit folder will be added to the participant's electronic file and the required forms will be added to this folder. If a participant originally enrolls as part of the 'Decliner Population' but later screens as part of the MTN-025 main study population, this field should be updated to trigger the appropriate MTN-025 main study forms (e.g., Eligibility Criteria and Participant Date of Visit).

Participant Date of Visit

This form is present at the following visits:

- V1 – Screening
- V2 – Enrollment

Please record the visit date by entering Day and Year and by selecting the correct Month from the drop down list in dd MMM yyyy format (for example, 01SEP2016) when entering in the study database.



If completing a paper CRF, please record the visit date in the dd MMM yyyy format.

Note:

- Complete the date on which visit procedures begin

Date of Visit

This form is present at the following visits:

- V3 – Month 1
- V4 – Month 2
- V5 – Month 3
- V6 – Month 6
- V7 – Month 9
- V8 – Month 12
- V9 – Study Exit/Termination
- Interim Visit

Field	Instructions
Did the participant complete this visit?	Select 'Yes' or "No' to indicate if the participant completed a visit. If 'No' is selected, the "Missed Visit" CRF will dynamically add to this folder and the remaining forms associated with visit will disappear. Complete a Missed Visit CRF.
Visit Date	Please record the visit date by entering Day and Year and by selecting the correct Month from the drop down list in dd MMM yyyy format (for example, 01SEP2016) when entering in the study database. Please use the date the first assessment was completed that is associated with this visit. If the visit reflects data collected across multiple days, enter the date of the earliest collection.

Eligibility Criteria

Purpose:
This form is used to document participant eligibility for enrollment in to MTN-025/HOPE study or reasons for study ineligibility.

General Instructions:
Complete this form for each participant screened for the MTN-025 main study. This form is present at the V1 – Screening visit. Complete this form once it is confirmed whether the participant will enroll in the MTN-025 main study. If the participant does not enroll, this form and the Pre-Screening Outcome form, are the only forms that should be entered into the study database for the participant.

If the participant completes another screening attempt, update this form – both the paper and electronic version - with data from the most recent screening attempt. Do **not** complete a new form for the additional screening attempt.

Field	Instructions
Does this participant meet all eligibility criteria?	Select 'Yes' or 'No'.
Was the participant enrolled into HOPE?	Select 'Yes' or 'No'. If 'Yes', end of form. Leave remaining items on the form blank. If 'No' is selected for the first question ("Does this participant meet all eligibility criteria?"), then this response is expected to be 'No' (otherwise, report as a protocol deviation).

Field	Instructions
Why was the participant not enrolled?	Mark the correct response or select it from the drop-down menu. If 'Eligible, but participant did not complete all screening procedures' is selected, then end of form and leave remaining items on the form blank. Select 'participant did not complete all screening procedures' when a participant begins the screening process and is eligible, but does not return to the clinic to complete screening procedures within the 56-day screening window or if a participant completed all screening visit procedures but did not return to the site to complete enrollment visit procedures within the allowable window. If 'Eligible, but participant declined enrollment' is selected, record the reason in the space provided, then end of form.
Reasons for ineligibility	Complete this item only if the response to the previous item ("Why was the participant not enrolled?") is 'Not eligible'. Select all of the reasons why the participant was ineligible to enroll in the MTN-025 main study. If 'Other, including IoR discretion' is selected, record the reason in the space provided.

Enrollment

Purpose:
This form is used to document a participant's study enrollment. This form is completed at Enrollment for participants who have provided informed consent and who are eligible to participate in the MTN-025 main study.

General Instructions:
Complete this form for each participant who is enrolled into the MTN-025/HOPE main study. This form is present at the V2 – Enrollment visit.

Field	Instructions
Date the participant marked or signed the study screening consent form:	Enter the complete date.
Date the participant marked or signed the study enrollment consent form:	Enter the complete date.
Did the participant agree to biological specimen and health data storage?	The consent for left-over specimen and health data storage item can be updated if the participant changes her consent decision after enrollment. Update this item as needed if the participant changes her consent during the study.
HIV status	Record the participant's HIV status as determined by testing performed on the day of enrollment. If 'Positive', do not enroll the participant.
Enrollment date	Enter the complete date.

Eligibility Criteria – Decliner Population

Purpose:
This form is used to document participant eligibility for enrollment into the Decliner Population, or reasons for study ineligibility.

General Instructions:
Complete this form for each participant screened to be part of the Decliner Population. Complete this form once it is confirmed whether or not the participant will enroll as part of the Decliner Population. This form is present within the Decliner Population Screening/Enrollment folder. If the participant is not enrolled as part of the Decliner Population, this form and the Pre-Screening Outcome form are the only forms that are entered into the study database for the participant.

If the participant completes another screening attempt, update this form – both the paper and electronic version - with data from the most recent screening attempt. Do not complete a new form for an additional screening attempt.

Field	Instructions
Does this participant meet all eligibility criteria as part of the decliner population?	Select 'Yes' or 'No'.
Was the participant enrolled into the MTN-025 Decliner Population?	Select 'Yes' or 'No'. If 'Yes', end of form. Leave remaining items on the form blank. If 'No' is selected for the first item on the form "Does this participant meet all eligibility criteria as part of the decliner population?", then the response to this item is expected to be 'No' (otherwise, report as a protocol deviation),
Why was the participant not enrolled?	Mark the correct response or select it from the drop-down menu. If item 1 is 'No', select 'Not eligible'. If for the first item on the form "Does this participant meet all eligibility criteria as part of the decliner population?" is 'Yes', select 'Eligible, but participant did not complete all screening procedures' or 'Eligible, but participant declined enrollment' as applicable; then, end the form and leave remaining items on the form blank. If 'Eligible, but participant declined enrollment' is selected, record the reason in the space provided.
Reasons for ineligibility	Complete this item only if the previous item "Why was the participant not enrolled" response is 'Not eligible'. Select all of the reasons why the participant was ineligible to enroll as part of the Decliner Population. If 'Other, including IoR discretion' is selected, record or enter the reason in the space provided.

Enrollment – Decliner Population

Purpose:
This form is used to document a participant's enrollment into the study's Decliner Population.

General Instructions:
Complete this form only if the participant enrolls into the study's Decliner Population. This form is present within the Decliner Population Screening/Enrollment visit folder.

Field	Instructions
Date the participant marked or signed the study screening and enrollment MTN-025 Decliner Population consent form:	Enter the exact date the participant signed or marked the informed consent for screening and enrollment into the study Decliner Population. A complete date is required.
Enrollment Date	Record or enter the date the participant enrolled as part of the Decliner Population. (Refer to section 2 of the SSP for more detailed information on enrollment into the Decliner Population).
Were all Decliner Population procedures completed on the Enrollment Date?	If 'Yes' is selected, end of form (leave item 3a blank). Select 'No' only if Decliner Population procedures for screening and enrollment were conducted over multiple days.
Date all Decliner Population procedures completed (if data is different than enrollment date):	Complete this item only if 'No' is selected for item 3. A complete date is required.

Follow-up Visit Summary

Purpose:
This form is used to summarize information from each follow-up visit performed for a participant.

General Instructions:
This form is completed for each scheduled visit and is present in each visit folder. This form is also completed for interim visits/contacts when a new form (other than the Follow-up Visit Summary and Concomitant Medications Log) is completed. When an Interim Visit is added, this form will dynamically appear within the corresponding Interim Visit folder.

Field	Instructions
Location of study visit	If this contact with a participant is over the phone and results in new forms that need to be completed, mark/select "other, specify" and record "phone contact" in the text field provided.

Since the last visit, has the participant taken HIV medication for post-exposure prophylaxis (PEP) against HIV?	If the participant has taken post-exposure prophylaxis (PEP) since her last visit, mark/select "yes". If the participant is currently using PEP, a Clinical Product Hold/Discontinuation log form must be completed.
Since the last visit, has the participant used oral or topical medicine for pre-exposure prophylaxis (PrEP) against HIV?	Record if the participant has used oral or topical medicine for pre-exposure prophylaxis (PrEP) against HIV by selecting "Yes" or "No". If "No", then skip item "Was oral or topical PrEP used?"
Was oral or topical PrEP used?	Indicate whether oral or topical PrEP was used if applicable. If either or both were used, record on the Concomitant Medications (CM) Log.
Is this an interim visit?	If this is an interim visit, select "Yes" and complete the reason (s) for interim visit by checking all that apply. If this is a regularly scheduled-follow-up visit, select "No" and skip to item "Is this visit a PUEV, scheduled Study Exit Visit, or an early termination?".
Is this visit a PUEV, scheduled Study Exit Visit, or an early termination?	If the visit completed was a Product Use End Visit (PUEV), early termination, or scheduled study termination visit, mark/select "yes". If the visit was a typical monthly or quarterly visit, mark/select "no". Note that visits where a participant is permanently discontinued from study product for clinical or protocol requirements (HIV seroconversion, for example), this is not a PUEV.
Visit type	Select the applicable visit type from the drop-down menu in Medidata Rave or if completing a paper CRF, then mark the applicable visit type. If the participant is terminating from the study early (she withdraws consent, for example), this is considered an early termination visit, not a PUEV. If participant terminates at V8, select/mark "PUEV". Select/mark "Scheduled termination" when the visit is the termination/study exit visit, and is being conducted after the completion of a PUEV.

ACASI Tracking Y/N Prompt

Purpose:
This form is used to document participant completion of the Audio Computer-assisted Self Interview (ACASI) questionnaires at Enrollment and during follow-up.

General Instructions:
This prompt is present at the following visits:

- V2 - Enrollment
- V5 – Month 3
- V8 – Month 12

Field	Instructions
Was an ACASI questionnaire completed at this visit?	Select 'Yes' or 'No'. If 'Yes' is selected, then the "ACASI Tracking" form appears dynamically. Complete "ACASI Tracking" CRF. If an ACASI questionnaire was completed by a participant, this item should be marked 'Yes' regardless of whether the questionnaire was eventually uploaded to SCHARP. If 'No' is selected, then record the reason why it was not done in the text field below. An "ACASI Tracking" CRF does not need to be completed.
If no, please explain:	Record the reason why an ACASI questionnaire was not completed in the text field.

ACASI Tracking

Purpose:
This form is used to document information about the Audio Computer-assisted Self Interview (ACASI) questionnaires at Enrollment and during follow-up.

General Instructions:
Selecting 'Yes' in the "ACASI Tracking Y/N" prompt will open up the "ACASI Tracking" CRF. Complete this form at Enrollment, Month 3, and at the participant's Product Use End Visit (PUEV) or early termination visit.

Additionally, complete this form (and the PUEV/Discontinuers ACASI questionnaire) if the participant is permanently discontinued from study product (as documented by a Clinical Product Hold/Discontinuation Log).

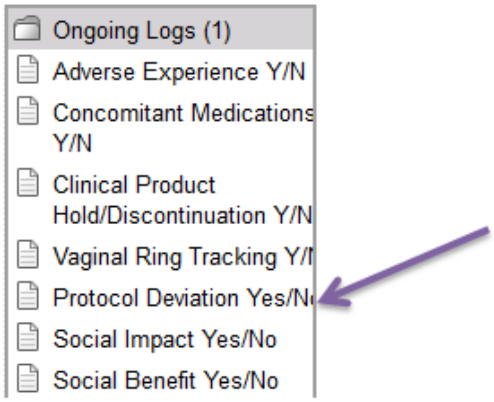
Field	Instructions
Which questionnaire was completed?	Mark the applicable questionnaire on the paper form or by selecting the applicable questionnaire from the drop down list that was completed for the participant. If this is the "Baseline" or "Month 3" questionnaire, then the next item "Reason PUEV/Discontinuers ACASI questionnaire was completed" should not be completed. This item should document the actual questionnaire that was completed at the visit, even if it is not the expected questionnaire.
Reason PUEV/Discontinuers ACASI questionnaire was completed:	This question should only be answered if the questionnaire completed is the "PUEV/Discontinuers" questionnaire. Select the applicable reason from the drop down list or marking the applicable reason on the paper form.
Were there any problems or issues related to the administration or completion of the questionnaire?	Select 'yes' or 'no'. If 'no', then this is the end of form and the remaining item can be left blank.

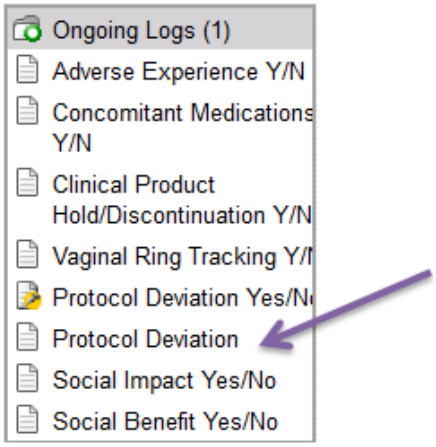
Field	Instructions
If yes, please describe:	Use the text field space to describe when and why multiple ACASI questionnaires are completed for a participant at a visit or if the incorrect ACASI questionnaire is completed at a visit. If an ACASI was completed in error at the wrong visit, use the text field to describe additional details, including which questionnaire was administered in error. Use this text field to indicate any technical errors that took place in the administration, storing, or uploading of an ACASI questionnaire. If there are any unusual details related to the ACASI questionnaire administration or completion, describe them in this field.

Protocol Deviation Yes/No Prompt

Purpose:
This form documents if a protocol deviation has occurred.

Generation Instructions:
This form is present within the "Ongoing Logs" folder. Selecting 'Yes' in the "Protocol Deviation Yes/No" prompt will add the "Protocol Deviation" CRF.





Field	Instructions
Have any protocol deviations occurred?	Select 'Yes' or 'No'. If 'Yes' is selected, then the "Protocol Deviation" form appears dynamically and can then be completed.

Protocol Deviation Log

Purpose:
This form documents and reports protocol deviations identified during the implementation of MTN-025/HOPE.

General Information/Instructions:
Complete this form each time a protocol deviation is identified, including protocol deviations identified prior to Enrollment. Once the Protocol Deviation Log form has been created, complete one page per protocol deviation when entering in the study database. To add an additional deviation within Medidata

Rave, clicking “Add a new Log line” will add an additional page for a new deviation to be completed. If completing protocol deviations on paper, print and complete one page for each protocol deviation. Consult the MTN Regulatory Team (mtnregulatory@mtnstopshiv.org) and the Study Management Team if you are unsure if an event required reporting as a deviation.

Field	Instructions
Site awareness date	Record the date the site became aware of the deviation.
Deviation date	Record the date the deviation occurred (start date).
Type of deviation	Record the applicable deviation by selecting from the drop down menu if completing electronically. If completing this form on a paper CRF, mark the applicable protocol deviation. Record “other” if none of the listed categories match.
Description of deviation	Use the text field/space to briefly describe the specific details of the deviation.
Plans and/or actions to address the deviation	Use the text field/space to provide a brief description of the plans to address the deviation.
Plans and/or actions to address for future deviations	Use the text field/space to provide a brief description of the plans to address future deviations.
Deviation reported by	Enter the staff code of the site staff person who completed the form. Sites will need to assign a four-digit staff code to each site staff person who will be completing this form. This list is created, maintained and kept at the study site.

Social Impact Y/N

Purpose:
This form documents if a social impact has occurred.

General Instructions:
This form is present within the “Ongoing Logs” folder. Selecting ‘Yes’ in the “Social Impact Yes/No” prompt will add the “Social Impact” CRF.

Field	Instructions
Did a social impact occur?	Select ‘Yes’ or ‘No’. If ‘Yes’ is selected, then the “Social Impact” form appears dynamically and can then be completed.

Social Impact Log

Purpose:
This form records the occurrence, update, and resolution of adverse social impacts reported by participants at any time during the study.

General Instructions:
This form should be completed only when a participant has a negative experience associated with study participation. A new form should be completed whenever a new social impact is recorded. This form can also be updated, as applicable. Once the Social Impact Log form has been created, complete one page

per social impact when entering in the study database. To add an additional social impact within Medidata Rave, clicking “Add a new Log line” will add an additional page for a new social impact to be completed. If completing social impacts on paper, print and complete one page for each social impact.

Field	Instructions
Onset date	Record the date the negative experience first started. At a minimum, a month and year are required.
Reported at Visit	Record the visit number (format X.XX) at which the social impact was reported.
Social Impact Type	Record the applicable social impact type by selecting from the drop down menu if completing electronically. If completing this form on a paper CRF, mark the applicable social impact type from the list.
What impact did this situation have on the participant’s quality of life?	Assess the impact of the social harm on the participant’s quality of life based on participant self-report.
Record current status	This item may be updated at subsequent visits.
Closure Date	Record the closure date if the current status is selected as “unable to resolve; no further action taken”, or “resolved”. Leave this item blank if the current status is selected as “Unresolved” or “Unresolved at end of study”.

Social Benefit Y/N

Purpose:
This form documents if a social benefit has occurred.

Field	Instructions
Did a social benefit occur?	Select ‘Yes’ or ‘No’. If ‘Yes’ is selected, then the “Social Benefit” form appears dynamically and can then be completed.

General Instructions:
This form is present within the “Ongoing Logs” folder. Selecting ‘Yes’ in the “Social Benefit Yes/No” prompt will add the “Social Benefit” CRF.

Social Benefit Log

Purpose:
This form records the occurrence, update, and resolution of social benefits reported by participants at any time during the study.

General Instructions:
This form should be completed only when a participant has a positive experience associated with study participation. A new form should be completed whenever a new social impact is recorded. This form can also be updated, as applicable. Once the Social Benefit Log form has been created, complete one page

per social benefit when entering in the study database. To add an additional social benefit within Medidata Rave, clicking "Add a new Log line" will add an additional page for a new social benefit to be completed. If completing social benefits on paper, print and complete one page for each social benefit.

Field	Instructions
Reported at Visit	Record the visit number (format X.XX) at which the social impact was reported.
What impact did this situation have on the participant's quality of life?	Assess the impact of the social benefit on the participant's quality of life based on participant self-report.
Person 1, Person 2, Person 3	For each person the social benefit involved, select the type of relationship. If the relationship is "other", please specify in the text field provided.
The social benefit was related to:	Record the applicable social benefit by selecting from the drop down menu if completing electronically. If completing this form on a paper CRF, mark the applicable social impact type from the list.

Participant Transfer

Purpose:
Complete this form when a participant is transferring to another study clinic/site.

General Instructions:
The Participant Transfer form is completed by the transferring site (the site that the participant is leaving). This form should be added to the participant case book by selecting it from the list of optional study procedures within the **Additional Study Procedures** or **Interim Visit Procedures** form. The participant transfer form should be added to the folder at which the participant is transferred to another site.

For more information on Participant Transfer and Receipt, refer to the MTN-025 protocol, Study-specific Procedures (SSP) manual, and/or Manual of Operations (MOP).

Field	Instructions
Name of transferring study site	If completing a paper CRF, mark the name of the transferring study site from the list provided. When completing the eCRF within Medidata Rave, select the transferring site from the drop down field.
Name of receiving study site	If completing a paper CRF, mark the name of the receiving study site from the list provided. When completing the eCRF within Medidata Rave, select the receiving site from the drop down field.
Date participant records were sent to receiving study site	A complete date is required.

Participant Receipt

Purpose:
Complete this form when a transferred participant has provided informed consent at the receiving study clinic/site.

General Instructions:
The Participant Transfer form is completed by the receiving site (the site at which the participant will continue her study visits) when the participant's electronic case book has been transferred to the receiving site. This form should be added to the participant case book by selecting it from the list of optional study procedures within the **Additional Study Procedures** or **Interim Visit Procedures** form within the last completed study visit at the transferring site (i.e., the Participant Transfer and Participant Receipt CRF should be completed within the same visit folder). The Participant Receipt form will then be added to the applicable study visit folder within Rave.

The participant will retain her original Participant ID (PTID) assigned by the original study site. Do not assign a new Participant ID.

For more information on Participant Transfer and Receipt, refer to the MTN-025 protocol, Study-specific Procedures (SSP) manual, and/or Manual of Operations (MOP).

Field	Instructions
Name of receiving study site	If completing a paper CRF, mark the name of the transferring study site from the list provided. When completing the eCRF within Medidata Rave, select the receiving site from the drop down field.
Name of transferring study site	If completing a paper CRF, mark the name of the transferring study site from the list provided. When completing the eCRF within Medidata Rave, select the receiving site from the drop down field.
Date informed consent signed at receiving site?	A complete date is required.
Did the participant provide informed consent for specimen storage at receiving study site?	If "No", end the form.
Date informed consent for specimen storage was signed	A complete date is required.

Additional Study Procedures Y/N

Purpose:
This form is used to record all additional procedures the participant received at her scheduled study visit (e.g. clinically indicated physical exam). Do *not* record any procedures required and performed per protocol on this form. Such procedures should be entered on the relevant CRF within the scheduled visit folder.

General Information/Instructions:
This form is present at the following visits:

- V2 – Enrollment
- V3 – Month 1
- V4 – Month 2
- V5 – Month 3
- V6 – Month 6
- V7 – Month 9
- V8 – Month 12
- V9 – Study Exit/Termination

Select 'Yes' for the applicable CRFs that will be submitted for the visit. For example, if a physical exam was performed (clinically indicated), select 'Yes' for **Physical Exam**. Selecting 'Yes' will dynamically add the applicable form(s) within the associated visit folder.

If it is determined that no additional study procedures and thus CRFs will not be completed at her scheduled study visit, then this form can be left blank (e.g. "No" does not need to be selected for each form). If this form is not completed, this may display in the "Overdue Data" section of the Task Summary, but can be ignored for this form.

Interim Visit Procedures

Purpose:
This form is used to record all procedures or assessments the participant received at any interim study visit (e.g., clinically indicated physical exam) that is completed during the study.

General Information/Instructions:

This form is required for each interim visit completed for a participant. Select 'Yes' for the applicable CRFs that will be submitted for the visit. For example, if a vaginal ring was dispensed at an interim visit, select 'Yes' for **Ring Collection and Insertion** and **Pharmacy Ring Dispensation** (to be completed by site Pharmacist). Selecting 'Yes' will dynamically add the applicable form(s) within the associated interim visit folder. Responses for other forms that were not completed as part of the interim visit may be left blank.

The interim visit number will be automatically generated on this form based on the participant's study visit dates. Once the "Date of Visit" form within the Interim Visit folder has been completed, the interim visit number will automatically populate in the format X.XX. For example, if a participant completes an interim visit after her Month 1 visit, the interim visit is assigned a visit number of 3.01. Refer to SSP section 14.3.3 for more information on visit numbers.

Missed Visit

Purpose:
Complete this form whenever an enrolled participant missed a required visit according to the visit window outlined in the protocol or Study-specific Procedures (SS) manual.

General Information/Instructions:

A missed visit form will be added to a visit folder if the response to "Did the participant complete this visit" on the Date of Visit from is "No". A missed visit form will be added dynamically to the visit folder and all other eCRFs will be removed from the folder. Complete the Missed Visit CRF only for this visit.

Field	Instructions
Target Visit Date:	Record the target date of the visit. A complete date is required
Reason visit was missed:	If completing a paper CRF, select the reason the participant missed the visit from the list of available options. When completing the eCRF within Rave, select the reason that the participant missed the visit from the drop down list. If the reason that the participant missed the visit is not included in this list, select other, and specify the reason that the reason was missed.

Termination

Purpose:
This form is completed for every enrolled participant at either the scheduled Study Exit Visit or when the participant is no longer participating in the study.

General Instructions:
This form is present within the V9 – Study Exit/Termination folder.

If a participant terminates prior to the V9 – Study Exit/Termination Visit, then the Follow-up Visit Summary CRF will need to be completed to dynamically add the "Termination" CRF to the applicable folder. Selecting 'Early termination' for the "Visit type" item will add the Termination form.

Field	Instructions
Termination Date	A complete date is required.
Reason for termination	Select the primary reason for termination.
Scheduled exit visit/end of study	*Scheduled exit visit/end of study*: Only select this reason if the participant completes the protocol-defined final visit. If this reason is selected, then this is the end of form and the remaining items do not need to be completed.
Early study closure:	Only select this reason when instructed by SCHARP.
Inappropriate enrollment *Invalid ID due to duplicate screening/enrollment*	If any of these items are recorded, then this is the end of form and the remaining items do not need to be completed.
Date of Death	At a minimum, a month and year are required.
Specify	Please provide further details if reason for termination is death – indicate cause of death, participant refused further participation, investigator decision, or other.
Was termination associated with an adverse experience?	If 'No' or 'Don't Know', then this is the end of form.

Adverse Experience	Within Medidata Rave, select the applicable Adverse Experience from the list of AE's in the drop down menu. In situations where more than one AE is associated with termination, record the AE that most strongly influenced the decision to terminate. If completing this form via paper, please write in the AE description and the Onset Date on the line provided.

RING DISPENSATION/COLLECTION FORMS

Pharmacy Ring Dispensation

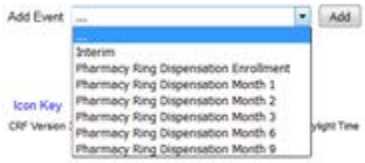
Purpose:
This form is used to collect vaginal ring dispensation information, including the lot number associated with each vaginal ring. **This form is completed by pharmacy staff only.**

General Instructions:
Complete this form at all study visits at which study product is dispensed to a participant. If completing a paper form, then print and complete this form at each study visit a vaginal ring(s) is/are dispensed.

To complete this form electronically within the study database:

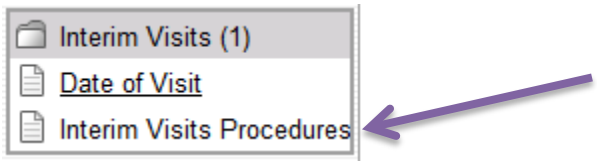
If a ring(s) is dispensed at a regularly scheduled visit:

- This form can be added using "Add event" drop down list on the participant's main overview page and click the 'Add' button after selecting the applicable form that indicates the corresponding visit (e.g. Pharmacy Ring Dispensation Enrollment). This form will then be added to the applicable visit folder (e.g. V2 – Enrollment).



If a ring(s) is dispensed at an interim visit:

- This form can be added to the applicable interim visit by navigating to the applicable Interim Visit folder for which the ring(s) are dispensed. Click the "Interim Visit Procedures" on the left hand side of the screen. This form will dynamically add to the applicable Interim Visits folder after selecting 'Yes' for Pharmacy Ring Dispensation and saving the form. Then complete the form.



- See section "Interim Visits" within the "Completion Guidelines for Standard CRFs" section to add an interim visit if this has not already been generated.

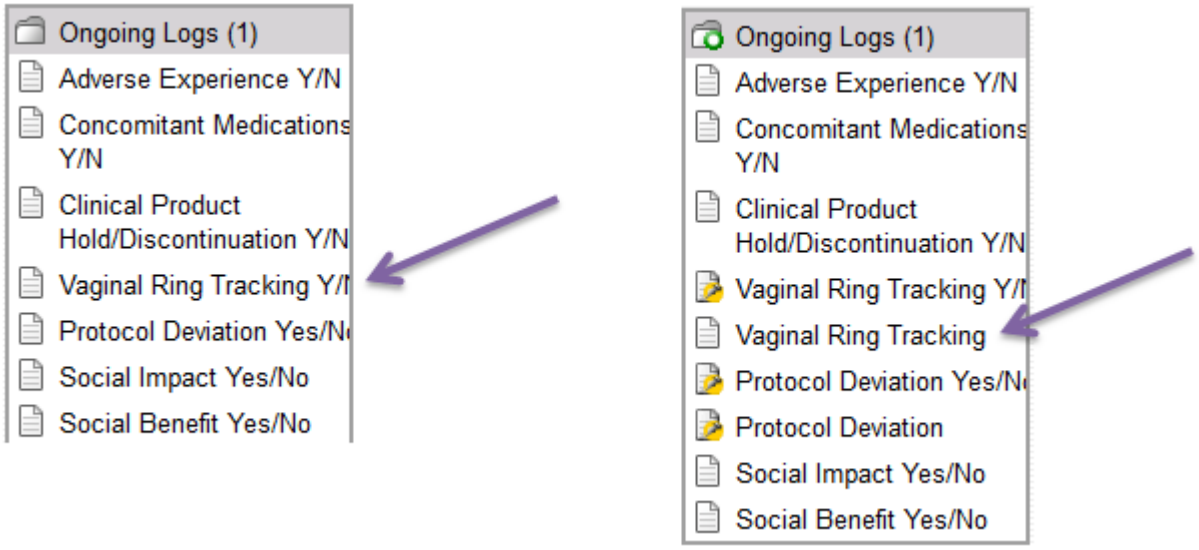
Field	Instructions
Date Vaginal Ring(s) dispensed:	Record the exact day, month, and year study product was dispensed to the participant.

How many vaginal rings were dispensed at this visit?	Select the number of vaginal ring(s) dispensed from the drop down list or by marking on the paper form.
Complete the ring code and lot number for each ring dispensed.	Record the ring code (notation X.X) and lot number of each vaginal ring dispensed at this visit. For example, the ring code for the first ring dispensed for a participant should be recorded as 1.0. A ring code and lot number can be provided for up to four dispensed rings. For example, if three vaginal rings are dispensed at a study visit, three entries to indicate the ring code and lot numbers for each of the three rings and do not answer the fourth vaginal ring entry.

Vaginal Ring Tracking Yes/No Prompt

Purpose:
This form documents if a vaginal ring was provided to the participant.

Field	Instructions
Did the participant have any vaginal ring(s) provided?	Select 'Yes' or 'No'. If 'Yes' is selected, then the "Vaginal Ring Tracking" log form appears dynamically and can then be completed.



General Instructions:

This form is present within the "Ongoing Logs" folder. Selecting 'Yes' in the "Vaginal Ring Tracking Yes/No" prompt will add the "Vaginal Ring Tracking" log form. Once the Vaginal Ring Tracking log has been created, log lines can be added/updated for completion of this form.

Vaginal Ring Tracking Log

Purpose:
This form is used to collect information on each study vaginal ring that is provided to the participant and returned to the clinic. This form also documents whether each ring was stored, and ring use per participant report.

General Instructions:
Complete a separate entry (e.g. log line) for each vaginal ring that is provided to a participant. Once a ring is returned, update the information for that specific ring on the applicable log line. If completing on a paper form, please complete a new row for each ring to document the ring provision information and update the applicable row to document ring returned information. Ensure the "Ring Collection and Insertion" form has also been completed

At Ring Provision:

- Complete the "Ring Provided" section of the vaginal ring tracking log each time a study vaginal ring is provided to a participant.
    - Specify the Ring Code, Date ring provided, and Visit ring provided.
- Leave remaining items for the log entry blank and save the form.

Subject: **123698575**
Page: **Vaginal Ring Tracking - Ongoing Logs (1)**

#	RING PROVIDED Ring Code	Date ring provided	Visit ring provided	RING RETURNED Date ring returned	Ring not returned	Ring not returned, specify reason:	Visit ring returned	Ring Storage	If not stored, specify reason:	Mark checkbox if ring code is unknown when ring returned.	If ring was stored, how did the participant rate her ability to keep the ring inserted as instructed, per participant report?	If ring was stored, how many days was the vaginal ring out for any reason, in total per participant report?	
1	1.0	12 AUG 2015	2.00	_	☐	_	_	_	_	☐	_	_	

Add a new Log line Inactivate

Printable Version View PDF Icon Key
CRF Version 85 - Page Generated: 01 Sep 2016 16:08:58 Pacific Daylight Time

Save Cancel

- To complete a new entry for another provided ring, click "Add a new Log line". This will open up a new page to complete information on a new ring.

Subject: **123698575**
Page: **Vaginal Ring Tracking - Ongoing Logs (1)**

#	RING PROVIDED Ring Code	Date ring provided	Visit ring provided	RING RETURNED Date ring returned	Ring not returned	Ring not returned, specify reason:	Visit ring returned	Ring Storage	If not stored, specify reason:	Mark checkbox if ring code is unknown when ring returned.	If ring was stored, how did the participant rate her ability to keep the ring inserted as instructed, per participant report?	If ring was stored, how many days was the vaginal ring out for any reason, in total per participant report?	
1	1.0	12 AUG 2015	2.00	12 SEP 2015	☐	_	3.00	Stored	_	☐	Excellent	0	
2	2.0	12 SEP 2015	3.00	_	☐	_	_	_	_	☐	_	_	

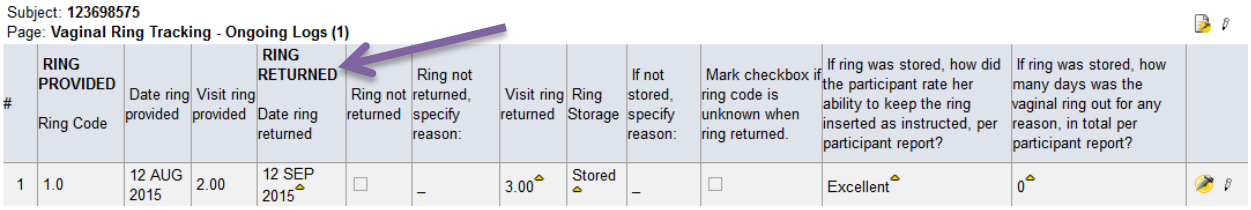
Add a new Log line Inactivate

Printable Version View PDF Icon Key
CRF Version 85 - Page Generated: 01 Sep 2016 16:10:58 Pacific Daylight Time

Save Cancel

At Ring Return:

- Complete the "Ring Returned" portion of the Vaginal Ring Tracking Log when each provided study vaginal ring is expected to be returned to the clinic by updating the information on the applicable log entry for that specific ring.



Subject: **123698575**
Page: **Vaginal Ring Tracking - Ongoing Logs (1)**

#	RING PROVIDED Ring Code	Date ring provided	Visit ring provided	RING RETURNED Date ring returned	Ring not returned	Ring not returned, specify reason:	Visit ring returned	Ring Storage	If not stored, specify reason:	Mark checkbox if ring code is unknown when ring returned.	If ring was stored, how did the participant rate her ability to keep the ring inserted as instructed, per participant report?	If ring was stored, how many days was the vaginal ring out for any reason, in total per participant report?	
1	1.0	12 AUG 2015	2.00	12 SEP 2015	☐	–	3.00	Stored	–	☐	Excellent	0	

Field	Instructions
Ring Code	Enter the ring code (notation X.X; example 1.0) for the ring provided.
Date Ring Provided	Record the exact date study product was provided to the participant.
Visit Ring Provided	Enter the study visit (notation X.XX) at which the ring was provided. For example, if a ring was provided at a participant's Enrollment Visit, enter 2.00.
Date Ring Returned/Ring not returned	Record the exact date study product was returned by the participant. If a ring(s) was expected to be returned at the visit but was not returned for whatever reason, do not enter the date but select 'Ring not returned' and specify the reason that the ring was not returned in the text field/space provided and the remaining items should not be completed Update this item if the ring is returned at a later date.
Visit Ring Returned	When the vaginal ring is returned, enter the visit at which the ring was returned with the notation X.XX. For example, if a ring was returned at a participant's Month 1 visit, enter 3.00.
Ring Storage	Document if the ring was stored. Select 'not stored' if the ring was sent for destruction, returned to the pharmacy (unused), or not stored for any other reason. Specify the reason why the ring was not returned in the text field/space provided.
Mark checkbox if ring code is unknown when ring returned	If the ring code of a ring is unknown at the time of return, select/mark the applicable checkbox. No additional items for this ring should be completed and this is the end of form. The following questions on ring use per participant self-report should not be completed.
If ring was stored, how did the participant rate her ability to keep the ring inserted as instructed, per participant report?	If the vaginal ring was returned, complete this item per participant report. If the ring was not stored or if the ring code was not known, leave this item blank.
If ring was stored, how many days was the vaginal ring out for any reason, in total per participant report?	Ring removals or outages as well as delays in initially inserting the ring should be included in the participant reported number of days each vaginal ring is out. Instances between quarterly visits when a ring is removed and there is a delay in inserting a new ring should be included in the number of days the vaginal ring was out. If the participant does not remember the exact number of days the ring was out, a best estimate should be provided by the participant. If the vaginal ring was not stored or if the ring code was not known, leave this item blank.

Ring Collection and Insertion

Purpose:
This form is used to document the rings that are inserted and collected for each participant for the duration of the study. The form also captures the participant decision to use the ring and whether she chooses to accept the ring on a monthly or quarterly schedule.

General Instructions:
This form is present at the following visits:

- V2 – Enrollment
- V3 – Month 1
- V4 – Month 2
- V5 – Month 3
- V6 – Month 6
- V7 – Month 9
- V8 – Month 12
- This form can also be added at an interim visit and/or an early termination visit.

Complete this form at Enrollment and at each scheduled follow-up visit including the Product Use End Visit (PUEV). Complete at interim visits as needed and at early termination visits, as applicable.

Field	Instructions
RING COLLECTION	If this is the V2 – Enrollment Visit, then please leave these items 1 – 2 (Items 1, 1a, 1b, 1b1, and 2) pertaining to Ring Collection blank.
1. Did the participant have a ring in place at the start of the visit?	Select 'Yes' or 'No'. If 'No', then the following ring code item does not need to be entered and skip to item 1b (When was a ring last in place?)
1a. Ring code for ring in place at start of visit:	Enter the ring code (X.X; example: 1.0) in the field provided. Skip "When was a ring last in place?" (Item 1b and 1b1)
1b. When was a ring last in place?	If the vaginal ring was not in place at the start of the visit, record the date the vaginal ring was last in place since the participant's last visit. If the participant is unable to recall the exact date, obtain the participant's best estimate. At a minimum, the month and year are required. If the ring was not in place at any time since this form was last completed, select the 'N/A (ring was not in place since last visit) box.
2. Was a used or unused ring(s) collected, or expected to be collected, at this visit?	Select 'Yes' or 'No.' If 'Yes', then update the "Vaginal Ring Tracking Log" form.
RING CHOICE	
3. Did the participant choose to use a new ring at this visit?	Select 'Yes', 'No', or 'Not applicable'. If 'No' is selected, then please leave the remaining ring choice item (item 4) blank and answer the "reasons that the participant opted to **not** use the ring at this visit" (item 5). Select the "Not applicable" option if this question is not applicable to the participant at this visit and go to item 6. For example, if the participant is on clinical product hold, has been permanently discontinued from study product, or if this visit is after her expected study product use period (e.g., her PUEV or early termination visit, if applicable).

4. Did the participant accept to receive the ring(s) on a quarterly schedule?	Select 'yes' or 'no' If 'no', specify the reason in the text field provided. **This item should only be completed at the quarterly visits (V5 – Month 3, V6 – Month 6, and V7 – Month 9).**
5. What are the reasons that the participant opted to not use the ring at this visit?	This item should only be completed if the participant did **not** choose to use a new ring at this visit (i.e. item 3 is 'No). Select all reasons that apply. If 'side effects' and/or 'other' is selected, then please provide specific details in the text field space provided. Once this item is completed, this is the end of the form and the RING PROVISION items should not be completed.
RING PROVISION	
6. Was a ring provided at this visit?	Select 'Yes' or 'No'. If 'Yes' is selected, then complete an entry on the "Vaginal Ring Tracking" Log form. Skip the next item "Reason ring not provided".
6a. Reason ring not provided:	Select the applicable reason if a ring was not provided at this visit. If 'other' is selected then please specify in the text field space provided. If this is the participant's scheduled PUEV visit or early termination visit, select this applicable response option from the drop-down menu. If the reason that a ring is not provided is due to or associated with an adverse event, document the adverse event on the "Adverse Experience Log". Once this item is completed, then this is the end of the form and the remaining items should not be completed.
7. Was a new ring inserted at this visit?	Select 'Yes' or 'No'. If 'No' is selected, then go to the item "Was a ring in place at the end of the visit?" and do not complete an entry for the "Ring code of ring inserted."
7a. Ring code of ring inserted:	Enter the ring code (X.X) in the field provided.
8. Was a ring in place at the end of the visit?	Select 'Yes' or 'No'. If 'Yes' is selected, then this is the end of form.
8a. Reason ring not in place at end of visit:	Select the applicable reason only if a ring was not in place at the end of visit. If 'other' is selected, then please specify in the text field space provided.

Ring Adherence Yes/No Prompt

Purpose:
This form is used to document whether the participant has ever used a vaginal ring since her last study visit.

General Instructions:
This prompt is present at the following visits:

- V3 – Month 1
- V4 – Month 2
- V5 – Month 3
- V6 – Month 6
- V7 – Month 9

- V8 – Month 12

Field	Instructions
Since the participant's last study visit, has she ever used a vaginal ring?	Select 'Yes' if the participant used a vaginal ring since her last study visit. If 'Yes' is selected, then the "Ring Adherence" form appears dynamically. Complete the "Ring Adherence" CRF. Select 'No' if the participant did not use a ring since her last study visit. If 'No' is selected, then the "Ring Adherence" form does not need to be completed.

Ring Adherence

Purpose:
This form is used to document the participant's self-reported study ring use during follow-up.

General Instructions:
Complete this form at each scheduled monthly and quarterly study visit, and the Product Use End Visit (PUEV), and at an early termination visit, as applicable. Note that this form will only be completed if the "Ring Adherence Yes/No" prompt is answered 'Yes'. All items on this form refer to ring access and use since the participant's last study visit, regardless of whether or not the participant missed her last study visit.

Field	Instructions
Did the participant disclose her ring use to her primary partner?	Select 'Not applicable' if the participant does not have a primary partner.
Since her last study visit, how many times in total has the participant had a vaginal ring out, excluding expected instances when a ring was briefly removed and replaced with a new ring?	The purpose of this question is to capture all instances when a ring was expelled, or was removed other than at regularly scheduled study visits. Do not count instances when the ring was removed to insert a new ring. If 0 times, then this is the end of the form and the remaining items do not need to be completed.
How many of these times since the participant's last study visit was a vaginal ring out for more than 12 hours continuously?	If 0 times, then skip item 4 and go to item "What are the reason(s) why the vaginal ring(s) were out?
Since the participant's last study visit, what is the longest number of days in a row the vaginal ring was out?	When determining the longest number of days in a row, include partial days as a day. For example, if a participant reports she removed the ring on a Wednesday and re-inserted it on a Friday, count this as 3 days (Wednesday, Thursday, Friday). This item should be an over-estimate rather than an exact or under-estimate.
What are the reason(s) why the vaginal ring(s) were out? Reason 1 – Reason 7	Refer to the list of reasons in the table below. Record the applicable reason why the vaginal ring was out since her last study visit (because the participant or clinical removed the ring, or ring expulsion occurred). Up to seven reasons may be recorded (Reason 1 – Reason 7). Record any additional reasons in Reason 2 – Reason 7 if applicable or leave these items blank. For example, if three reasons apply, record the reasons for Reason 1, Reason 2, and Reason 3, and leave Reasons 4 - Reason 7 blank.

	When completing these items within Medidata Rave, select the applicable reason from the drop-down menu. When completing these items on a paper CRF, write out the reason on the line provided using the list of reasons from the table below.
Other reason ring removed by participant or clinician, specify: Other reason ring came out on its own, specify:	If there is a reason that is not represented in the Reason list, select either of these reasons, as applicable, and record the reason on the adjacent specify lines in the field provided. Otherwise, these items can be left blank.

REASONS FOR RING OUTAGE(S)
REASONS RING REMOVED BY PARTICIPANT OR CLINICIAN
Hygienic or Physical Reasons
Discomfort/symptoms: Ring caused discomfort/participant experienced genital or other symptoms
Ring falling out: Ring was partially falling out
Ring placement: Didn't feel the ring was correctly placed
Ring presence: Wanted to look at the ring or see if the ring was still in place
Menses/Bleeding: Had or was expecting menses/any type of genital bleeding or spotting
Cleaned ring: Removed ring to clean it
Cleaned vagina: Removed ring to clean vagina
Felt sick: Felt sick/had non-genital side effects from the ring
Emotional worries: Had emotional worries about the ring
Social or Sexual Reasons
Partner ring knowledge: Did not want husband or primary sex partner to know about ring
Partner concerns/objections: Husband or any sex partner did not like the ring and/or wanted her to remove/stop using the ring
Family concerns/objections: Family member (other than husband/primary sex partner) did not like the ring and/or wanted her to remove/stop using the ring
Friend or peer concerns/objections: Friend or peer did not like the ring and/or wanted her to remove/stop using the ring
Removal for sex: Participant or partner did not want to have vaginal sex with the ring in place
Discomfort during sex: The ring feeling uncomfortable or painful during vaginal sex
Partner felt ring during sex: The sex partner feeling the ring during sex
Showed ring: Removed ring to show it to someone
Not having sex: Participant was not having sex so she decided to remove/stop using the ring
Interfered with sexual pleasure: The ring interfered with her sexual pleasure
Interfered with partner's sexual pleasure: the ring interfered with her partner's sexual pleasure
Disliked ring: Removed ring because did not like the ring
Partner disliked ring: Removed ring because partner did not like the ring
Participant wanted to get pregnant
Partner wanted her to get pregnant
Study-related or Procedural Reasons

Product hold: Participant placed on product hold
Product permanently discontinued: Participant permanently discontinued from product
Procedure: Ring removed for clinical procedure (e.g., IUCD insertion, pelvic exam) that was *not* conducted at a regularly scheduled study visit
Inserted new ring: Ring removed to insert new ring between study visits or at an interim visit
Missed visit: Participant removed ring due to missed scheduled visit
REASONS RING CAME OUT ON ITS OWN
Urination
Bowel movement: Having a bowel movement
Sex: Having sex or just finished sex
Physical activity: Physical activity (other than sex),including lifting heavy objects
Body position: Was squatting or sitting or changing body position (i.e., move from lying down to standing up)
Menses: Had her menses

CLINICAL FORMS

Physical Exam

Purpose:
This form is used to document the participant's physical exam findings.

General Instructions:
This form is present at the following visits:

- V1 – Screening
- V8 – Month 12 (Product Use End Visit)
- This form can also be added at other scheduled study visits, an interim visit and/or an early termination visit.

Complete this form at Screening, Product Use End Visit (PUEV), Early Termination Visit, and as indicated at all other study visits. If abnormal findings are found, for items 1-12, transcribe the information on the Baseline Medical History Log or Adverse Experience Log form(s) as applicable.

Field	Instructions
Exam Date:	Enter the date the physical exam was performed. Exact day, month, and year are required.
Organ Systems or Body Parts Evaluated:	For each organ system or body part evaluated, indicate whether the findings were normal or abnormal. If abnormal, describe the findings in the text field/space provided. Normal findings may also be described in the text field/space, but is not required. If not evaluated, select 'Not done'. Additional information may also be provided in the text field/space for why 'Not done', but this is not required. Per protocol, lymph nodes, neck, heart, lungs, extremities, skin, and neurological may be omitted after the Screening Visit.

Field	Instructions
Other:	If there is an abnormal finding in another body system that is not listed, select 'Abnormal'. Specify the body system being referenced and describe the findings in the text field provided. If another body system was evaluated and the findings were normal, select 'Normal'. The body system can be specified in the text field provided. If no other abnormal findings are identified, select 'Not Done'.

Vital Signs

Purpose:
This form is used to document the participant's vital signs.

General Instructions:
This form is present at the following visits:

- V1 – Screening
- V8 – Month 12 (Product Use End Visit)
- This form can also be added at other scheduled study visits, an interim visit and/or an early termination visit.

Complete this form at Screening, Product Use End Visit (PUEV), Early Termination Visit, and as indicated at all other study visits.

Field	Instructions
Exam Date	Enter the date the participant's vital signs were measured. Exact day, month, and year are required.
Weight	Enter the participant's weight in kilograms (kg). Enter a whole number for this item by rounding to the nearest Kilogram, if needed.
Body Temperature	Enter the participant's temperature in degrees Celsius (C).
Systolic BP*	Enter the participant's systolic blood pressure in mmHg.
Diastolic BP*	Enter the participant's diastolic blood pressure in mmHg.
Pulse	Enter the participant's pulse in beats per minute.
Respirations	Enter the participant's respiratory rate in breaths per minute.
Height	Enter the participant's height in centimeters (cm). Per protocol, height may be omitted after the Screening Visit.

* In Medidata Rave, the most recent BP reading that is used for clinical management should be recorded on the Vital Signs eCRF. In instances where the BP has already been entered within Medidata Rave, these fields (Systolic BP and Diastolic BP) can be updated within the form and re-saved. If completing paper, please record both readings on the paper form (i.e., update this item with a second reading and initial/date) and enter/update the most recent BP reading within Medidata Rave.

Pregnancy Report and History

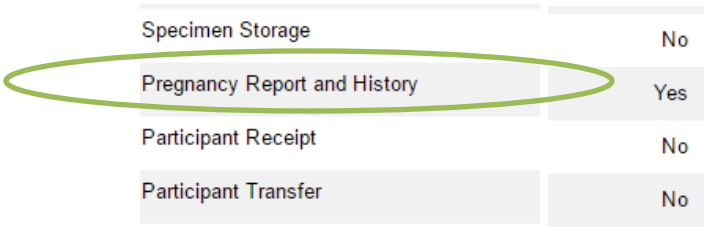
Purpose:

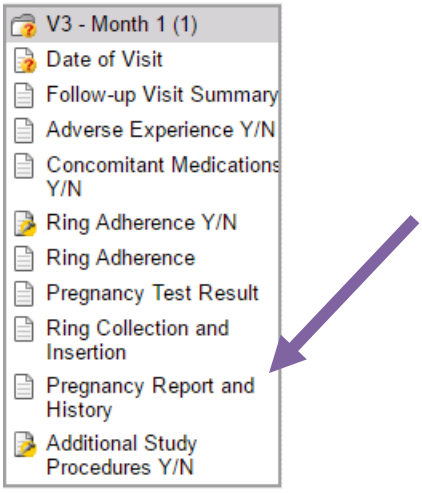
Complete this form when reporting a pregnancy of a study participant post enrollment through study termination.

General Instructions:

A Pregnancy Report and History form is required for each new pregnancy that the participant experiences during the study.

To complete a Pregnancy Report and History form within Medidata Rave, select "yes" for **Pregnancy Report and History"** within the Additional Study Procedures form (at a scheduled study visit) or within the Interim Visit Procedures form (at an interim visit). The Pregnancy Report and History form will dynamically be added to the list of available forms to complete for applicable visit with the participant's case book.





Field	Instructions
First day of last menstrual period	A complete date is required. Record best estimate if date not known. If the participant is amenorrheic, mark this checkbox and leave the date fields blank.
Estimated date of delivery	A complete date is required.
3d. Physical exam	A physical examination to determine estimated date of delivery includes fundal height, uterine size by pelvic exam, and/or fetal heart rate.
Has the participant ever been pregnant before?	If the participant has never been pregnant before, select or mark "No" and end the form.
Is this the participant's first pregnancy since enrollment in this study.	If this pregnancy is not the first reported pregnancy since the participant's enrollment in the study, select or mark "No" and skip to the item, "Does the participant have a history of pregnancy complications or fetal/infant congenital anomalies?"

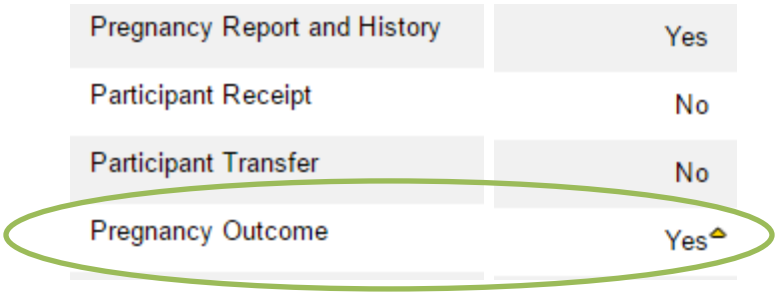
Field	Instructions
Does the participant have a history of pregnancy complications or fetal/infant congenital anomalies?	If the participant does not have a history of pregnancy complications, mark or select “No” and end the form. If “Yes”, specify information on pregnancy complications and fetal/infant congenital anomalies experienced prior to enrolling in the study as well as any conditions experienced/reported during the study.

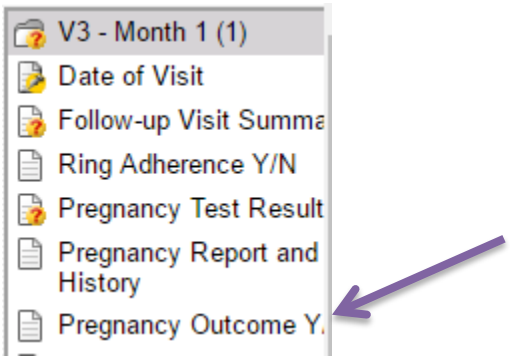
Pregnancy Outcome YN prompt

Purpose:
Complete this form when information about a pregnancy outcome becomes available to study staff or when it is determined that the pregnancy outcome is unobtainable. A Pregnancy Outcome YN prompt must be completed for each pregnancy reported during the study.

General Instructions:

To complete the Pregnancy Outcome form within Medidata Rave, add a Pregnancy Outcome form to the visit folder at which the pregnancy was reported (i.e., add the Pregnancy Outcome form to the visit where the Pregnancy Report and History form was completed) by selecting “yes” for **Pregnancy Outcome** within the Additional Study Procedures form (at a scheduled study visit) or within the Interim Visit Procedures form (at an interim visit). The Pregnancy Outcome YN prompt dynamically will be added to the list of available forms to complete for applicable visit with the participant’s case book.





Field	Instructions
Did this pregnancy have an obtainable outcome?	If site staff were able to ascertain an outcome for this pregnancy from the participant, select “Yes”. If ‘Yes’ is selected, then the Pregnancy Outcome form appears dynamically within the visit folder, which can

	then be completed. If site staff were not able to ascertain an outcome for this pregnancy from the participant, select "No".

Pregnancy Outcome

Purpose:
This form is used to report pregnancy outcome information for a pregnancy reported post-enrollment.

General Instructions:

This form will dynamically be added to the participant's visit folder if the Pregnancy Outcome Y/N prompt indicates that the outcome is obtainable by study staff.

Field	Instructions
Outcome number	A pregnancy outcome can be an infant or fetus. The conception of twins, for example, will result in reporting of two outcomes. For a pregnancy resulting in one outcome, record '1' here. For a pregnancy with multiple outcomes, record the outcome number corresponding to the outcome data recorded on the form.
How many pregnancy outcomes resulted from this reported pregnancy?	If the pregnancy results in two or more outcomes, complete a Pregnancy Outcome form for each outcome. If the item is completed as greater than "1", additional Pregnancy Outcome CRFs will be added to the visit folder, as needed. Each Pregnancy Outcome form will have different outcome numbers.
Specify Outcome	If the outcome is spontaneous fetal death, still birth, spontaneous abortion, therapeutic/elective abortion, or ectopic pregnancy, the outcome itself is not an adverse experience (AE). If a therapeutic/elective abortion is performed due to a pregnancy complication, the pregnancy complication should be reported on an Adverse Experience (AE) Log, if prior to termination, with "procedure/surgery" marked within the "Treatment" item. If there are any maternal complications as a result of the pregnancy outcome, refer to the protocol, Study-specific Procedures (SSP) manual, and *Manual for Expedited Reporting of Adverse Events to DAIDS, Version 2* for guidance on AE and expedited AE reporting requirements.
Method	Complete this item if "Specify outcome" is 'full term live birth' or 'premature term live birth'. If "Specify outcome" is 'full term live birth' only, then go to item "Were there any complications related to the pregnancy outcome?'.
Provide a brief narrative of the circumstances	Include information on medical conditions associated with the outcome, including early contractions, rupture of membranes, and cramping, along with actions taken as a result of these conditions.

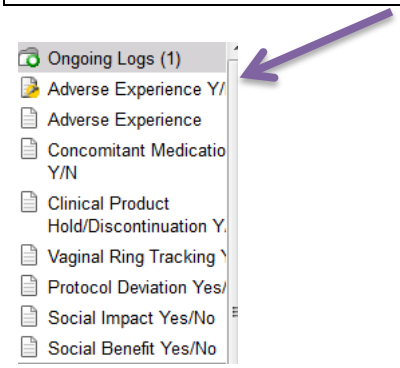
Field	Instructions
Were there any complications related to the pregnancy outcome?	If "No", skip to "Were any fetal/infant congenital anomalies identified?"
Delivery-related complications	Select the applicable delivery-related complication(s), or 'none'. 'None' should only be marked if there is at least one non-delivery complication in the next section (6b). If there are no complications in sections 6a and 6b, both sections should be skipped (e.g. 'none' should not be marked in either section).
Non-delivery related complications	Select the applicable non-delivery related complication(s), or 'none'. 'None' should only be marked if there is at least one delivery-related complication in the previous section (6a). If there are no complications in sections 6a and 6b, both sections should be skipped (e.g. 'none' should not be marked in either section).
Were any fetal/infant congenital anomalies identified?	If "No" or "Unknown", go to statement above "Infant Gender".
Congenital anomalies identified. *Mark all that apply.*	If a woman on study has a baby with a congenital anomaly, report the event on an Adverse Experience (AE) log, if prior to study Termination. On the AE Log, record "Congenital Anomaly in Offspring" as the AE term, record the Outcome Date as the Onset Date, and record the specific anomaly in the Comment Section. Submit an Expedited Adverse Event (EAE) Reporting form. When completing the eCRF within Medidata Rave, select the appropriate AE log page from the drop down item provided. If completing a paper CRF prior to data entry, record the AE log page information on the line provided.
Infant Gender, Infant birth length, Infant birth head circumference, Infant birth abdominal circumference	Complete these items for live births only. Record the information as documented in medical records. If no medical record documentation of the information is available, complete this item based on participant report. Mark the "unavailable" box if no medical record documentation is available and the participant does not know the information.
Infant Gestational age by examination in weeks	Record the infant's gestational age at birth. If the infant's gestational age is determined using the Ballard method, record "0" in the "days" box. Mark the "unavailable" box if no medical record documentation of the infant's gestational age is available and end the form.

Adverse Experience Y/N Prompt

Purpose:
This form documents if an adverse event was experienced by the participant during the study.

General Instructions:
In addition to this prompt being asked within the "Ongoing Logs" folder, this prompt will be asked at every scheduled study visit beginning at V3 – Month 1 through the V9 – Study Exit/Termination Visit.

Field	Instructions
Has the participant experienced any new adverse events or are there any updates to previously reported AEs?	Select 'Yes' or 'No'. Within the "Ongoing Logs" folder, if 'Yes' is selected, then the "Adverse Experience" log form appears dynamically and can then be completed. Complete as many Adverse Experience CRFs as needed. Please note that this question should be answered at each scheduled study visit as it appears in each participant's visit folder. Navigate to the Ongoing logs folder to update the Adverse Experience Log as needed.



Adverse Experience Log

Purpose:
To document all MTN-025 Adverse Experiences (AEs) required to be reported per protocol. This includes all genital, genitourinary, reproductive system, and laboratory AEs as well as all other Grade 2 or higher AEs, all SAEs, and all AEs that result in permanent product discontinuation.

General Instructions:
Complete a separate entry (e.g. log line) for each adverse event when entering into the study database. If completing on a paper form, please print and complete one separate page for each adverse experience.

Whenever possible, report a diagnosis instead of listing a cluster of symptoms. If no diagnosis is identified, each symptom must be recorded as a separate AE on separate AE Log pages or separate log entries as applicable. If a cluster of symptoms reported on separate AE Log pages is later attributed to a single diagnosis, change/update the earliest reported symptom page to the diagnosis. In addition, mark the AE Log pages for the other symptoms with the words "Delete due to diagnosis" if completing on paper. In the study database, these other symptoms can be deleted by clicking "Inactivate" and selecting the applicable rows within the "Adverse Experience – Ongoing Logs" folder that should be inactivated.

Field	Instructions
Date Reported to Site	Record the date the site became aware of the AE. For lab AEs, record the date the lab result was received.
Adverse Experience	Use medical terminology to describe the AE. Record a diagnosis if available. Include the anatomical location if applicable. Do not include text on the relationship to study product or timing of AE onset with regard to product use. For lab abnormalities, record the lab name with the direction (i.e., increased or decreased). For example, "increased ALT".

Field	Instructions
Onset Date	At a minimum a month and year are required. Record one of the following, as appropriate: the date on which the participant reports first experiencing the AE (onset of first symptom if diagnosis has multiple associated symptoms); date of the study visit/study exam (for physical or pelvic exam findings); specimen collection date (for lab abnormality AEs).
Severity Grade	Record the severity grade using the current version of the *Division of AIDS (DAIDS) Table for Grading the Severity of Adult and Pediatric Adverse Events* (including relevant appendices/addendums).
Relationship to Study Product	Mark/select 'related' if there is a reasonable possibility that the AE may be related to the study agent. Mark/select 'not related' if there is not a reasonable possibility that the AE is related to the study agent. Provide the clinical rationale (the reason) the AE is judged to be 'related' or 'not related' in the applicable Comments section/text field provided for each reported AE.
Study Product Administration	***- No change****:* Mark/select if there is no change to the participant's planned use of study product as a result of the AE. This option should be marked if the participant is still in the product use period and the AE does not result in a clinician initiated product hold or permanent discontinuation of study product. - ***Held****:* Mark/select if the AE results in a clinician initiated product hold. If multiple AEs are reported at the same visit, mark 'held' for each AE contributing to the hold. A Clinical Product Hold/Discontinuation Log entry/form should be completed for each AE with 'held' marked. If the AE results in a hold, then a permanent discontinuation, update this item to 'permanent discontinuation' at the time that the participant is permanently discontinued, - ***Permanently discontinued*****:** Mark if the AE results in permanent discontinuation of study product. If multiple AEs are reported at the same visit, select/mark "permanently discontinued" for each AE contributing to the permanent discontinuation. For each AE completed with this option selected, there should be a PH log entry/form with item "Was the participant instructed to resume study product use" marked/selected, "no – permanently discontinued". - ***N/A (not applicable)*****:** Mark if the AE's onset date is on or after the participant's PUEV or early termination visit date. Also mark/select this option if the AE's onset date is on or after the date of permanent discontinuation.
Status/Outcome	***Continuing****:* AE is continuing at the time it is first reported ***Resolved****:* AE is no longer present or has returned to baseline severity/frequency. Note that if a participant started taking medication once enrolled to control an AE, the AE is not considered resolved while the medication is still indicated. ***Death****:* Mark/select only if the severity grade of this AE is Grade 5. Any other AEs continuing at the time of death should be changed to 'continuing at the end of study participation" ***Severity/frequency increased****:* If an AE increases in severity/frequency after it has been first reported on this form, line through the 'continuing' option box and mark 'severity/frequency increased' if completing a paper form. Update to 'severity/frequency increased' in the study database. Record the date of increase as the 'Status/Outcome Date." Report the increase in severity/frequency as a new AE. For this new AE, the "onset date" will be the same as the "Status/Outcome Date" of the first reported AE. Note that decreases in severity (AE improvements) are not recorded as new AEs. ***Continuing at end of study participation****:* Mark/select this option whenever an AE is continuing at the time of participant termination from the study.

Field	Instructions
Status/Outcome Date	This field should be left blank if the "Status/Outcome" is 'Continuing' or 'Continuing at end of study participation'. A month and year are required at a minimum. Record one of the following, as appropriate: the date on which the participant reports no longer experience the AE or associated symptoms, or the date of the study visit or specimen collection at which it is first noted the AE has resolved or returned to baseline status.
Treatment	Select 'none' or all that apply. ***Medication(s)***: Mark/select 'medication(s)' only if the participant reports taking the medication. Report the medication(s) on the "Concomitant Medications Log" form. If medication is indicated, but not yet used, mark/select 'other' and describe the medication indicated in the text field/space provided; update this item to 'medication(s)' once the medication has been used and report on the "Concomitant Medications Log". ***New/prolonged hospitalization/procedure/Surgery/Other***: If any of these options are marked/selected, record additional details in the text field/space provided.
Has/will this AE be reported as an EAE? EAE Number	For questions about ICH guidelines and EAE reporting, refer to the current *Manual for Expedited Reporting of Adverse Events to DAIDS.* If this AE was/is reported as an EAE (indicated as 'yes'), provide the EAE number and complete any subsequent updates to this form on the applicable EAE form.
Was this AE a worsening of a baseline medical condition?	Select 'Yes' or 'No'.
Comments	Provide the clinical rationale (the reason) the AE is judged to be 'related' or 'not related' in the applicable Comments section/text field provided for each reported AE.

Grade 1 Adverse Experience Log

Purpose:
To document MTN-025 Grade 1 non-genital, non-laboratory Adverse Experiences (AEs). All genital, genitourinary, reproductive system, and laboratory value AEs, all other AEs grade 2 and higher, all SAEs, and any AE resulting in a clinical product hold or permanent product discontinuation are reported using the Adverse Experience (AE) Log.

General Instructions:
****THIS FORM IS NOT DATA ENTERED INTO MEDIDATA RAVE****
This form is available on the MTN-025 Atlas webpage:
https://atlas.scharp.org/cpas/project/MTN/025/begin.view?. Please refer to the back of the form for specific guidelines on completing this form. This form will be completed via paper and not submitted into the study database unless directed by SCHARP.

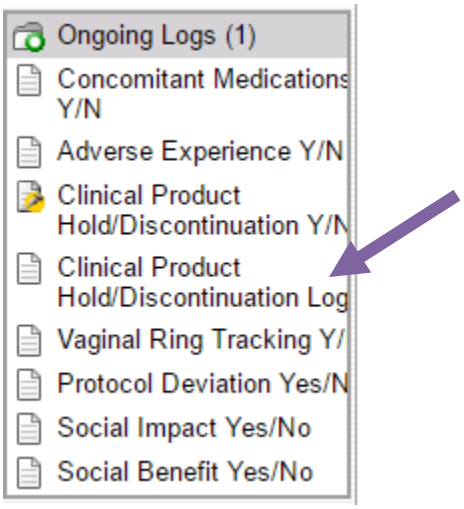
Clinical Product Hold/Discontinuation Yes/No Prompt

Purpose:
This form documents if a clinician-initiated product hold or discontinuation was applied during the study.

General Instructions:

This form is present within the "Ongoing Logs" folder. Selecting 'Yes' in the "Clinical Product Hold/Discontinuation Yes/No" prompt will add the "Clinical Product Hold/Discontinuation" log to the "Ongoing Logs" folder.

Field	Instructions
Does the participant have any clinical product holds/discontinuations to be applied?	Select 'Yes' or 'No'. If 'Yes' is selected, then the "Clinical Product Hold/Discontinuation" log appears dynamically and a log line can then be completed or updated for each applicable clinical product hold or discontinuation.



Clinical Product Hold/Discontinuation

Purpose:
This form is used to document temporary clinical holds and clinical permanent discontinuations of study product use as instructed by study site staff. This form is completed each time a participant is instructed by study staff to temporarily stop (hold) or permanently discontinue study product use. If, at the same visit, a product hold/discontinuation is initiated for more than one reason, complete one Product Hold/Discontinuation log page for each reason. To add an additional Clinical Product Hold/Discontinuation log form within Medidata Rave, click "Add a new Log line" to add an additional page for a new product hold to be completed.

Complete this form for any clinical reason that warrants a product hold or discontinuation regardless of whether participants choose to use the ring or who choose to not use study product during the study. Do not complete this form in cases where a participant has decided herself to not use the study vaginal ring.

General Instructions:

Complete a separate entry (e.g., log line) for each clinical product hold or discontinuation when entering into the study database. If completing on a paper form, please print and complete one separate page for each clinical product hold.

Field	Instructions
Date when study product hold was initiated:	Record the date when the product hold was initiated or would have been initiated in instances where the participant has chosen not to use the ring. A complete date is required.
Why is study product being held?	Record the reason that study product is being held. If study product is held for any reason not specified, mark "Other, specify" and specify the reason in the space provided. Note that participant decline or refusal of study product is not documented as a product hold. Do not record this as a reason in 'other, specify".
Adverse Experience	If study product is being held due to "Adverse Experience" or due to "Allergic reaction to the study product", specify the AE in the line provided if completing a paper CRF. When completing the log form within Rave, select the applicable AE from the drop-down field provided. **Note**: If study product is being held due to an AE or allergic reaction to study product, the AE log page must be entered into Rave prior to completion of the Clinical Product Hold/Discontinuation log form in order for the AE to be available to select with the drop down field.
Concomitant Medication	If study product is being held due to "Report of PEP use for HIV exposure", specify the corresponding concomitant medications log form on which the PEP medication was reported in from the drop down field provided with Rave or on the line provided on the paper log from. **Note**: If the product hold is due to report of PEP use, the corresponding concomitant medications log page must be entered into Rave prior to completion of the Clinical Product/Hold/Discontinuation log form in order the medication be to be available within the drop down field.
Date of last study product use	Record the last date the study product was present in the vagina. Use a best estimate if the actual date cannot be determined. If the participant has never used the ring during HOPE, mark the "participant did not use ring" checkbox and leave the date fields blank.
Was the participant instructed to resume study product use?	Mark, "No – hold continuing for another reason" if the participant would have been instructed to resume study product based on the resolution of the reason indicated on this form. Mark, "No – early termination" if the product hold was ongoing at the visit at which the participant terminated early from the study. Mark, "No – hold continuing at scheduled PUEV" if the product hold was ongoing at time of the participant's scheduled Product Use End Visit. Mark, "No – permanently discontinued" if the participant was permanently discontinued from study product due the reason indicated on this form. Administer the PUEV/Discontinuers ACASI questionnaire and complete the ACASI Tracking CRF at the time of permanent discontinuation instead of at the participant's scheduled PUEV.
Date	Record the date at which the participant was instructed to resume study product, was permanently discontinued from study product, or

	the date that the participant completed her PUEV or early termination visit while the product hold was ongoing.

Concomitant Medications Y/N Prompt

Purpose:
This form documents if any concomitant medications were reported the participant during the study.

General Instructions:
In addition to this prompt being asked within the "Ongoing Logs" folder, this prompt will be asked at every scheduled study visit beginning at V1– Screening through the V9 – Study Exit/Termination Visit.

Field	Instructions
Is the participant taking any new concomitant medications that have not been previously reported or are there any updates to existing concomitant medications?	Select 'Yes' or 'No'. If 'Yes' is selected within the Ongoing Logs folder, then the "Concomitant Medications" log form appears dynamically within the "Ongoing Logs" folder and complete as many Concomitant Medication forms as needed. Please note that this question should be answered at each scheduled study visit as it appears in each participant's visit folder. Navigate to the Ongoing logs folder to update the Concomitant Medications Log as needed.

Concomitant Medications

Purpose:
This form is used to document all medications taken by the participant starting at the Screening Visit. This includes, but is not limited to: prescription medications, non-prescription (i.e., over-the-counter) medications, contraceptive hormonal medications, preventive medications and treatments (e.g., allergy shorts, flu shots, and other vaccinations), herbal preparations, vitamin supplements, and naturopathic preparations.

Oral contraceptive pill packs and hormonal injections taken and received prior to a participant's Screening Visit should not be recorded on the concomitant medications log. If a participant initiated a LARC method such as IUCD or implant, prior to her Screening Visit, this should be recorded on the Concomitant Medications log CRF.

General Instructions:
Submit this form into the study database once a participant has enrolled in the study. Complete a separate entry (e.g. log line) for each reported concomitant medication when entering into the study database. If completing a paper form(s), please print and complete one separate page for each reported concomitant medication.

Field	Instructions
Medication Name	Record the trade or generic name of the medication based on exactly what the participant is taking. If a trade name is not available or not reportable per national guidelines, record the generic name of the medication. A combination medication can be recorded as one entry using the generic name. If a combination medication does not have a generic name, or the generic name is unknown, each active ingredient must be reported as a separate entry.
Indication	For health supplements, such as multivitamins, record 'general health'. For preventive medications, record 'prevention of [insert condition]" (e.g., for flu shot, record "prevention of influenza").
Date Started	If the participant is unable to recall the exact date of medication initiation, obtain participant's best estimate. At a minimum, the year is required. For injections, record each injection as a separate entry, with the same date used for start and stop date. For oral contraceptives, record the start date (and stop date) for each pill pack.
Date stopped	Enter the stop date of this medication if known. At a minimum, the month and year is required. This item can be completed at any time during study participation when the stop date is known. At the participant's Study Exit/Termination Visit, the "Date Stopped" must be recorded for each medication OR the "Continuing at end of study" box must be selected.
Taken for a reported AE?	If the concomitant medication was taken for a reported AE, select "yes". The relevant AE log form must be completed to link the concomitant medication to the AE log form entered. Choose the applicable AE(s) from the drop-down list. The AE description can be recorded if completing the Concomitant Medications as a paper form.
Frequency	Select the frequency from options provided in the drop-down list or marking on the paper form. Below is a list of common frequency abbreviations: PRN: as needed QD: every day TID: three times daily QID: four times daily QHS: at bedtime ONC: one time BID: twice daily Other: alternative dosing schedule or unknown If 'Other' is selected, specify in the corresponding text field/space provided.
Dose	Record the dose. If the participant does not know the exact dose units (e.g., "250 mg"), record an estimate (e.g., "1 tablet"). For combination drugs, use the '/' or '-' to distinguish the different doses (i.e., hydrocodone/acetaminophen 5/500). For multivitamin tablets or liquids, record the number of tablets or liquid measurement (e.g. "1" pill or "1" tablespoon") if the exact dosage is unknown. If the dose is unknown, record "unknown" in the space provided. When documenting medical devices with no active medication, such as an IUCD, mark the dose as "1".

Dose Units	Select/record the applicable dose units provided in the drop-down list or marking the appropriate units on the paper form. If the participant does not know the exact dose units (e.g., “250 mg”), record an estimate (e.g., “1 tablet”). If no information on units is known, select the ‘Unknown’ option. When documenting medical devices with no active medication, such as an IUCD, mark the Dose Unit as “other, specify” and specify “device” in the text field provided.
Route	Select the route from options provided in the drop-down list or marking the appropriate response on the paper form. Below is a list of common route abbreviations: PO: oral IM: intramuscular IV: intravenous TOP: topical IHL: inhaled VAG: vaginal REC: rectal SC: subcutaneous Other: alternative routes or unknown If ‘Other’ is selected, specify in the corresponding text field/space provided.
If contraceptive, was it dispensed at research center?	Mark/select the ‘yes’ option if the medication is a contraceptive, regardless of indication, and it was dispensed by the study site pharmacy. This item should be completed if a contraceptive is dispensed to a participant for reasons other than family planning (e.g., to treat an AE). If the participant is taking contraceptive pills dispensed by a local health clinic at Screening, then starts receiving oral contraceptives dispensed by the site pharmacy at Month1, record a new entry for the OCPs at Month 1 with this item marked ‘yes’. Keep the original “no’ response for the OCP entry made at the Screening Visit, and update the entry by completing a stop date to this entry as needed.

Family Planning (Log)

Purpose:
This form is used to document the methods of contraception/family planning used by the participant beginning at baseline and during study follow-up per participant self-report.

General Instructions:
This form is present within the V2 – Enrollment folder.
Complete this form at the Enrollment Visit and each time a participant starts or stops using a contraceptive or family planning method during the study. Only current methods should be recorded (not methods that the participant is planning to use). Navigate back in the V2 – Enrollment folder to update this log form. (Note that this form is not present within the “Ongoing Logs” folder). If completing a paper form, update the applicable form as needed and fill out a new Family Planning form for each new method of contraception/family planning reported.

<table>
<tr><th>Field</th><th>Instructions</th></tr>
<tr><td>Date of Completion</td><td>Enter the date this form is completed whenever a method(s) of contraception/family planning is added. A complete date is required.</td></tr>
<tr><td>What method(s) of contraception/family planning is the participant currently using?</td><td>Record the method of contraception/family planning the participant reports currently using. For each specific method reported, a new form or log line will need to be completed. When adding in Medidata Rave, click the “Add a new Log line” to add an additional method of contraception/family planning and complete the form as appropriate. If completing the paper form, a new page/form will need to be printed and completed and the applicable method of contraception/family planning can be recorded. Record any hormonal methods used on the Concomitant Medications Log as well using the trade name of the contraceptive if possible. (Concomitant Medications records individual methods, while the Family Planning Log records the regimen). The family planning/contraception methods are as follows:
<table>
<tr><th colspan="2">Contraceptive Methods</th></tr>
<tr><td>Spermicide</td><td>Diaphragm</td></tr>
<tr><td>Sponge</td><td>Intrauterine Device (IUD)</td></tr>
<tr><td>Oral contraceptive birth control pills</td><td>Injectable contraceptive – Depo</td></tr>
<tr><td>(Ortho Evra) – The Patch</td><td>Injectable contraceptive – NET-EN</td></tr>
<tr><td>Implants</td><td>Injectable contraceptive – Cyclofem</td></tr>
<tr><td>Female Condoms</td><td>Injectable contraceptive – Other</td></tr>
<tr><td>Male Condoms</td><td>Natural methods such as the withdrawal or rhythm method</td></tr>
<tr><td>Sterilization (tubal ligation/hysterectomy/laparoscopy/ other surgical procedure that causes sterilization)</td><td>Sex with partner who had vasectomy</td></tr>
<tr><td>Other, specify</td><td>Emergency contraception</td></tr>
</table></td></tr>
<tr><td>Other, specify</td><td>If a contraceptive/family planning method is selected as ‘other’, then specify the contraceptive/family planning method in the text field space provided.</td></tr>
<tr><td>Date Regimen Started</td><td>Record the date the participant started using the current contraceptive regimen. At a minimum, a month and year is required.

For hormonal methods, record the date that the participant started using that particular method.

For example:
If a participant reports that she started using “Injectable contraceptive – Depo” every 3 months, starting in October 2012, the date regimen started is October 2012 (month and year required) and should be entered as “Un-OCT-2012”. Use</td></tr>
</table>

	this as the start date even if the participant missed an occasional injection. Do not record the date of her last injection as date regimen started. • If a participant reports starting oral contraceptives on 13-MAR-2012, record this as the date regimen started (even if she missed pills or an occasional pill pack during that time). Do not record the start date of her most recent/current pill pack. • For a participant with implants inserted most recently 3 months ago, and has had implants inserted starting 3 years prior (January 2009), record "Un-JAN-2009" as the date regimen started.
Ongoing	Select 'ongoing' by checking the applicable box if the participant is currently using the applicable contraceptive/family planning method. If the method is not ongoing, leave this item blank and complete the Date Regimen Stopped.
Date Regimen Stopped	If a participant has stopped a contraceptive/family planning method since her last visit, record the stop date. At a minimum, a month and year are required. If a participant has stopped a contraceptive/family planning method since her last visit, provide the reason(s) for changing or stopping the family planning method. At the V2 – Enrollment Visit, please leave this item blank. If a participant reports that she has defaulted on her family planning method, do not close out the family planning/contraceptive entry on the log form (i.e., do not enter the stop date for this method).
Reason(s) for changing or stopping the family planning method:	If a participant discontinues a contraceptive/family planning method during the study and a regimen stop date has been provided, provide the reason(s) that the participant is changing or stopping the family planning method. For ongoing family planning methods, leave this item blank. Select all reasons that apply. If 'bleeding concerns' is selected, then specify the type of vaginal bleeding. Select all types that apply. If 'other' or 'medical contraindication' is selected, then specify the reason in the text field space provided.
Is this the same family planning method that the participant used at her last visit in ASPIRE?	Please complete this item only at the V2- Enrollment Visit. If additional methods of contraception/family planning are added after the V2 – Enrollment visit, then leave this item blank. Select 'Yes' or 'No' based on participant self-report. If 'Yes' is selected, go to item "If yes, was there a break in use of this method for more than 1 month". If the family planning method used at her last visit in ASPIRE is unknown, leave this item blank. A system query will fire indicating this as a missing value. Please indicate this is unknown per participant report in response to this query.
If yes, was there a break in use of this method for more than 1	Please complete this item only at the V2-Enrollment Visit if the participant indicates that she is using the same family planning method

month?	that was used at her last ASPIRE study visit. If the participant indicates that she is not using the same family planning method that was used at her last ASPIRE study visit, select 'No' and then this is the end of the form. If there was a break in use of this method for more than 1 month, provide the reason(s) for changing or stopping the family planning method.
Reason(s) for changing or stopping the family planning method the participant used at her last ASPIRE visit:	Please complete this item at the V2- Enrollment Visit if the participant is no longer using the same family planning method that she used at her last study visit in ASPIRE or if there was a break in use of this method for more than 1 month. Check all reasons that apply. If 'bleeding concerns' is selected, then specify the type of vaginal bleeding. Select all types that apply. If 'other' or 'medical contraindication' is selected, then specify the reason in the text field space provided.

Pelvic Exam

Purpose:
This form is used to document the participant's pelvic exam assessment.

General Instructions:
This form is present at the following visits:

- V1 – Screening
- V8 – Month 12
- This form can also be added at other scheduled study visits, an interim visit and/or an early termination visit.

Complete this form at Screening, Product Use End Visit (PUEV), and as clinically indicated at all other study visits. Transcribe information on abnormal findings from the Pelvic Exam Diagrams form onto this form.

Field	Instructions
Exam Date	A complete date is required.
Pelvic exam assessment	If 'not done' is selected, then this is the end of form and all remaining items should be left blank. If 'no abnormal findings' is selected, then skip the 'abnormal findings' section.
Abnormal findings	Mark/select the box to the right of each abnormal finding observed, and mark all that apply. Specify additional details in the text field/space provided where applicable. If an observed abnormal finding is not listed, mark/select "other abnormal findings" and specify/describe the abnormal findings in the text field/space provided, including the

	anatomical location. Record abnormal findings on the Baseline Medical History Log form as applicable. In general, for abnormal findings reported as adverse events on an AE log, use the abnormal finding text provided on this form as the AE descriptive text. Note that any genital bleeding related to changes in contraceptive method is not considered an abnormal finding and is not a reportable AE, per protocol.
Were any new pelvic finding AEs reported at this visit?	Record whether an AE was identified and reported at this visit as part of the pelvic exam assessment by selecting 'Yes' or 'No'. If an AE was reported at the study visit, select the corresponding AE log form within the dynamic searchlist function on the eCRF or indicate the AE term, page number if applicable, and onset date within the line provided on the paper CRF. This item should be marked "no" prior to participant enrollment in the study (i.e., prior to the AE reporting period).
Cervical Ectopy	Select the percentage of cervical ectopy observed during the pelvic exam assessment by selecting the appropriate drop down option within the eCRF or marking the applicable response on the paper CRF. If cervical ectopy was not assessed, leave this item blank. When a system query is placed, document this was not completed in the query response.

Pelvic Exam Diagrams Form

Purpose:
This form is used to document all variants of normal and all abnormal findings observed during study pelvic exams (screening through termination/study exit).

General Information/Instructions:
This form is completed at the Screening Visit and at the Product Use End Visit (PUEV), and whenever a pelvic exam is clinically indicated during the study. Transcribe information onto the appropriate Pelvic Exam CRF and store this form in the participant's chart notes. This form is available to download and print on the MTN-025 Atlas webpage under "Other Documents" within the Visit Packets and Individual CRFs section. Please refer to the back of the form for specific guidelines on completing this form.

Baseline Medical History Y/N Prompt

Purpose:
To document any baseline medical history conditions/events reported at the Screening visit or recalled by the participant during follow-up.

General Instructions:
This prompt will be asked at the V1 – Screening visit. (Note that this form is not present within the "Ongoing Logs" folder).

Field	Instructions
Does the participant have any medical history to report?	Select 'Yes' or 'No'.

	If 'Yes' is marked, then the "Baseline Medical History" log form appears dynamically within the V1 – Screening Visit folder. Complete entries within the Baseline Medical History Log form as needed. If 'No' is selected, no further action is required. If the participant reports any baseline medical history conditions/events after the Screening visit, update the response to this field to 'Yes' and complete the Baseline Medical History Log as needed.

Baseline Medical History

Purpose:
This form is used to document information on the participant's baseline medical history, including but not limited to: history of hospitalizations, surgeries, allergies, any condition that required prescription or chronic medication (that is, more than 2 weeks in duration), and acute conditions ongoing at screening and/or that occur between screening and enrollment.

This form will appear in the V1 - Screening folder after the "Baseline Medical History Y/N" prompt has been answered as 'Yes'.

General Instructions:

- At the Screening Visit, record relevant baseline medical history. This includes conditions and symptoms reported by the participant during the baseline medical/menstrual history as well as any conditions identified via pelvic exam, physical exam, or laboratory testing.
- At the Enrollment Visit, review and update as needed. Navigate back to the V1 – Screening visit folder to update this log form if needed or add additional entries as needed. Those conditions that are ongoing at the time of enrollment (including ongoing chronic conditions) are considered the participant's pre-existing conditions.
- During follow-up, review and update the "Is the Condition Ongoing?" and "Date medical history condition/event ended/resolved" fields as needed.
- Do record baseline medical conditions identified during follow-up. Write a chart note to explain why the entry was added after the Enrollment Visit.
- Complete a separate entry (e.g. log line) for each baseline medical history condition/event when entering into the study database. If completing on a paper form, please print and complete one separate page for each baseline medical history condition/event.

Field	Instructions
Date medical history collected	Record the date the medical history condition/event was reported by the participant. A complete date is required.
Description of medical history condition/event	Whenever possible, provide a diagnosis instead of listing a cluster of symptoms. If no diagnosis is identified, each symptom must be recorded as a separate term. If an abnormal lab value is reported at the Enrollment visit, record the lab assay with the direction (i.e., increased or decreased) of the abnormality. For example, "decreased hematocrit" or "increased ALT". Additional information on the frequency and duration of chronic condition outbreaks can also be provided within this description.

Field	Instructions
Is condition/event gradable?	If a condition is not gradable (below Grade 1), select 'No'. Review and update as needed for conditions that are ongoing during the study. If a condition is gradable, select 'Yes' and complete the Toxicity (Severity) Grade.
Toxicity (Severity) Grade	This item is required if 'Is condition/event gradable?' is 'Yes'. Select from the options provided in the drop-down list or by marking the option on the paper form. The toxicity grade reported in Baseline Medical History should reflect the status at baseline. • If the severity grade has increased or decreased in severity or frequency during the study AE reporting period, then this should be reported as an AE and the Toxicity Grade should remain unchanged on this CRF. However, this should be updated as needed if the severity grade and increased or decreased on or prior to the Enrollment Visit. • If the item improves severity or resolves during the study, then the Toxicity Grade should remain unchanged on this CRF. For each condition, grade the severity using the current version of the *Division of AIDS (DAIDS) Table for Grading the Severity of Adult and Pediatric Adverse Events* (including relevant appendices/addendums).
Date medical condition/event started	Record the date the medical condition was first diagnosed or the date the surgery/procedure was performed as applicable. If the participant is unable to recall the exact date, obtain her best estimate. At a minimum, a year is required. If the exact day is unknown, enter 'UN' for the day field. If the exact month is unknown, then select 'UNK' for the month field. For example, If a partial date may be recorded as: UN-Jan-2010 or UN-UNK-2010.
Is the condition ongoing?	Select 'Yes' for chronic conditions, as well as any other conditions that are currently ongoing. During each follow-up visit, routinely follow-up on any and all ongoing conditions. If the condition resolves during follow-up, update this response to 'No' and record the date the condition/event ended or resolved. If this item is marked 'Yes', then this is the end of form and the "Date medical condition/event ended/resolved" should be left blank.
Date medical condition/event ended/resolved	A date is required if required if 'Is the condition ongoing?' is 'No'. Record the date the medical condition was considered resolved. For surgeries/procedures, record the date the surgery/procedure was completed. If the condition resolves during the study, the Baseline Medical History form should be updated with a resolution or end date for the medical condition. If the exact day is unknown, enter 'UN' for the day field. If the exact month is unknown, then select 'UNK' for the month field. At a minimum, a year is required.

LABORATORY FORMS

Please remember to record clinically significant laboratory results on the" Baseline Medical History" Log form or "Adverse Experiences" CRF as applicable.

- Clinically significant laboratory results do NOT have to be reported as an AE if the lab result is clinically significant due to an indication in the subject's medical history.
- If the clinically significant laboratory result is already recorded in the baseline medical history but has increased in severity, frequency, or character, it should be recorded as an AE.

General Instructions:
Record specimen test results on this form as they become available from the local lab.

- **[Specimen] Collection Date**: Record the date that the first specimen(s) was collected (NOT the date the results were reported or recorded on the form) for this visit. A complete date is required.
- **[Specimen] Not done/Not collected:** Select this option in the event that a specimen was not collected, or if the specimen was collected, but a result is not available due to specimen loss or damage. When this option is selected, then the sub-items for that specific specimen/test do not need to be completed. For example, if the "Trichomonas Rapid Test" was "not done/not collected", then the corresponding "test result do not need to be completed.
- **Not reported:** If a specific lab test was not done or not reported for whatever reason, select 'Not reported' on the form for that applicable test.

HIV Test Results

Purpose:
This form is used to document HIV rapid test results and confirmatory results from local lab confirmatory HIV testing.

General Instructions:

Record HIV test results on this forma s they become available from the local lab.

Field	Instructions
Rapid HIV test 1 (Alere HIV Combo or backup) Kit	When completing the paper CRF, select the kit name used from the list names provided. When completing the eCRF, select the kit name that was used from the drop down field. Mark 'not applicable' if a 4th generation test was not available and a 3rd generation test was used and contact the MTN Laboratory Center and specify the name of the 3rd generation test that was used in the "not applicable, specify' text field.
Rapid HIV test 1	When completing the paper CRF, select the test result from the list provided. When completing the eCRF, select the test result from the drop down field. If "antibody positive", "antigen positive", or "antibody and antigen positive" is selected, complete a Clinical Product Hold/Discontinuation Log form.
Rapid HIV test 2 Kit	When completing the paper CRF, select the kit name used from the list names provided. When completing the eCRF, select the kit name that was used from the drop down field. If the kit that was used is not available from the drop down menu, select 'Not applicable' and specify the name of the 3rd generation test that was used in the 'If not applicable, specify" text field.

Field	Instructions
Rapid HIV test 2	If the rapid HIV test 2 results is "Positive' complete a Clinical Product Hold/Discontinuation Log form. **If Rapid HIV test 1 and test 2 are both "Negative", end the form. A Final HIV Status is not required.**
Geenius HIV-1/2 confirmatory test	Record the Geenius Confirmatory Assay results as determined by the Geenius reader and software.
Was plasma stored for HIV confirmatory testing?	If plasma was not stored or was not required to be stored, skip to the HIV RNA PCR item.
Plasma for HIV confirmatory testing collection date:	A complete date is required if plasma for HIV confirmatory testing was stored.
HIV RNA PCR	Record the participant's HIV RNA PCR result exactly as it appears on the lab report source documentation, regardless of whether the result is more or less than the limit of detection for the assay. Note that the ">" symbol is "greater than" and the "<" symbol is "less than." When completing this item on the eCRF within Rave, include the ">", "<", or "=" symbols in the same field as the number of viral copies. For example, if the result is greater than 10,000,000 viral copies/mL, record ">10000000". If the HIV RNA PCR target is not detected, mark the "target not detected" box and leave the HIV RNA PCR field blank. If HIV RNA PCR testing is not done/not collected, skip to the Absolute CD4+ items.
HIV RNA PCR Kit	Select the HIV RNA PCR testing kit that was used. If completing a paper CRF, mark the kit from the response options provided. When completing the eCRF within Rave, select the kit from the drop down field.
HIV RNA PCR Kit Lower limit of detection	Select "20" or "40" as the lower limit of detection or record the viral copies/mL.
Absolute CD4+	Absolute CD4+ units are recorded in cells/mm^3. Note that the following units are equivalent: $mm^3 = \mu L$
CD4%	If automatically calculated, record the CD4+ percentage that was reported for the specimen in the item, "Absolute CD4". If the CD4+ percentage is not available (i.e., it was not reported and would have to be manually calculated), mark the "not available" box.
Final HIV Status	Once a participant's HIV status has been determined, record the final HIV status. If the participant's final HIV status is determined to be positive (according to the protocol testing algorithm), update the Clinical Product Hold/Discontinuation Log to reflect permanent discontinuation of study product. If the participant status is not clearly negative or clearly positive, mark the "pending" box and updated this item once the participant's final HIV status is known. When completing the paper CRF, mark the participant's final HIV status from the list of outcomes provided. When completing the eCRF, select the participant's HIV status from the drop down field.

Seroconverter Laboratory Results YN Prompt

Purpose:
This form is used to document MTN-015 enrollment status for a participant who has been confirmed as HIV-1 infected.

General Instructions:
Complete this form for participants with a final HIV status of infected per the HIV Test Results form. Complete this form at each regularly scheduled visit after determination of HIV infection.

This form is present within the "Additional Study Procedures" form. Selecting "Yes" to indicate that a Seroconverter Laboratory Results YN CRF was completed at a scheduled follow-up visit will add the Seroconverter Laboratory Results YN form to the visit folder.

Field	Instructions
Is the participant enrolled in MTN-015?	If the participant is enrolled in MTN-015 mark or select "yes" and end the form. If the participant is enrolled in MTN-015, a Seroconverter Laboratory Results is not required to be completed as CD4+ and HIV RNA test results will be collected within the MTN-015 protocol. If the participant is not enrolled in MTN-015, mark or select "No". The Seroconverter Laboratory Results form will dynamically be added to the Medidata Rave visit folder for completion.

Seroconverter Laboratory Results

Purpose:
This form is used to document CD4+ and HIV RNA test results for participants who have been confirmed HIV infected and who are not enrolled in MTN-015.

General Instructions:

This form will be dynamically added to the study visit folder within Medidata Rave when the response to the item on the Seroconverter Laboratory Results YN form indicates the participant is not enrolled in MTN-015. To complete this form within Medidata Rave, navigate back to the visit folder, select and complete the form.

Field	Instructions
T CELL SUBSETS	If T Cell Subsets were collected, complete T Cell Subsets Collection date, as well as Absolute CD4+ and CD4% sections, as applicable. If T Cell Subsets were not collected, mark the "T CELL SUBSETS not done/not collected" box, then skip to HIV RNA PCR section.
Absolute CD4+	Absolute CD4+ units are recorded in cells/mm^3. Note that the following units are equivalent: $mm^3 = \mu L$
CD4 %	If automatically calculated, record the CD4+ percentage that was reported for the specimen in the item, "Absolute CD4". If the CD4+ percentage is not available (i.e., it was not reported and would have to be manually calculated), mark the "not available" box.

Field	Instructions
HIV RNA PCR	Record the participant's HIV RNA PCR result exactly as it appears on the lab report source documentation, regardless of whether the result is more or less than the limit of detection for the assay. Note that the ">" symbol is "greater than" and the "<" symbol is "less than." When completing this item on the eCRF within Rave, include the ">", "<", or "=" symbols in the same field as the number of viral copies. For example, if the result is greater than 10,000,000 viral copies/mL, record ">10000000". If the HIV RNA PCR target is not detected, mark the "target not detected" box and leave the HIV RNA PCR field blank. If HIV RNA PCR testing is not done/not collected, skip to the Seroconverter Plasma Storage items.
HIV RNA PCR Kit	Select the HIV RNA PCR testing kit that was used. If completing a paper CRF, mark the kit from the response options provided. When completing the eCRF within Rave, select the kit from the drop down field.
HIV RNA PCR Kit Lower limit of detection	Select "20" or "40" as the lower limit of detection or record the viral copies/mL.
Seroconverter Plasma Storage specimen collection date	A complete date is required. If the plasma is not stored, provide the visit date and the reason that the plasma was not stored.

STI Test Results

Purpose:
This form is used to document STI test results performed by the local site laboratory.

General Instructions:
This form is present at the following visits:

- V1 – Screening
- V8 – Month 12
- This form can also be added at other scheduled study visits, an interim visit and/or an early termination visit.

Complete this form at the Screening Visit, the participant's Product Use End Visit (PUEV), at early termination (as applicable) and as indicated during the study.

If any or all of the lab tests listed on this form are repeated (re-drawn) between the Screening and Enrollment Visit, document the repeated results on the same STI Results form. Update the original paper form with the new result(s) and collection date(s). If the participant enrolls, the updated results should be submitted into the study database.

At Screening, record STI diagnoses in Baseline Medical Conditions Log form when applicable.

During follow-up, if a test result(s) recorded on this form indicates that the participant has a new (or increased severity) laboratory-confirmed infection or diagnosis, this infection/diagnosis must be recorded as an adverse experience on an Adverse Experience (AE) Log form.

Field	Instructions
Syphilis Serology	If "Syphilis serology" was not done or not collected, mark/select the 'Not done/not collected' option. and do not complete the 'Collection date' or corresponding test results. If the syphilis screening test was done, complete the 'Collection date' and the test result (either 'Non-reactive' or 'reactive'). If the test result is 'reactive', then complete the remaining Syphilis items. If 'non-reactive', then proceed to the Trichomonas Rapid Test items.
Syphilis titer	Record the titer in the format 1: XXXX. When completing this form in Medidata Rave, please include the "1:" in the same field for the syphilis titer.
Syphilis confirmatory test	If the result of the Syphilis screening test is 'reactive,' complete the Syphilis confirmatory test results (either 'Negative,' 'Positive,' or 'Indeterminate').
Trichomonas Rapid Test	If "Trichomonas Rapid Test" was not done or not collected, mark/select the 'Not done/not collected' option and do not complete the 'Collection date' or corresponding test result. If the specimen was collected, complete the 'Collection date' and the test result (either 'Positive' or 'Negative').
N. gonorrhoeae	If "N. gonorrhoeae" was not done or not collected, mark/select the 'Not done/not collected' option and do not complete the 'Collection date' or corresponding test result. If the specimen was collected, complete the 'Collection date' and the test result (either 'Positive' or 'Negative').
C. trachomatis	If "C. trachomatis" was not done or not collected, mark/select the 'Not done/not collected' option and do not complete the 'Collection date' or corresponding test result. If the specimen was collected, complete the 'Collection date' and the test result (either 'Positive' or 'Negative').

Laboratory Results

Purpose:
This form is used to provide data on the participant's baseline and follow-up laboratory test results.

General Instructions:
This form is present at the following visits:

- V1 – Screening Visit
- V8 – Month 12
- This form can also be added at other scheduled study visits, an interim visit and/or an early termination visit.

Use this form to report the hematology, differential, and serum chemistries test results obtained from specimens collected at Screening, the Product Use End Visit (PUEV), and as indicated at other study visits. Record results on this form as they become available.

If any or all of the lab tests listed on this form are repeated (re-drawn) between the Screening and Enrollment Visit, document the repeated results on the same Laboratory Results form. Update the original paper form with the new result(s) and collection date(s). If the participant enrolls, the updated results should be submitted into the study database.

At Screening, record any applicable diagnoses within the Baseline Medical Conditions Log form, when applicable.

During follow-up, if a test result(s) recorded on this form indicates that the participant has a new (or increased severity) laboratory-confirmed infection or diagnosis, this infection/diagnosis must be recorded as an adverse experience on an Adverse Experience (AE) Log form.

Entering Laboratory Results

- The lab that collected the specimens used for these tests will be automatically defaulted from the Lab dropdown list at the top of the form. The units and lab ranges for each result will be populated at the bottom of the form after selecting the appropriate lab.

- For each lab test (e.g., Hemogram and Serum Chemistries), enter the specimen collection date at the top of the form for that specific test each time this form is completed unless it was not done/not collected

- For each individual lab result, record the numeric results in the appropriate field at the bottom of the form.

	Data	Range Status	Unit	Range
Hemoglobin	13.4		g/dL	11.5 - 16.5
Hematocrit	40.1		%	36 - 47
MCV	86		fL	76 - 99
Platelets	262		10^3/mm^3	150 - 450
WBC	5.4		10^3/mm^3	4 - 12
Neutrophils	2440		cells/mm^3	2000 - 7500
Lymphocytes	2290		cells/mm^3	1000 - 4000
Monocytes	470			
Eosinophils	170			
Basophils	20			
AST(SGOT)	25		U/L	14 - 36
ALT(SGPT)	19		U/L	10 - 43
Creatinine	0.5		mg/dL	0.5 - 0.9

- If the lab result requires entry of the severity grade, enter the grade at the top of the form for that specific result. The following results require entry of the severity grade (if applicable):

  - **HEMOGRAM:** Hemoglobin, Platelets, WBC
  - **DIFFERENTIAL:** Neutrophils, Lymphocytes
  - **SERUM CHEMISTRIES:** AST (SGOT), ALT (SGPT), Creatinine

  See the *Severity Grade* section for further instructions on completing the severity grade.

- If a specific lab test was not done, select 'Not reported' at the top of the form for that applicable test.

Lab Result Units and Rounding

- Results should be documented on the form using the units present on the source laboratory results document so that no conversion is necessary. If the units present on the form do not match your source results report, contact the MTN-025 Management Team. Note that the following units are equivalent:

IU/L = U/L I/I x 100 = % 10^9/L = 10^3/mm^3 = 10^3/µL

For creatinine, only record the result in the units listed on the source document.

All analytes should be recorded using the same level of precision according to the source laboratory results documents.

Reporting Severity Grade

- Record the severity grade at the top of the form by selecting from the drop-down menu for each corresponding lab analyte when applicable. If completing a paper form, mark the applicable severity grade. If the analyte does not meet criteria for severity grade 1 or greater per the DAIDS Toxicity table (Version 2.0), select the 'Not gradable' option.

- The severity grade options are as follows:
    - Grade 1 – Mild
    - Grade 2 – Moderate
    - Grade 3 – Severe
    - Grade 4 – Potentially life-threatening
    - Not gradable

- If any values meet the criteria for severity grade 1 or greater, according to the appropriate *DAIDS Table for Grading the Severity of Adult and Pediatric Adverse Events*, record the grade. If the value is below Grade 1, select the option 'Not gradable'.

- Always compare the severity grade range to the value that was recorded on the form (not the lab-reported value).

- When working with calculated severity grade ranges (e.g., 1.1–1.5 times the site lab upper limit of normal), the calculated range may have more significant digits than the lab result.

    - Treat all missing digits in the lab value as zeros.
    - If the lab value falls between two calculated severity grade ranges, assign it the higher grade.

- Record any Grade 1 or higher lab values on the "Baseline Medical History" log or "Adverse Experience" log as applicable.
- If an abnormal lab finding meets AE reporting criteria, select the corresponding AE within the drop-down menu. Please note that the AE must be entered within the Ongoing Logs folder prior to completing this form in order to link the associated AE.

Pregnancy Test Result

Purpose:
This form is used to document the pregnancy test result as the result becomes available from the local lab. This form also documents information about the last menstrual period.

This form is present at the following visits:

- V2 – Enrollment
- V3 – Month 1
- V4 – Month 2
- V5 – Month 3
- V6 – Month 6
- V7 – Month 9
- V8 – Month 12
- V9 – Study Exit/Termination
- This form can also be added at interim visits and/or an early termination visit.

Field	Instructions
hCG for pregnancy Not done/Not collected	Select this box if the sample was not done or not collected. Do NOT select this box if a hCG pregnancy test was done. • If the sample was not done or not collected, please do NOT complete the "Specimen Collection Date" or "hCG for pregnancy" test result. • If the sample was collected, then complete the "Specimen Collection Date" and "hCG for pregnancy" test result.
Specimen Collection Date	Enter the exact sample collection date. If urine is not collected at a study visit for hCG testing, record the visit date. This field is a required field. A complete date is required.
Result of pregnancy test	Indicate if result was positive (pregnant) or negative (NOT pregnant) by selecting the appropriate radio button. If the result is **"Positive"** at a follow-up visit, then complete a Clinical Product Hold/Discontinuation Log and Pregnancy Report CRF. If the result is **"Positive"** at the Enrollment visit, then the participant is not eligible and should not be enrolled into MTN-025.
First day of last menstrual period	Enter the first day of the last menstrual period (first day of bleeding). If the participant has been "amenorrheic for the past 6 months" OR has had "no menses since participant's last visit", select the applicable option from the drop-down menu or mark the applicable box on the paper form. If one of these options is selected, then a date does not need to be recorded. **If either of these options is selected, then this is the end of form and the next item "last day of last menstrual period" does NOT need to be completed.** The month and year are required.
Last day of last menstrual period	Enter the last day of the last menstrual period (last day of bleeding). However, if the participant is currently menstruating, then select the "ongoing" box and the date should be left blank. The month and year are required.

Specimen Storage

Purpose:
This form is used to document collection and storage of hair, vaginal fluid, and plasma specimens by the local site laboratory during follow-up.

General Instructions:
This form is present at the following visits:

- V2 – Enrollment
- V3 – Month 1

- V4 – Month 2
- V5 – Month 3
- V6 – Month 6
- V7 – Month 9
- V8 – Month 12
- V9 – Study Exit/Termination
- This form can also be added at interim visits and/or an early termination visit.

Complete this form at Enrollment, Month 1, 2, quarterly visits, the Product Use End Visit (PUEV), early termination (as applicable), and Termination/Study Exit visits.

Field	Instructions
Hair collection for PK	Record the collection date. If hair is not collected at a study visit, record the visit date. This field is a required field. Select/mark 'stored' or 'not stored'. This field is also a required field regardless whether hair was or was not collected. If 'stored', then go to the "Self-Collected Vaginal Fluid Swab" items and skip the "Reason hair collection was not done."
Reason hair collection was not done	Select the reason(s) why hair collection was not done. If completing a paper form, mark all that apply in the box provided. If completing electronically, click the applicable box to the left of the corresponding reason(s). Specify additional details as required in the corresponding text field/space provided if applicable.
Self-Collected Vaginal Fluid Swab Collection	Record the collection date. If vaginal fluid is not collected at a study visit, record the visit date. This field is a required field. If the specimen is not required to be collected at this visit, select the 'not required' option. If the specimen is required to be stored, but for some reason it is not stored, select the 'not stored' option and record the reason in the corresponding text field/space provided. If 'not required' or 'not stored' is entered, then skip items 'Was blood visible on the swab?' and 'Was a used ring in place at time of swab collection?', and go to the plasma storage section.
Plasma Storage Collection	Record the collection date. If plasma is not collected at a study visit, record the visit date. This field is a required field. If the specimen is not required to be collected at this visit, select the 'not required' option. If the specimen is required to be stored, but for some reason it is not stored, select the 'not stored' option and record the reason in the corresponding text field/space provided.

BEHAVIORAL FORMS

For all interviewer-administered forms, please enter the responses in the English language when entering the data into Medidata Rave. For example, if completing the interviewer-administered forms in the local

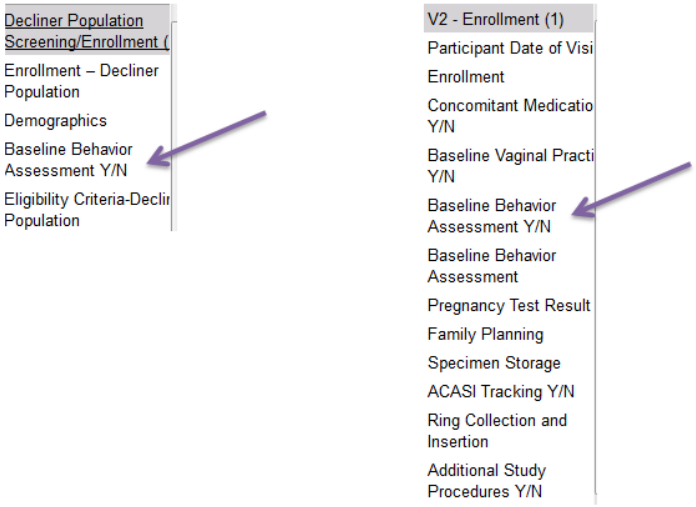
language and additional information was required to be specified, please enter the specified information in English on the paper form and in Medidata Rave.

Baseline Behavior Assessment Y/N Prompt

Purpose:
This form is used to document participant completion of the Baseline Behavior Assessment for a participant as part of the MTN-025 main study population or Decliner population.

General Instructions:
This prompt is present at the following visits depending on whether the participant enrolled in the MTN-025 main study population or Decliner population.

- Decliner Population Screening/Enrollment
- V2 - Enrollment



Field	Instructions
Was a Baseline Behavior Assessment Questionnaire completed?	Select 'Yes' or 'No'. If 'Yes' is selected, then the "Baseline Behavior Assessment" form appears dynamically. Complete the "Baseline Behavior Assessment" form.

Baseline Behavior Assessment

Purpose:
This form is used to document participant sexual behavior, information on her male sex partners, risk perception, and reasons for declining MTN-025 participation or willingness to enroll in MTN-025.

General Instructions:
This is an interviewer-administered form. Read each item aloud and record the participant's response. Complete this form if the participant enrolls in MTN-025 or participates in the MTN-025 Decliner Population.

Field	Instructions
At any time during the past 3 months, have you had a primary sex partner? (Item 1)	Select 'Yes' or 'No'. If 'No' is selected, then go to item 13 ("How many sex partners other than a primary sex partner have you had in the past 3 months?")
How old is your primary sex partner? (Item 3)	If the participant is unsure of her primary sex partner's age, leave item 3 blank and select item 3a-'Don't know primary sex partner's age'.
Don't know (age of primary sex partner) (Item 3a)	Mark or select the box only if the participant does not know her primary sex partner's age. Otherwise, leave blank.
Items 6-8	Mark or select the participant's response from the drop-down list.
What is the HIV status of your primary sex partner? (Item 9)	Mark or select the participant's response from the drop-down list. Complete this item even if the participant is unsure of her partner's HIV status.
Some people infected with the HIV virus are prescribed medications called antiretrovirals or ARVs by a doctor or nurse to help them live longer. Is your primary sex partner taking ARVs? (Item 10)	Mark or select the participant's response from the drop-down list. Complete this item regardless of the response to item 9. Having a primary sex partner who is taking ARVs could impact the participant's HIV risk, so we want this item answered by all participants who answered the previous item.
In the past month, has your primary sex partner come to the study clinic?	Select 'Yes' or 'No'. If 'No', then skip items 11a – 11c1 and go to item 12.
Did he come to the study clinic for any other reason? (Item 11c)	If the participant's primary sex partner has come to the clinic within the past month for a reason other than accompanying the participant to her study visit or to receive counseling or other services form the study clinic, select the 'yes' box and enter the reason in English in the 'If yes, please specify' field.
How many sex partners other than a primary sex partner have you had in the past 3 months? (Item 13)	If the participant has had no sex partners other than her primary sex partner in the past 3 months, enter '0'.
In the past 3 months, how many times in total have you had vaginal sex? (Item 16)	If the participant has not had vaginal sex in the past 3 months, enter '0' and go to item 19 ("During the last act of vaginal sex that you had, was a male and/or female condom used?")
The next questions are about your sexual behavior in the past 7 days, not including today. In the past 7 days, how many acts of vaginal sex did you have? (Item 17)	If the participant has not had any acts of vaginal sex in the past 7 days, enter '0' and skip item 18 and go to item 19.
During the last act of vaginal sex that you had, was a male and/or female condom used? (Item 19)	Mark or select the participant's response from the drop-down list.

Field	Instructions
In the past 3 months, how many times have you had anal sex? (Item 20)	If the participant has not had anal sex in the past 3 months, enter '0' and go to the statement above item 22 (skip item 21).
Items 22-27	Mark or select the participant's response from the drop-down list.
HOPE DECLINER GROUP questions (Items 28-29)	Complete these items only if the participant is in the Decliner Group. If the participant is enrolling in the MTN-025 main study, skip these items. If 'Yes' is selected for item 28r (Other), provide a response in English in the item 28r1 'Other, specify' field. If one or more reason(s) is selected as 'Yes' in item 28, select the main reason the participant is not willing to participate in HOPE from the drop-down menu. If all reasons are marked 'no', then end of form.
HOPE ENROLLER GROUP question (Items 30-31)	Complete the set of questions in item 30 only if the participant is enrolling in the MTN-025 main study. If the participant is in the Decliner Population, skip this item. If 'Yes' is selected for item 30m (Other), provide a response in English in the item 30m1 'Other, specify' field. If one or more reason(s) is selected as 'Yes' in item 30, select the main reason the participant is willing to participate in HOPE from the drop-down menu. If all reasons are marked 'no', then end of form.

Baseline Vaginal Practices Y/N Prompt

Purpose:
This form is used to document completion of the Baseline Vaginal Practices questionnaire at Enrollment.

This prompt is present at the V2 – Enrollment Visit.

Field	Instructions
Was a Baseline Vaginal Practices questionnaire done?	Select 'Yes' or 'No'. If 'Yes' is selected, then the **"Baseline Vaginal Practices"** form appears dynamically. Complete "Baseline Vaginal Practices" CRF.

Baseline Vaginal Practices

Purpose:
This form is used to document a participant's vaginal practices at baseline. Only complete this form if the participant enrolls in MTN-025.

General Instructions:
This is an interviewer-administered form. It is completed at the Enrollment Visit and is found in the V2 – Enrollment folder. Read each item aloud and record the participant's response. Select 'Yes' or 'No' for each item.

Field	Instructions
In the last 3 months, have you had any menstrual bleeding or spotting?	Select 'Yes' or 'No'. If 'No' is selected, then go to the statement above item 3 ("In the past 3 months, have you put any of the following inside your vagina"). The items pertaining to "In the last 3 months, what have you used to control or manage the menstrual blood or spotting" (Items 2a-2g1) should not be completed.
Anything else? Specify	If the participant indicates 'yes' for "Anything else", then specify in English in the text field space provided.
Fingers, to clean or insert something	Note that this question does not include instances where the participant has used her fingers to insert a study vaginal ring.

Demographics

Purpose:
This form is used to document a participant's demographics and socioeconomic information.

General Instructions:
This form is present in the following visit folders:

- Decliner Population Screening/Enrollment
- V1 – Screening

This form is completed at the Screening Visit for the MTN-025 main study and at the Screening/Enrollment Visit for the Decliner Population. Only enter this form into the study database if the participant enrolls in the MTN-025 main study or Decliner Population. Responses should reflect the participant's status at screening, and should not be changed after screening unless correction is needed.

Field	Instructions
Gender	This field has been pre-selected as "Female" per protocol Inclusion Criteria. This field is locked and cannot be edited.
Date of birth	Please provide the date of birth. If the exact day or month is unknown, then this can be left blank and select the "Date of birth Unknown" and enter the participant's age.
Date of Birth Unknown	Mark this box only if the participant's birth year is unknown.
Age (Entered by Site)	If any portion of the participant's date of birth is unknown, record the participant's age at the time of Screening. If her age is unknown, record the participant's best estimate of her age. Leave this field blank if the participant's full date of birth (day, month, and year) are known.
Age	This is an automatically derived field based on the participant's date of birth and the date of initial data entry. No data entry is required.
Is the participant currently married?	Complete this item based on participant self-report.
Highest level of education	If the participant attended or completed a post-secondary diploma or certificate program, mark/select the 'attended college or university' box.

<table>
<tr><th>Field</th><th>Instructions</th></tr>
<tr><td>Ethnic group or tribe</td><td>Select one option based on participant self-report. If the participant does not identify with any of the ethnic groups or tribes listed, select ‘other’ and provide the name of her ethnic group or tribe in the ‘If other, specify’ field.

<table>
<tr><th>Malawi</th><th>South Africa</th><th>Uganda</th><th>Zimbabwe</th></tr>
<tr><td>Chewa</td><td>Zulu</td><td>Black</td><td>Shona</td></tr>
<tr><td>Lomwe</td><td>Xhosa</td><td>White</td><td>Ndebele</td></tr>
<tr><td>Yao</td><td>Indian</td><td>Other</td><td>Other African Tribe</td></tr>
<tr><td>Tumbuka</td><td>Colored</td><td></td><td>White</td></tr>
<tr><td>Other African tribe</td><td>Other African Tribe</td><td></td><td>Other</td></tr>
<tr><td>White</td><td>White</td><td></td><td></td></tr>
<tr><td>Other</td><td>Other</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Number of alcohol drinks per week</td><td>Enter the number of alcohol drinks the participant reports drinking, on average, per week. If the participant does not drink alcohol or has less than one drink per week, enter ‘0’.</td></tr>
<tr><td>Number of cigarettes per day</td><td>If the participant does not smoke cigarettes or smokes less than one cigarette per day, enter ‘0’.</td></tr>
<tr><td>How long did it take the participant to travel from home to the clinic today?</td><td>If the participant did not travel from home for this visit, ask her to estimate the travel time it will take her to get to the clinic from home.

Mark or select her response from the drop-down list. If this visit was completed as an off-site visit, mark or select ‘N/A’.</td></tr>
<tr><td>Does the participant earn an income of her own?</td><td>Select ‘Yes’ or ‘No’.
If ‘No’ is selected, skip the item “How does she earn her income?”.</td></tr>
<tr><td>How many times has the participant been pregnant?</td><td>If the participant has never been pregnant, enter ‘0’.</td></tr>
<tr><td>How many live births have the participant had?</td><td>If the participant has not had any live births, enter ‘0’.</td></tr>
<tr><td>Did the participant become pregnant since the end of ASPIRE?</td><td>Select ‘Yes’ or ‘No”.
If the participant did not fall pregnant since her last ASPIRE study visit, skip to the item, “What is the participant’s religion?”</td></tr>
<tr><td>If yes, at the time of the pregnancy, was the participant taking any measures to avoid falling pregnant?</td><td>Select ‘Yes’ or ‘No’.</td></tr>
<tr><td>What is the participant’s religion?</td><td>Mark or select the participant’s response from the drop-down list.

If ‘Other’ is selected, enter the participant’s religion in the ‘If Other religion, please specify’ field.

If ‘None’ is selected, then skip the item “How many times a week does the participant attend religious services?”.</td></tr>
<tr><td>How many times a week does the participant attend religious services?</td><td>Mark or select the participant’s response from the drop-down list.</td></tr>
</table>

Field	Instructions
In the past four weeks, how often was the participant worried that she will not have enough food?	Mark or select the participant's response from the drop-down list.
Does the participant's household have…?	Read the options aloud and indicate 'yes' or 'no' for all items.

Behavior Assessment Y/N Prompt

Purpose:
This form is used to document completion of the Behavior Assessment questionnaire during study follow-up.

This prompt is present at the following visits:

- V5 – Month 3
- V6 – Month 6
- V7 – Month 9
- V8 – Month 12 (Product Use End Visit)

Field	Instructions
Was a Behavior Assessment questionnaire done?	Select 'Yes' or 'No'. If 'Yes' is selected, then the **"Behavior Assessment"** questionnaire appears dynamically. Complete "Behavior Assessment" CRF.

Behavior Assessment

Purpose:
This form is used to document participant sexual behavior and information on her male sex partners during follow-up.

General Instructions:
This is an interviewer-administered form. It is completed at quarterly visits as well as the V8 – Month 12 Product Use End Visit (PUEV), or at an early termination, as applicable.

Read each item aloud and record the participant's response.

Field	Instructions
At any time during the past three months, have you had a primary sex partner? (Item 1)	Mark or select 'Yes' or 'No'. If 'No', then go to item 10 "How many sex partners other than a primary sex partner have you had in the past 3 months?"
What is the HIV status of your primary sex partner? (Item 6)	Complete this item even if the participant is unsure of her partner's HIV status
Is your primary sex partner taking ARVs? (Item 7)	Complete this item regardless of the response to item 6. Having a primary sex partner who is taking ARVs could impact the participant's HIV risk, so we want this item answered by all participants who answered item 6.
In the past month, has your primary sex partner come to the study clinic? (Item 8)	Mark or select 'Yes' or 'No'. If 'No', go to item 9 "Have you had the same primary sex partner for the last three months?"
Did he come to the study clinic for any other reason? (Item 8c)	If the participant's primary sex partner has come to clinic within the past month for a reason other than accompanying the participant to her study visit or to receive counseling or other services form the study clinic, mark the 'yes' box and record the reason in English on the line provided in item 8c1 when completing the paper CRF or record the reason in the text box provided when completing in Medidata Rave.
Slapped you, hit you with a fist or something else, or beaten you? (Item 11a)	Mark or select 'Yes' or 'No'. If 'Yes', please complete a **Social Impact Log**, if applicable.
Kicked, dragged, pushed, pulled your hair, choked or burnt you? (Item 12)	
In the past 3 months, has your primary sex partner or ANY other current or previous partner ever forced you to have sex by holding you down or hurting you? (Item 13)	
In the past 3 months, has anyone (not including current or past sexual partners) ever forced you to have sex by holding you down or hurting you?	
In the past 7 days, how many acts of vaginal sex did you have? (Item 14)	Record the number reported by the participant. If 0, then go to item 16 "During the last act of vaginal sex that you had, was a male and/or female condom used?
Does it bother you to wear the ring every day? (Item 18)	If the participant has not yet used the ring, mark the 'not applicable (hasn't use ring)" box.

Field	Instructions
At any time during the past 3 months, have you experienced a positive change, event or experience in your life related to your study participation? (Item 19)	Mark or select 'Yes' or 'No'. If 'Yes', please complete a **Social Benefit Log**, if applicable.
At any time during the past 3 months, have you experienced a negative change, event or experience in your life related to your study participation? (Item 20)	Mark or select 'Yes' or 'No'. If 'Yes', please complete a **Social Impact Log**, if applicable.
Items 21-25	Complete these items if this visit is the participant's Product Use End Visit or her early termination visit, if applicable. For all other visits, leave these items blank.
How worried are you about having a vaginal ring inside of you every day for a year? (Item 21)	Complete this item regardless of whether the participant used the ring or not.
How difficult was it to store the ring(s) at home? (Item 22)	If "not applicable – never used the ring during HOPE", then skip to item 24 "Do you prefer to receive one ring or three rings at a time?"
Vagina wetter (Item 23a) Vagina drier (Item 23b) Change in scent or smell from the vagina (Item 23c)	Mark or select 'Yes' or 'No'. If 'No', then skip item "Was this change a problem for you?" If 'Yes' to any of these items, then please answer the corresponding item "Was this change a problem for you?"
What does your primary partner prefer? (Item 26)	If the participant does not have a primary partner (Item 1 is 'No'), then this item should not be completed.

Vaginal Practices Y/N Prompt

Purpose:
This form is used to document completion of the Vaginal Practices questionnaire during study follow-up.

This prompt is present at the V8 – Month 12 Visit (PUEV).

Field	Instructions
Was a Vaginal Practices questionnaire done?	Select 'Yes' or 'No'. If 'Yes' is selected, then the **"Vaginal Practices"** form appears dynamically. Complete "Vaginal Practices" CRF.

Vaginal Practices

Purpose:
This form is used to document a participant's vaginal practices during study follow-up.

General Instructions:
This is an interviewer-administered form. It is completed at the V8 – Month 12 Product Use End Visit (PUEV), or at an early termination, as applicable.

Read each item aloud and record the participant's response. Select 'Yes' or 'No' for each item.

Field	Instructions
In the last 3 months, what have you used to control or manage the menstrual blood or spotting?	'NA' can be selected if the participant has not had menses or spotting in the last 3 months. If 'NA' is selected, then 1a – 1g1 can be skipped and continue to paragraph above item 2.
Anything else? Specify	If the participant indicates 'yes' for "Anything else", then specify in English in the text field space provided.
Fingers, to clean or insert something	Note that this question does not include instances where the participant has used her fingers to insert a study vaginal ring.

Social Influences Assessment Y/N Prompt

Purpose:
This form is used to document completion of the Social Influences Assessment.

General Instructions:
This prompt is present at the V8 – PUEV (Month 12) Visit.

Field	Instructions
Was a Social Influences Assessment completed?	Select 'Yes' or 'No'. If 'Yes' is selected, then the **"Social Influences Assessment"** form appears dynamically. Complete "Social Influences Assessment" CRF.

Social Influences Assessment

Purpose:
This form is used to identify the people in the participant's life who may have influenced her study participation and use of the study ring.

General Instructions:

This is an interviewer-administered form. It is completed once for each participant at her scheduled PUEV (Product Use End Visit) or at a participant's early termination visit, if applicable.

Read each item aloud and record the participant's response.

Field	Instructions
How many people in your life did you talk to about the HOPE study besides clinic staff? (Item 1)	If the participant indicates that she talked to '0' people, end the form.
Person 1 (Item 2)	If completing a paper CRF, complete the first column (items 2a-2d) for the first person. When completing the eCRF within Rave, complete

	items 2a-2e.
Person 2, Person 3, Person 4, Person 5 (Items 3, 4, 5, and 6)	If the participant identifies more than one person in item 1, complete the questions within each column for each subsequent person (up to five people are allowable). If the participant indicates that she talked to fewer than five people, leave the applicable items blank. For example, if the participant indicates that she talked to two people about the HOPE study besides clinic staff in Item 1, complete Person 1 and Person 2 columns and leave items for Person 3, 4, and 5 blank.
What is your relationship with this person? (Items 2a, 3a, 4a, 5a, and 6a)	Select the relationship of each identified person to the participant from the drop down field within the eCRF. When completing the paper CRF, mark the relationship from the response options available. If the relationship is not provided as a response option, select the "Other" response option and specify the participant's response in English in the box provided. If 'Other family member', then specify the participant's response in English in the specify text field. If completing a paper CRF, specify the participant's response in English on the line provided. If a person could belong to more than one category, choose the category that reflects the person's primary or strongest relationship to the participant. For example, if the participant reports her sister, who is also a neighbor, the primary relationship is "sister".
Did this person participate in HOPE? (Items 2c, 3c, 4c, 5c, and 6c)	If this item is not applicable, (for example, if this person is male), mark "no" for this item.
Overall, was this person in favour or against you using the ring? ***Read each response aloud.*** *(Items 2e, 3e, 4e, 5e, and 6e)*	Mark or select "N/A" if the person was unaware that the participant was offered to use the vaginal ring as part of her study participation.

Social Influences Supplement Y/N Prompt

Purpose:
This form is used to generate the Social Influences Supplement CRF and is conditional on the number of people the participant reported talked to about the HOPE study.

General Instructions:

This prompt is present at the V8 – PUEV (Month 12) Visit. This is an interviewer-administered form. It is completed once for each participant at her scheduled PUEV (Product Use End Visit) or at a participant's early termination visit, if applicable.

Field	Instructions
How many people did the participant report talking to about the HOPE study, per item 1 on the Social Influences Assessment?	Enter the number of people the participant reported talking to about the HOPE study. This response should match the number of people indicated on the Social Influences Assessment, item 1. If a number greater than 1 is entered, then the **"Social Influences**

	Supplement" form appears dynamically. Complete "**Social Influences Supplement**" CRF. If '0' is selected, the **Social Influences Supplement** will not be generated, and does not need to be completed.

Social Influences Supplement

Purpose:
This form, together with the Social Influences Supplement, is used to gather additional information regarding the strength and structure of the participant's social network per responses already entered on the Social Influences Assessment CRF.

General Instructions:
Complete this form once for each participant at her scheduled PUEV (Product Use End Visit) or at a participant's early termination visit, if applicable.

The form is automatically generated based on the number entered on the Social Influences Supplement Y/N prompt.

Before administering this form, review responses for "What is your relationship with this person?" for each Person referenced on the Social Influences Assessment form. Reference each Person by the relationship indicated on the Social Influences Assessment form. For example, if the participant referenced Person 1 as "Mother", on the Social Influences Supplement form the first question would read, "How well do you know your mother?", rather than "How well do you know [Person 1]?" Read each item aloud and record the participant's response.

Only complete sections (e.g., **Person 2**) on this form if that section was completed on the Social Influences Assessment. For example, if the Person 2 section was completed on the Social Influences Assessment form, it should also be filled on the Social Influences Supplement form.

Field	Instructions
How well do you know [Person X]	Select "Not at all", "A little", or "Very well" from the drop-down menu.
How well does [Person X] know [Person Y]?	Select "Not at all", "A little", or "Very well" from the drop-down menu.

Study Exit Assessment Y/N Prompt

Purpose:
This form is used to document completion of the Study Exit Assessment.

This prompt is present at the V9 – Study Exit/Termination (Month 13) Visit.

Field	Instructions
Was a Study Exit Assessment completed?	Select 'Yes' or 'No'. If 'Yes' is selected, then the **"Study Exit Assessment"** form appears dynamically. Complete "Study Exit Assessment" CRF.

Study Exit Assessment

Purpose:
This form is used to document a participant engagement in study group activities, participant sexual behavior and vaginal hygiene practices, and impressions of participation in HOPE.

General Instructions:
This is an interviewer-administered form. It is completed once for each participant at her scheduled Study Exit Visit. It is not required at early termination visits.

Read each item aloud and record the participant's response.

Field	Instructions
During your participation in HOPE, did you attend any study organized group discussions, activities, or events that were not part of your usual scheduled study visit? (Item 1)	Provide site-specific examples of study organized group discussions, activities, or events that the participant might have participated in during HOPE, as applicable. Waiting room discussions with the participant should not be considered a study organized group discussion. If 'Never', go to item 2 "How many participants do you personally know in the HOPE study?"
How many participants do you personally know in the HOPE study? (Item 2)	If the participant cannot recall an exact number, provide her best estimate. Record the number reported by the participant. If '0', then go to item 3 "In the past 7 days, how many acts of vaginal sex did you have?"
Of these women, how many are: (Items 2a – 2e)	If item 2 is greater than 0, a response is required for each field in items 2a-2e. If participant does not know any HOPE participants in a given category (for example, does not know any participants in 'Other' category), enter '0'. The number of women reported in Items 2a-2e should add up to the total number of women reported in item 2. If any discrepancies are noted, clarify these with the participant and update the item 2a-2e responses as appropriate. If a woman could belong to more than one category, choose the category that reflects the woman's primary or strongest relationship to the participant. For example, if the participant reports her sister, who is also a neighbor, the primary relationship is 'sister' and the woman should be counted in item 2b. As needed, ask the participant to clarify what the primary or strongest relationship is in her opinion.
Other, specify (Item 2e)	Record the participant's response in English on the line provided if completing a paper CRF and/or enter the response in the text field provided.
In the past 7 days, how many acts of vaginal sex did you have? (Item 3)	Record the number reported by the participant. If '0', then go to item 5 "During the last act of vaginal sex that you had, was a male and/or female condom used?"
Other, specify (Item 6l)	Record the participant's response in English on the line provided if completing a paper CRF and/or enter the response in the text field provided.
Were any of the rings dispensed to you ever used by someone else?	If the participant was not dispensed a ring during study participation, mark "Not applicable".

Field	Instructions
In the future, if a vaginal ring similar to the one used in this study becomes widely available for HIV prevention, would you be interested in using it for HIV prevention?	Record the response for each participant regardless of whether she personally used the vaginal ring during study participation.

SUMMARY OF CHANGES

Version		CRF Name	Summary of Changes
Number	**Date**		
2.1	5 July 2018	Eligibility Criteria	*Added clarification when 'Eligible, but participant did not complete all screening procedures' should be completed.* If 'Eligible, but participant did not complete all screening procedures' is selected, then end of form and leave remaining items on the form blank. Select 'participant did not complete all screening procedures' when a participant begins the screening process and is eligible, but does not return to the clinic to complete screening procedures within the 56-day screening window **or if a participant completed all screening visit procedures but did not return to the site to complete enrollment visit procedures within the allowable window.** *Deleted instruction on selecting 'Not eligible' if the participant did not meet all eligibility criteria.* *Added clarification that the end of form if 'Eligible, but participant declined enrollment' is selected after the specify reason is provided.*
2.1	5 July 2018	Pregnancy Outcome	*Removed instruction for Specify Outcome, per proper skip pattern* *Added instructions for when Method should be completed* **Complete this item if "Specify outcome" is 'full term live birth' or 'premature term live birth'.** **If "Specify outcome" is 'full term live birth' only, then go to item "Were there any complications related to the pregnancy outcome?'.** *Added new instructions for Delivery-related complications (6a) and Non-delivery related complications (6b):* **Select the applicable delivery-related complication(s), or 'none'.** **'None' should only be marked if there is at least one non-delivery complication in the next section (6b). If there are no complications in sections 6a and 6b, both sections should be skipped (e.g. 'none' should not be marked in**

			either section). **Select the applicable non-delivery related complication(s), or 'none'.** **'None' should only be marked if there is at least one delivery-related complication in the previous section (6a). If there are no complications in sections 6a and 6b, both sections should be skipped (e.g. 'none' should not be marked in either section).**
2.1	5 July 2018	Seroconverter Laboratory Results	*Added new instruction for "T CELL SUBSETS":* **If T Cell Subsets were collected, complete T Cell Subsets Collection date, as well as Absolute CD4+ and CD4% sections, as applicable.** **If T Cell Subsets were not collected, mark the "T CELL SUBSETS not done/not collected" box, then skip to HIV RNA PCR section.**
2.1	5 July 2018	Laboratory Results	*Updated wording in General Instruction* : If any values meet the criteria for severity grade 1 or greater, according to the appropriate *DAIDS Table for Grading the Severity of Adult and Pediatric Adverse Events*, record the grade. If the value is below Grade 1, select the option '**Not gradable'**.
2.1	5 July 2018	Specimen Storage	*Updated instruction on "Self-Collected Vaginal Fluid Swab Collection":* If 'not required' or 'not **stored'** is entered, then skip items 'Was blood visible on the swab?' and 'Was a used ring in place at time of swab collection?', and go to the plasma storage section.
2.1	5 July 2018	Behavior Assessment	*Moved instruction from item 21 to item 22:* If "not applicable – never used the ring during HOPE", then skip to item 24 "Do you prefer to receive one ring or three rings at a time?"
2.1	5 July 2018	Study Exit Assessment	*Added new instruction for items 2a-2e:* **If item 2 is greater than 0, a response is required for each field in items 2a-2e. If participant does not know any HOPE participants in a given category (for example, does not know any participants in 'Other' category), enter '0'.**