**Infant ARV prophylaxis Post follow**

**At 3 months (Quarterly Call #1) and to continue at 6 months (Quarterly call #2 or at Ultrasound Visit) if Q3 is “Yes” (If a quarterly call is missed, ask at the following quarterly call until CRF is completed)**

**\*\*To be collected at Follow-up visit for Cohort A participants who never had this CRF completed previously**

1. Infant visit:
2. Report Date:
3. Did the baby take prophylactic antiretroviral medication for any period since the last attended scheduled visit? □Yes □No □ Does not recall
	1. If “Yes” skip to Q6
	2. If “No” proceed to Q4
4. If “No” to Q3, what was the reason the baby did not take antiretroviral medication?
* □ Mother did not understand medication instructions and did not collect.
* □ Mother forget to collect medication.
* □ Medication was out of stock.
* □ 72hrs period to start prophylactic antiretroviral medication elapsed.
* □ Medication collected and did not give the baby.
* □ Does not recall
* Other
1. If “Other” to Q4: Other, specify
2. If yes to Q3, what is the status of participant's ARV prophylaxis at this visit?
* □ In progress, still taking prophylaxis.
* □ Completed PMTCT intervention within stipulated prophylaxis time (28 days)
* □ Completed PMTCT intervention with prophylaxis greater than 28 days
* □ Incomplete, did not finish within stipulated prophylaxis time.
1. If “Completed PMTCT intervention with prophylaxis greater than 28 days” to Q6 approximately how many days did the infant receive prophylaxis \_\_\_\_\_\_ (range 29-90)
2. If “incomplete” to Q6, provide reason (unlimited allow free text)
3. What ARV did the baby take? (allow multiple selections)
* □ NVP
* □ AZT
* □ 3TC
* □ FTC
* □ ALU
* □ TRV
* □ TDF
* □ ABC
* □ RAL
* □ Unknown

If Q9 “NVP” was selected, Q10 &Q11 are required

1. NVP Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. NVP Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “AZT” was selected, Q12 &Q13 are required

1. AZT Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. AZT Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “3TC” was selected, Q14 & Q15 are required

1. 3TC Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. 3TC Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “FTC” was selected, Q16 & Q17 are required

1. FTC Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. FTC Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “ALU” was selected, Q18 & Q19 are required

1. AZT Start date \_\_\_\_\_\_\_\_DD/MM/YYYY
2. AZT Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “TRV” was selected, Q20 & Q21 are required

1. TRV Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. TRV Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “TDF” was selected, Q22 & Q23 are required

1. TDF Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. TDF Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “ABC” was selected, Q24 & Q25 are required

1. ABC Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. ABC Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY

If Q9 “RAL” was selected, Q26 & Q27 are required

1. RAL Start date. \_\_\_\_\_\_\_\_DD/MM/YYYY
2. RAL Stop date. \_\_\_\_\_\_\_\_DD/MM/YYYY
3. Was there any Modification occurred since the baby was started on ARV prophylaxis? □Yes □No □Does not recall

If “Yes” to Q28, Q29 & Q30 are required

1. Date modification occurred.
2. If yes, what was the reason?
* □ Toxicity decreased/resolved
* □ Scheduled dose increase
* □ Triple ARTs not available
* □ Anemia
* □ Bleeding
* □ Side effects
* □ Toxicity
* □ Other,
1. If Side Effects” , Specify:\_\_\_\_\_\_\_
2. If “Other” Specify:\_\_\_\_\_\_\_
3. Has the baby missed any dose since last scheduled visit? □Yes □No □Does not recall

If “Yes” to Q33, Q34 & Q35 are required

1. If yes, how may doses missed?
2. Reason for missing doses. (Text box, unlimited text)