

QUESTIONNAIRE

Survey date : |__| 20__| **Identifier** |_____|

SECTION 1: SOCIO-DEMOGRAPHIC DATA

1. **Age:** |_____| years

2. **Sex:** |_____|

Male = 1; Female = 2

3. **Profession:** |_____|

Public sector employee = 1; Private sector employee = 2; Informal sector employee = 3 ;
Homemaker/No profession = 4

4. **Marital Status:** |_____|

In a union = 1; Not in a union = 2; Don't know = 99

5. **Last grade/class attended:** |_____|

6. **Highest school diploma obtained:** |_____|

No diploma = 0; Primary School Certificate (CEPD) = 1; Junior High School Diploma (BEPC) = 2;
High School Diploma (Baccalaureate) = 3; ≥ Baccalaureate = 4

7. **Place of residence:** |_____|

Urban = 1; Rural = 2

8. **Religion:** |_____|

No religion or traditional religion = 1; Islam = 2; Christianity = 3;

9. **Do you have children?** |_____|

Yes = 1; No = 2; Prefer not to answer = 3

10. If yes, how many children do you have? |____|

11. Do you live together with your children? |____|

Yes = 1; No = 2; Prefer not to answer = 3

12. Is one or more of them infected with HIV? |____|

Yes = 1; No = 2; Prefer not to answer = 3.

SECTION 2: CLINICAL, BIOLOGICAL AND THERAPEUTIC DATA

13. Weight |____| kg 14. Height |____| cm

15. Waist circumference |____| cm 16. Hip circumference |____| cm

17. Date of HIV diagnosis |__|__| ____|

18. How would you describe your current HIV symptoms? |____|

None = 1; Mild = 2; Moderate = 3; Severe = 4; Prefer not to answer = 99

19. Current clinical stage: |____|

Stage I = 1; Stage II = 2; Stage III = 3; Stage IV = 4

20. Are you on ARV treatment? |____|

Yes = 1; No = 2

21. If yes, treatment start date: |__|__| ____|

22. Therapeutic regimen: |____|

1st line = 1; 2nd line = 2; 3rd line = 3

23. What type of ARV? | |

1st line: TDF+3TC (or FTC)+EFV = 1; TDF+3TC (or FTC)+NVP = 2; AZT+3TC+EFV = 3;
AZT+3TC+NVP = 4; ABC+3TC+NVP = 5; ABC+3TC+EFV = 6; TDF+3TC+DTG (Dolutegravir) = 7

2nd line: AZT+3TC+LPV/r = 8; AZT+3TC+ATV/r = 9; TDF+3TC (or FTC)+ATV/r = 10; TDF+3TC (or FTC)+LPV/r = 11; ABC+3TC+LPV/r = 12; ABC+3TC+ATV/r = 13 ;

Other = 14. (please specify if possible) | _____ |

3rd line: TDF+3TC+DRV (Darunavir)/r+RAL (Raltegravir) = 15; AZT+3TC+DRV (Darunavir)/r+RAL (Raltegravir) = 16; ABC+3TC+DRV (Darunavir)/r+RAL (Raltegravir) = 17;

Other = 18 (please specify if possible) | _____ |

24. Do you understand how to take your ARVs?

Not at all = 1; Moderately = 2; Perfectly = 3

25. In the past month, have you ever forgotten to take your ARVs?

Yes = 1; No = 2

26. If yes, how many times?

27. For what reason(s)? _____

28. Are you sometimes negligent in taking your ARVs?

Yes = 1; No = 2

29. If you sometimes feel worse, do you stop taking your ARVs?

Yes = 1; No = 2

30. In the past week, how many times did you not take your ARVs?

31. Did you miss taking your ARVs during the last weekend?

Yes = 1; No = 2

32. In the past three months, how many days did you not take your ARVs at all? _____

33. Date of last check-up: / /

34. CD4 count at last check-up: |_____|

35. Viral load at last check-up |_____| copies/ml.

36. Compared to people your age, would you say your health is: |_____|

Not at all satisfactory = 1; Slightly satisfactory = 2; Rather satisfactory = 3; Very satisfactory = 4;

37. Do you regularly take (at least once a week for 6 months) one or more medication(s)? |_____|

Yes, for a physical health problem = 1; Yes, for a psychological problem = 2; No = 3;

If yes, please specify the medication(s) |_____|

38. Are you currently being followed by a doctor? |_____|

Yes, for a physical health problem = 1; Yes, for a psychological problem = 2; No = 3;

If yes, please specify the problem(s) |_____|

SECTION 3: SEXUAL ACTIVITY

39. Are you sexually active? |_____|

Yes = 1; No = 2; Prefer not to answer = 3

40. When was your last sexual intercourse? |_____| weeks ago

41. How many sexual partners have you had in the last three months? |_____|

42. Sex of your regular partner? |_____|

[Questions to be asked to men only]

Male = 1; Female = 2

43. HIV status of your regular partner? |_____|

HIV positive = 1; HIV negative = 2; Has not been tested = 3; Don't know = 99

44. Have you ever had sexual intercourse under the influence of drugs or alcohol? |_____|

Yes = 1; No = 2

45. In the last three (3) months, during sexual intercourse with your regular sexual partner, did you use a condom? |____|

Never = 1; Rarely = 2; Often = 3; Very often = 4; Always = 5

46. In the last three (3) months, during sexual intercourse with your casual sexual partner, did you use a condom? |____|

Never = 1; Rarely = 2; Often = 3; Very often = 4; Always = 5

47. Your last sexual intercourse was with? |____|

A regular sexual partner = 1; a casual sexual partner = 2

48. During this last sexual intercourse, did you use a condom? |____|

Never = 1; Rarely = 2; Often = 3; Very often = 4; Always = 5

SECTION 4: ALCOHOL AND TOBACCO CONSUMPTION

49. In your lifetime, have you ever drunk alcohol (beer, cider, wine, aperitifs, spirits...)? |____|

Yes = 1; No = 2

50. In the last 30 days, have you drunk... (multiple answers possible)

Beverage	No	Yes
<i>Beer</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Strong beer in 50 cl can (type 8.6)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Wine</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Aniseed aperitif (type pastis, Martini, port, muscat)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Tchoukoutchou/tchakpalo</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Sodabi</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Champagne, sparkling wine</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Sangria, punch</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Rhum (Ti punch...)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Spirits (whisky, vodka, calvados, cognac...)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
<i>Cocktail (whisky-coke, vodka-orange...)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other alcoholic beverages (specify) 	1 <input type="checkbox"/>	2 <input type="checkbox"/>

51. What is the frequency of your alcohol consumption? |____|

Never = 0; 1 time/month or less = 1; 2 to 4 times per month = 2; 2 to 3 times per week = 3; At least 4 times per week = 4

52. How many drinks containing alcohol do you consume on a typical day when you drink? |____|

1 or 2 = 0; 3 or 4 = 1; 5 or 6 = 2; 7 or 8 = 3; 10 or more = 4

53. How often do you have 6 or more drinks on one occasion? |____|

[One drink = one bottle or a "half-pint" of beer or cider (25 cl), a glass of wine (12 cl), a shot of spirits (4 cl), a cocktail...]

Never = 0; Less than once a week = 1; 1 time/month = 2; 1 time/week = 3; Daily or almost daily = 4

54. Have people around you made remarks about your alcohol consumption? |____|

No = 0; Yes = 4;

55. Have you ever consumed alcohol in the morning to feel in shape? |____|

No = 0; Yes = 4

56. Have you ever drunk and the next morning could not remember what you had said or done? |____|

No = 0; Yes = 4

57. In your lifetime, have you ever smoked tobacco (at least one cigarette)? |____|

No = 1; Yes = 2

58. Currently, do you smoke tobacco? |____|

I smoke every day (at least one cigarette per day) = 1; I smoke occasionally = 2; I used to smoke but I quit = 3; I tried but never became a smoker = 4; I have never smoked = 5

59. If you smoke daily, at what age did you start smoking every day? |____| years

60. In the last 30 days, have you smoked cigarettes? |____|

None = 1; Less than one per day = 2; Between 1 and 5 per day = 3; Between 6 and 10 per day = 4; Between 11 and 20 per day = 5; More than 20 per day = 6

61. Have you ever consumed coffee or beverages containing caffeine (coca-cola, etc.)?

Only one cross per line

Product	No	Daily	Weekly	Monthly	Occasionally	Never
Coffee	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Tea	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Coca-cola	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Red Bull	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Dark chocolate	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Milk chocolate	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Cocoa drink	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
Caffeinated pain medication, specify []	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

62. On a typical day, what quantity do you consume?

Product	Quantity
Coffee (number of cups)	
Tea (number of cups)	
Coca-cola (number of 330ml bottles)	
Red Bull (number of 330ml bottles)	
Dark chocolate (100g)	
Milk chocolate (100g)	
Cocoa drink (250ml)	
Caffeinated pain medication, specify []	

SECTION 5: ILLICIT SUBSTANCE USE**63. In your lifetime, have you ever used illicit substances?**

If yes, at what age the first time?

Only one cross per line

Substance	No	Yes	Age (years)
Cannabis (hashish, weed, joint, marijuana, shit)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Medication for nerves, for sleeping	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Hallucinogenic mushrooms	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Poppers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Products to inhale/sniff (glue, solvents, trichloroethylene)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Ecstasy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Amphetamines, speed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
LSD (acid, blotter)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Crack	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]
Cocaine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	[]

Heroin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____
Ketamine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____
Subutex	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____
GHB	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____
Tramadol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____
Moringa	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____
Other drugs (specify)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	_____

64. What were the reasons that led you to use these substances? |_____|

Lack of work = 1; Drugs are cheaper = 2; It's our occupation = 3; Provides pleasure = 4;
Suppression of poverty = 5; Illness = 6; Disappointment/discouragement = 7; Other = 14; specify
|_____|

65. How do you usually consume these substances? |_____|

Smoked = 1; Inhaled = 2; Snorted = 3; By intravenous injection = 4; Ingestion (drunk or swallowed) = 5

66. Have you taken any of the following substances in the last 12 months?

Only one cross per line

Substance	No	1 or 2 times	Between 3 and 5 times	Between 6 and 9 times	10 times and more
Cannabis (hashish, weed, joint, marijuana, shit)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Medication for nerves, for sleeping	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Hallucinogenic mushrooms	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Poppers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Products to inhale/sniff (glue, solvents, trichloroethylene)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Ecstasy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Amphetamines, speed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
LSD (acid, blotter)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Crack	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Cocaine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Heroin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Ketamine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Subutex	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
GHB	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Tramadol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Moringa	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Other drugs (specify)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

67. Have you taken any of the following products in the last 30 days?

Only one cross per line

Substance	No	1 or 2 times	3 to 5 times	6 to 9 times	10 to 19 times	20 to 29 times	Every day
Cannabis (hashish, weed, joint, marijuana, shit)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Medication for nerves, for sleeping	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Hallucinogenic mushrooms	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Poppers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Products to inhale/sniff (glue, solvents, trichloroethylene)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Ecstasy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Amphetamines, speed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
LSD (acid, blotter)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Crack	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Cocaine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Heroin	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Ketamine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Subutex	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
GHB	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Tramadol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Moringa	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Other drugs (specify)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>