

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; \geq 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
Beer	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Strong beer in 50 cl can (type 8.6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Wine	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Aniseed aperitif (type pastis, Martini, port, muscat)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Tchoukoutchou/tchakpalo	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Sodabi	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Champagne, sparkling wine	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Sangria, punch	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Rhum (Ti punch...)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Spirits (whisky, vodka, calvados, cognac...)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Cocktail (whisky-coke, vodka-orange...)	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"/>	<input type="text"/>
Ketamine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input type="text"/>
Subutex	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input type="text"/>
GHB	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input type="text"/>
Tramadol	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input type="text"/>
Moringa	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input type="text"/>
Other drugs (specify) 	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<input type="text"/>

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"/>