British Columbia CARMA CHIWOS Collaboration – Study Questionnaire

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If you have any questions, please contact one of the study coordinators:

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BC CARMA CHIWOS COLLABORATION

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BCC3 Participant Type

Please complete the survey below.

Thank you!

1) Participant

◯ HIV+
◯ Control
◯ Control, exposed but uninfected

2) Visit date

_____

3) BCC3 Participant ID

_____
(eg BCC3-001, 002 etc for HIV+; BCC3-501, 502 etc for controls)

4) Have you participated in the CARMA or CHIWOS studies before? If yes, which one (or both)?

Select all that apply.

☐ CARMA
☐ CHIWOS
☐ Neither
☐ Don't know
☐ Prefer not to answer

BCC3 Demographics - Clinical

Please complete the survey below.

Thank you!

The questions in this survey have been peer-reviewed by women living with HIV and women not living with HIV who have experienced all aspects of this survey. Together, we have tried to make the questions as safe as possible. Your answers are very valuable for improving the health, aging, and wellbeing of women.

Let's begin! This first section includes questions on gender, sexual orientation, income, education, housing, and other social factors that may influence overall health and well-being. Let's begin.

What was your biological sex at birth?
Select one

*Intersex people are individuals born with any of several variations in sex characteristics including chromosomes, testicles/ovaries, sex hormones or genitals that, according to the UN Office of the High Commissioner for Human Rights, "do not fit the typical definitions for male or female bodies"

- ◯ Female
- ◯ Male
- ◯ Intersex*
- ◯ Undetermined
- ◯ Other, please specify: _____
- ◯ Don't know
- ◯ Prefer not to answer

Please specify "Other"

_____

With respect to your gender, how do you currently identify?
Select all that apply

*Intersex people are individuals born with any of several variations in sex characteristics including chromosomes, testicles/ovaries, sex hormones or genitals that, according to the UN Office of the High Commissioner for Human Rights, "do not fit the typical definitions for male or female bodies"

- ☐ Woman (cis-gender)
- ☐ Man
- ☐ Transgender Man, Female to Male
- ☐ Transgender Woman, Male to Female
- ☐ Two-spirit
- ☐ Intersex*
- ☐ Gender Queer
- ☐ Non-binary
- ☐ Other, please specify:_____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

With respect to your sexual orientation, how do you currently identify?
Select all that apply

* Asexuality is the lack of sexual attraction to others, or low or absent interest in or desire for sexual activity. * Pansexuality, also called omnisexuality, is the sexual, romantic or emotional attraction towards people regardless of their sex or gender identity. Pansexual people may refer to themselves as gender-blind, asserting that gender and sex are not determining factors in their romantic or sexual attraction to others.

- ☐ Heterosexual / Straight
- ☐ Lesbian
- ☐ Gay
- ☐ Queer
- ☐ Bisexual
- ☐ Two-spirited
- ☐ Questioning
- ☐ Asexual*
- ☐ Pansexual*
- ☐ Other, please specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

_____

What is your date of birth? (dd-mm-yyyy)

_____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Were you born in Canada?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

In what country were you born?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

In what year did you first come to Canada to live?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

What is your current legal status in Canada?
Select one

Undocumented/Non-Status/Immigrant*: undocumented: includes people who are living in any country without legal documentation; non-status: includes people who have been waiting for years in the refugee claim process through no fault of their own; those who were unjustly denied refugee status based on arbitrary policies such as designated safe country lists; migrant workers who are fired after a workplace injury or forced to leave the country after a certain time limit or other similarly inhumane rules; those who have fallen through the cracks of an unfair immigration and refugee system; as well as those who have remained undocumented for many years.

◯ Canadian citizen
◯ Landed Immigrant/Permanent Resident
◯ Refugee/Protected Person*
◯ Refugee claimant/Person in need of protection*
◯ Here with Temporary Work Papers*
◯ Here with Humanitarian and Compassionate approval
◯ Here as a visitor
◯ Here on a Student Visa
◯ Undocumented/Non-Status/Immigrant*
◯ Other, please specify: _____
◯ Don't know
◯ Prefer not to answer

Please specify "Other"

_____

What is your current legal relationship status?
Select one

"Common-law" means you are living with a person who you are not legally married to, but with whom you are in a relationship with, and to whom at least one of the following situations applies:

They have been living with you in a spouse-like relationship for at least 12 continuous months. They are the parent of your child by birth or adoption. They have custody and control of your child (or had custody and control immediately before the child turned 19 years of age) and your child is wholly dependent on that person for support.

◯ Legally married
◯ Common-law
◯ In a relationship, living together (but not legally married or common-law)*
◯ In a relationship, not living together
◯ Single
◯ Separated / Divorced
◯ Widowed
◯ Other, please specify: _____
◯ Don't know
◯ Prefer not to answer

Please specify "Other"

_____

What do you consider to be your racial and/or ethnic background?
Select all that apply

- ☐ Indigenous person living in Canada (e.g., First Nations, Métis, and Inuit)
- ☐ Indigenous Person from a country outside of Canada
- ☐ Black African (e.g., Nigerian, Somali)
- ☐ Black Caribbean (e.g., Haitian)
- ☐ Black Other (e.g., Black Canadian)
- ☐ White
- ☐ Chinese or Taiwanese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Latin American (e.g., Chilean, Costa Rican, Mexican)
- ☐ South Asian (e.g., Indian, Bangladeshi, Pakistani, Punjabi, and Sri Lankan)
- ☐ Southeast Asian (e.g.,Cambodian, Laotian, Malaysian, Vietnamese)
- ☐ Arab (e.g., Egyptian, Kuwaiti, and Libyan)
- ☐ West Asian (e.g. Iraqi, Isreali, Lebanese, Afghani, Iranian)
- ☐ Central Asian (e.g., Kazakhstan, Krgyzstan, Tajikistan, Turkmenistan)
- ☐ Multiple races / Multiracial / "Mixed"
- ☐ Other, please specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

_____

What is the highest level of formal education you have completed?
Select one

- ◯ No formal education
- ◯ Some Elementary / Grade school
- ◯ Completed Elementary / Grade school
- ◯ Some High school / Secondary / GED
- ◯ Completed High school / Secondary / GED
- ◯ Some Trade or Technical training
- ◯ Completed Trade or Technical training
- ◯ Some CEGEP / College / University
- ◯ Completed CEGEP / College / University
- ◯ Other please specify _____
- ◯ Don't know
- ◯ Prefer not to answer

Please specify "other"

_____

Are you currently employed?

Employment includes any work at a job that is paid work, and includes people who have a job but are not at work due to maternity leave or illness.

Select all that apply

- ☐ Yes, I have a paid job, where income tax is deducted
- ☐ Yes, I have a paid job, but no income taxes are deducted
- ☐ Yes, I am self-employed
- ☐ No, I am not currently employed
- ☐ I am a student
- ☐ Other, please specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

In the last year, have you received social assistance from welfare or disability?

In British Columbia, welfare is known as BC Employment and Assistance (BCEA).

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Considering all income sources (i.e. Pension (including federal CPPD, Private LTD, or other sources),Sex work, Selling drugs / drugs paraphernalia, Pan-handling/ 'squeegeeing' / recycling, Personal Savings, Loan(s) / Student Loan(s), Parent / friend / relative / partner income, Honoraria (workshops, trainings), Money from First Nations Band) how much does YOUR HOUSEHOLD make in a year, before taxes (i.e. household gross yearly income)?

Select one

- ◯ Less than $10,000
- ◯ $10,000 to $19,9999
- ◯ $20,000 to $29,9999
- ◯ $30,000 to $39,9999
- ◯ $40,000 to $49,9999
- ◯ $50,000 to $59,9999
- ◯ $60,000 to $69,9999
- ◯ $70,000 to $79,9999
- ◯ $80,000 to $99,9999
- ◯ $100,000 or more
- ◯ Don't know
- ◯ Prefer not to answer

Considering all income sources (i.e. Pension (including federal CPPD, Private LTD, or other sources),Sex work, Selling drugs / drugs paraphernalia, Pan-handling/ 'squeegeeing' / recycling, Personal Savings, Loan(s) / Student Loan(s), Parent / friend / relative / partner income, Honoraria (workshops, trainings), Money from First Nations Band) how much do YOU make in a year, before taxes (i.e. personal gross yearly income)?

Select one

- ◯ Less than $10,000
- ◯ $10,000 to $19,9999
- ◯ $20,000 to $29,9999
- ◯ $30,000 to $39,9999
- ◯ $40,000 to $49,9999
- ◯ $50,000 to $59,9999
- ◯ $60,000 to $69,9999
- ◯ $70,000 to $79,9999
- ◯ $80,000 to $99,9999
- ◯ $100,000 or more
- ◯ Don't know
- ◯ Prefer not to answer

Given your total household income, how difficult is it to meet your monthly housing costs (including rent, mortgage, property taxes, heat, electricity, water and/or gas)?
Would you say that it is...
Select one

- ◯ Not at all difficult
- ◯ A little difficult
- ◯ Fairly difficult
- ◯ Very difficult
- ◯ Not applicable - Do not have monthly housing costs (homeless, shelter, couch surfing)
- ◯ Don't know
- ◯ Prefer not to answer

What are the first 3 digits of the postal code for the place where you are currently living or regularly sleep?

_____

(Enter x0x if "Don't know" or "Prefer not to answer")

Can you indicate the city and a major intersection near where you regularly sleep?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Which BC Regional Health Authority do currently you live in?	◯ Interior Health ◯ Fraser Health ◯ Vancouver Coastal Health ◯ Vancouver Island Health ◯ Northern Health ◯ Don't know ◯ Prefer not to answer
Have you ever experienced homelessness? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you been homeless in the last 6 months?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you get income support/subsidy to help pay for your housing? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How safe do you feel in the place where you are currently living or regularly sleep? Select one	◯ Extremely safe ◯ Somewhat safe ◯ Less than safe ◯ Not safe at all ◯ Don't know ◯ Prefer not to answer
How much do you agree or disagree with the statement: My current housing situation is stable. Select one	◯ Strongly agree ◯ Somewhat agree ◯ Neither agree or disagree ◯ Somewhat disagree ◯ Strongly disagree ◯ Don't know ◯ Prefer not to answer
If you know your biological family, do you know your..... Biological Mother's Date of Birth (dd-mm-yyyy)	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
What is your biological mother's age today, or how old would your biological mother be today?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
If you know your biological family, do you know your..... Biological Father's Date of Birth (dd-mm-yyyy)	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown.Enter 1900 if YEAR unknown.)

What is your biological father's age today, or how old would your biological father be today?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

The following questions are for participants who selected "Indigenous person living in Canada" (either alone, or as a combination). If you do not wish to answer any questions, you can select "prefer not to answer".

Do you identify as:
Select one

- ◯ First Nations (Status)*
- ◯ First Nations (Non-status)*
- ◯ Métis
- ◯ Inuit
- ◯ None of the above - I am not an Indigenous person living in Canada
- ◯ Don't know
- ◯ Prefer not to answer

Are you eligible for health services through the Non-Insured Health Benefits Program* provided to status First Nations people through Health Canada (i.e., a Status card)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Many people move to and from Indigenous communities (i.e., First Nations Reserve or Métis and Inuit community). Which of the following statements applies best to your situation?
Select one.

- ◯ I have moved both inside and outside of an Indigenous community
- ◯ I have moved away from an Indigenous community
- ◯ I have moved into an Indigenous community
- ◯ I have only lived inside an Indigenous community
- ◯ I have only lived outside an Indigenous community
- ◯ Don't know
- ◯ Prefer not to answer

What were the reasons you moved away from the Indigenous community?
Select all that apply

- ☐ Family
- ☐ Employment /Job opportunities
- ☐ Education
- ☐ Relationship
- ☐ Housing
- ☐ Employment of spouse/partner
- ☐ Marital/relationship/domestic problems
- ☐ Violence (physical, sexual, and/or emotional)
- ☐ Support for disability
- ☐ Medical needs
- ☐ Social supports / services
- ☐ HIV diagnosis
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

What were the reasons you moved into the Indigenous community?
Select all that apply.

- ☐ Connection to community/home
- ☐ Exposure of children to culture
- ☐ Family
- ☐ Employment /Job opportunities
- ☐ Education
- ☐ Relationship
- ☐ Housing
- ☐ Employment of spouse/partner
- ☐ Marital/relationship/domestic problems
- ☐ Violence (physical, sexual, and/or emotional)
- ☐ Support for disability
- ☐ Medical needs
- ☐ Social supports / services
- ☐ HIV diagnosis
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

The following questions ask whether you or anyone in your family attended residential schools. If you prefer, you have the option to skip any question or this entire section. How would you like to continue?
Select one

- ◯ Proceed with the first question
- ◯ Skip this section altogether

Did you attend residential school?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How old were you when you first started attending residential school?

Indicate age in years:

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

How old were you when you left residential school?

Indicate age in years:

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Did anybody else in your family attend a residential school?
Select one per row.

	Yes	No	Don't know	Prefer not to answer	N/A
Mother	◯	◯	◯	◯	◯
Father	◯	◯	◯	◯	◯
Maternal grandmother	◯	◯	◯	◯	◯
Maternal grandfather	◯	◯	◯	◯	◯
Paternal grandmother	◯	◯	◯	◯	◯

Paternal grandfather	◯	◯	◯	◯	◯
Any siblings	◯	◯	◯	◯	◯

The following questions are in regards to early life experiences that include adoption, children protection services, and foster care. I can guide you through these questions or you can complete them on your own. If there is something you prefer not to answer, you are welcome to select "prefer not to answer".

Were you adopted?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

Have you ever been under the care of Child Protection Services?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

Have you ever been in foster care?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

BCC3 Vaccinations and Viruses

Please complete the survey below.

Thank you!

This next section asks about certain vaccinations and viruses that are of interest to this study.

Have you ever received the HPV* (human papilloma virus) vaccine? *HPV - the human papilloma virus, a sexually transmitted virus that causes cervical cancer Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, when? Select one	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer
Have you ever had Chicken Pox (includes natural infection or receiving the vaccine)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Was it from natural infection (chicken pox) or did you receive the vaccine?	◯ Natural infection (chicken pox) ◯ Vaccine ◯ Don't know ◯ Prefer not to answer
If yes, when did you have Chicken Pox (includes natural infection or receiving the vaccine)? Select one	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer
Have you ever had Shingles (natural infection or the vaccine)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Was it from a natural infection (shingles) or a vaccine?	◯ Natural infection (shingles) ◯ Vaccine ◯ Don't know ◯ Prefer not to answer
If yes, when did you have Shingles (includes natural infection or receiving the vaccine)?	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer

Have you ever had Hepatitis B (includes natural infection or receiving the vaccine)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Was it from natural infection or did you receive the Hepatitis B vaccine?	◯ Natural Infection ◯ Vaccine ◯ Don't know ◯ Prefer not to answer
If yes, when did you get the Hepatitis B vaccine or natural infection?	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer

BCC3 Non-HIV Medications

Please complete the survey below.

Thank you!

Now we will be asking questions about your current medications.

For participants living with HIV, these are non-HIV medications only.

Please include all CURRENT prescribed (Rx) medications with attention to antibiotics, insulin, hormonal contraception, puffers, steroids, and seizure medications.

Are you currently taking opiates*?

*Prescription opiates are used mostly to treat moderate to severe pain.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

If yes, are you prescribed your opiates?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

If yes, what is your opiate dosage?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Do you currently take any of the following vitamins or supplements regularly?
Select all that apply

- ☐ NONE
- ☐ Vitamin B12 daily
- ☐ Iron/ferritin daily
- ☐ Calcium daily
- ☐ Vitamin D daily
- ☐ Multi vitamins daily to weekly
- ☐ Other, please specify:

Please specify "other"

_____

Have you taken any medications in the past 3 months? (non-HIV medications only)

Includes antibiotics, insulin, heart medications, diuretics, antidepressants, hormonal contraception, steroids, seizure medications, smoking cessation methods, pain medications, puffers for asthma or COPD, etc.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What have you been taking?

_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_2] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_2] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'

_____

Are you still taking [nhivmeds_3] ?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

When did you stop [nhivmeds_3] ?

_____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months? (non-HIV medications only)

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

What have you been taking?

_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'

_____

Are you still taking [nhivmeds_4] ?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

When did you stop [nhivmeds_4] ?

_____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months? (non-HIV medications only)

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

What have you been taking?

_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping/ Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_5] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_5] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_6] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_6] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_7] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_7] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'

_____

Are you still taking [nhivmeds_8] ?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

When did you stop [nhivmeds_8] ?

_____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months? (non-HIV medications only)

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

What have you been taking?

_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_9] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_9] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_10] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_10] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_11] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_11] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_12] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_12] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_13] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_13] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_14] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_14] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	_____

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Premature ovarian failure (< 40) / early menopause (< 45)
- ◯ Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)
- ◯ Polycystic ovary syndrome (PCOS)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthirtis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism (PE)
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Contraception
- ◯ Menstrual cramps
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	_____
Are you still taking [nhivmeds_15] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_15] ?	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Please write down any other non HIV medications the participant is taking or has taken in the last 3 months.	_____
Have you taken any 'as needed' medication in the past 3 months? If so, for what reasons do you take them? i.e. taking ibuprofin for mentstrual cramps or headaches.	☐ Pain (ibuprofen/Advil, acetaminophen/Tylenol, etc) ☐ Allergies (Benadryl, Claritin, Aleve, etc) ☐ Sleep (melatonin or other sleep aids) ☐ Other
Please Specify 'Other'	_____

BCC3 Medical and HIV

Please complete the survey below.

Thank you!

Have you ever been tested for HIV?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
This section covers medical information as it pertains to your general health and well-being such as other conditions you may be living with, as well as HIV-related health and well-being such as your potential use of HIV antiretroviral therapy medications (i.e., ARVs) and your viral load and CD4 count.	
When were you diagnosed with HIV? dd-mm-yyy Indicate month and year if possible, otherwise year only.	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When were you diagnosed with HIV?	◯ Don't know ◯ Prefer not to answer
When did you receive your lowest (nadir) CD4 count results? dd-mm-yyyy Indicate month and year if possible, otherwise year only.	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When did you receive your lowest (nadir) CD4 count results?	◯ Don't know ◯ Prefer not to answer
What was your lowest (nadir) CD4 count? Indicate count: _____ cells/mm3	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Are you able to estimate your lowest (nadir) CD4 count? Select one.	◯ < 200 cells/mm3 ◯ 200-500 cells/mm3 ◯ >500 cells/mm3 ◯ Unable to estimate ◯ Prefer not to answer
When did you last receive your CD4 count results? dd-mm-yyyy Indicate month and year if possible, otherwise year only.	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When did you last receive your CD4 count results?	◯ Don't know ◯ Prefer not to answer

What was your most recent CD4 count? Indicate count: _____ cells/mm3	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Are you able to estimate your most recent CD4 count? Select one.	◯ < 200 cells/mm3 ◯ 200-500 cells/mm3 ◯ >500 cells/mm3 ◯ Unable to estimate ◯ Prefer not to answer
Have you ever had a viral load (VL) over 100,000 copies/mL? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you last receive your HIV viral load results? dd-mm-yyyy Indicate month and year if possible, otherwise year only.	_____ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When did you last receive your HIV viral load results?	◯ Don't know ◯ Prefer not to answer
What was your most recent viral load, undetectable or detectable? Select one	◯ Undetectable (i.e. below 40 copies/mL) ◯ Detectable (i.e. over 40 copies/mL) ◯ Don't know ◯ Prefer not to answer
Do you remember the exact result? If so, what was it? Indicate count: _____ cells/mm3	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Are you currently taking ARVs? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

What ARV side effects did you experience IN THE PAST, whether diagnosed by a healthcare provider or not? Select all that apply

- ☐ NONE
- ☐ Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)
- ☐ Diarrhea, gas and bloating
- ☐ Emotional and mental problems (foggy thinking, memory loss, nightmares)
- ☐ Fatigue (not made better by resting)
- ☐ Stomach aches or pain
- ☐ Headaches
- ☐ Menstrual changes (unexpected changes in the cycle)
- ☐ Mouth and throat problems (tingling, inflammation, blisters)
- ☐ Muscles aches and pain
- ☐ Nausea, vomiting, appetite loss
- ☐ Nerve pain and numbness
- ☐ Rash, skin, hair, nail problems
- ☐ Sexual difficulties (libido or sex drive, sexual functioning)
- ☐ Sleep problems - insomnia (falling asleep, staying asleep)
- ☐ Gall stones
- ☐ Kidney stones
- ☐ Other (please specify)_____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

What ARV side effects do you CURRENTLY experience, whether diagnosed by a healthcare provider or not? Select all that apply

- ☐ NONE
- ☐ Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)
- ☐ Diarrhea, gas and bloating
- ☐ Emotional and mental problems (foggy thinking, memory loss, nightmares)
- ☐ Fatigue (not made better by resting)
- ☐ Stomach aches or pain
- ☐ Headaches
- ☐ Menstrual changes (unexpected changes in the cycle)
- ☐ Mouth and throat problems (tingling, inflammation, blisters)
- ☐ Muscles aches and pain
- ☐ Nausea, vomiting, appetite loss
- ☐ Nerve pain and numbness
- ☐ Rash, skin, hair, nail problems
- ☐ Sexual difficulties (libido or sex drive, sexual functioning)
- ☐ Sleep problems - insomnia (falling asleep, staying asleep)
- ☐ Gall stones
- ☐ Kidney stones
- ☐ Other (please specify)_____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Which ARVs are you currently taking?
A card containing pictures of each of these ARVs will be available.
Select all that apply

- ☐ 3TC (lamivudine)
- ☐ Atripla (FTC+Tenofovir+Sustiva)
- ☐ Biktarvy (Bictegravir. FTC, TAF)
- ☐ Celsentri (Maraviroc)
- ☐ Combivir (3TC + AZT)
- ☐ Complera (FTC+Tenofovir+Rilpivirine)
- ☐ Crixivan (indinavir) *super rare
- ☐ Descovy (FTC + TAF)
- ☐ Dolutegravir
- ☐ Doravirine*super rare
- ☐ Edurant (Rilpivirine, TMC-125)
- ☐ Fortovase (saquinavir) *super rare
- ☐ Fostemsavir*super rare
- ☐ FTC (emtricitabine)
- ☐ Fuzeon (enfuvirtide, T-20) *super rare
- ☐ Genoya (elvitegravir, cobicistat, TAF. FTC)
- ☐ Intelence (etravirine)
- ☐ Isentress (Raltegravir)
- ☐ Kaletra (lopinavir + ritonavir)
- ☐ Kivexa (abacavir+ lamivudine)
- ☐ Norvir (ritonavir)
- ☐ Prezcobix (darunaiv, cobicistat)
- ☐ Prezista (darunavir)
- ☐ Retrovir (AZT, zidovudine)
- ☐ Reyataz (atazanavir)
- ☐ Stribild (elvitegravir, cobicistat, TAF. FTC)
- ☐ Sustiva (efavirenz)
- ☐ Trizivir (ABC + 3TC + AZT)
- ☐ Triumeq (dolutegravir, 3TC, abacavir)
- ☐ Truvada (FTC + tenofovir)
- ☐ Viramune (nevirapine)
- ☐ Viread (tenofovir)
- ☐ Ziagen (abacavir)
- ☐ Other, please specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

We understand that many people on HIV medications find it difficult to take them regularly and often miss doses. It is common to miss some doses. Many of us have missed doses. We would like to know how many doses you have missed. Please indicate on the line beside the point showing your best guess about how much medication you have taken in the last month.

0% means you have taken no medication; 50% means you have taken half your medication; 100% means you have taken every single dose of medication

0% 50% 100%

(Place a mark on the scale above)

Have you ever taken a double dose to make up for any missed doses of HIV medication, or if you forgot you had taken it already and took it again?

Please note: taking a double dose is not recommended by healthcare providers, we would just like to know how often people practice this.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever received pediatric HIV care?
Select one

- ◯ Yes, but I now receive adult HIV care
- ◯ Yes, and I am still receiving pediatric HIV care
- ◯ No, I have never received pediatric HIV care
- ◯ Don't know
- ◯ Prefer not to answer

Did you acquire HIV through vertical transmission (this means that you acquired HIV from your mother during birth or breastfeeding) ?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever discussed with a health care provider the impact of your viral load on the risk of transmitting HIV?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Are you aware of the Women-Centred HIV Care toolkit, which was developed to help women living with HIV make informed choices about your health and healthcare?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

The Women-Centred HIV Care Toolkit was designed by, with, and for women living with HIV across Canada in collaboration with healthcare providers and researchers. Women-centred HIV care acknowledges each woman as a unique individual and works with them in a participatory model of decision making to provide holistic care. These toolkits are designed to support clinicians and women by providing them with guidance on the various components of women-centred HIV care. The Women-Centred HIV Care Toolkit (offered both in English and French) provides women with the information they need to advocate for and make informed choices about their health care.

The Toolkits are free to download here: https://cep.health/media/uploaded/CEP_WomenHIV_Info.pdf

Would you be interested in using the Women-Centred HIV Care toolkit?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How would you prefer to access the Women-Centred HIV Care toolkit?

Please select all that apply.

- ◯ Online website
- ◯ Digital PDF file
- ◯ An Application "App" on a smartphone
- ◯ Paper copy
- ◯ Another format [please specify]
- ◯ I am not interested in accessing the toolkit
- ◯ Don't know
- ◯ Prefer not to answer

How do you think taking ARVs* changes your risk of transmitting HIV?

*Antiretroviral medication

Select one

- ◯ Makes the risk of transmission a lot lower
- ◯ Makes the risk of transmission a little lower
- ◯ Makes little difference to the risk of transmission
- ◯ Makes the risk of transmission a little higher
- ◯ Makes the risk of transmission a lot higher
- ◯ Don't know
- ◯ Prefer not to answer

Have you heard of Undetectable equals Untransmittable?

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What does it mean to you?

_____

Undetectable = Untransmittable (U=U) means that when a person living with HIV is taking antiretroviral therapy and has an undetectable viral load in their blood, they cannot transmit HIV to their drug or sex partners.

BCC3 Medical History

Please complete the survey below.

Thank you!

This section covers medical information as it pertains to your general health and well-being, including conditions you may be living with. We will go through a list of different health diagnoses, and then there will be a text box at the end to add anything that was not included. Please indicate any that you have been diagnosed with by a healthcare provider.

Have you ever been told by a doctor or nurse that you have hepatitis C (Hep C)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you taken any medication for hepatitis C?

Medications include: Interferon, Intron, Peg-Intron, Virazole, Remeron, Rebetron, Ribavirin
Select one

- ◯ Yes
- ◯ No
- ◯ No, but spontaneously cleared
- ◯ Don't know
- ◯ Prefer not to answer

Which medication for hepatitis C did you take?
Select one

- ◯ Interferon
- ◯ Newer Agent
- ◯ Don't know
- ◯ Prefer not to answer

Were you cured?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you been told by a doctor or nurse that you have hepatitis B (Hep B)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever taken medication for hepatitis B?

Medications include: Interferon, Intron, Peg-Intron, Virazole, Remeron, Rebetron, Ribavirin
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have asthma?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have emphysema/COPD (is a long-term, progressive disease of the lungs that primarily causes shortness of breath due to over-inflation of the alveoli (air sacs in the lung)?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have hypothyroidism (underactive thyroid) ? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have hyperthyroidism (overactive thyroid)? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have adrenal insufficiency (not enough cortisol)? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have Cushing's disease (too much cortisol)? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have premature ovarian failure (< 40) / early menopause (< 45)? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Has a doctor ever told you that you have dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have polycystic ovary syndrome (PCOS)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have had a stroke?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have coronary artery disease or have had myocardial infarction / heart attack?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have cardiac arrhythmia / atrial fibrillation / abnormal heart rhythm?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have heart failure?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have peripheral vascular disease*? Select one * when blocked / narrowed arteries reduce blood flow to your limbs.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have glaucoma*? Select one *condition of increased pressure within the eyeball, causing gradual loss of sight.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have cataracts? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have osteoporosis / osteopenia / decreased bone density? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take vitamins for this?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have osteoarthritis? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have rheumatoid arthirtis? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have had fractures? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, were any fractures a result of low bone density?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have insulin resistance / pre-diabetes / borderline diabetes? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have diabetes ? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Are you currently taking any medications (prescription or non prescription) for your diabetes ? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What type of medication? Indicate :	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Has a doctor ever told you that you have deep vein thrombosis (DVT)* / pulmonary embolism (PE)** ?
Select one

*DVT is the formation or presence of a blood clot in a blood vessel deep in the body.

** PE is a sudden blockage in a lung artery. It usually happens when a blood clot breaks loose and travels through the bloodstream to the lungs.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have high cholesterol?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have high blood pressure / hypertension?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have liver disease or fatty liver?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have liver cirrhosis?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have inflammatory bowel disease (IBD) ? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have diverticulitis*? Select one *the infection or inflammation of pouches that can form in your intestines.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have a renal problem/ kidney problem/ kidney stones? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have neuropathy*? Select one *damage, disease, or dysfunction of one or more nerves especially of the peripheral nervous system that is typically marked by burning or shooting pain, numbness, tingling, or muscle weakness or atrophy.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have vitamin B12 deficiency? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication/vitamins to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have peptic ulcer disease / gastroesophageal reflux disease (GERD) / acid reflux? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have seizures/ epilepsy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have fibromyalgia*? Select one *chronic disorder characterized by widespread musculoskeletal pain, fatigue, and tenderness in localized areas.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have metabolic syndrome? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have Herpes Simplex Virus I / HSV1 / Cold Sores?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one	☐ Yes, I take medication to prevent an outbreak ☐ Yes, I take medication to treat an outbreak ☐ Yes, I use cream to treat ☐ No ☐ Don't know ☐ Prefer not to answer
Has a doctor ever told you that you have Herpes Simplex Virus II / HSV 2 / Genital Herpes?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one	☐ Yes, I take medication to prevent ☐ Yes, I take medication to treat an outbreak ☐ Yes, I use cream to treat ☐ No ☐ Don't know ☐ Prefer not to answer
Has a doctor ever told you that you have insomnia / difficulty sleeping?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have an iron deficiency?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medicaton/vitamins to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have migraines?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medicaton to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have precancer? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What type(s) of precancer were you diagnosed with ? DO NOT READ LIST, MULTIPLE RESPONSES ALLOWED	☐ High Grade Cervical precancer (Cervical Intraepithelial Neoplasia or CIN 2 OR 3) ☐ High Grade Vulvar or vaginal precancer (Vulvar or Vaginal Intaepithelial Neoplasia, VIN or VaIN 2 or 3) ☐ High Grade Anal precancer (Anal Intraepithelial Neoplasia, AIN 2 or 3) ☐ Other, please specify: _____ ☐ Don't know /no answer ☐ Prefer not to answer
Please specify 'Other'	_____

Have you ever undergone any precancer treatment (ie. colposcapy, LEEP)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have cancer?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What type(s) of cancer were you diagnosed with ?

DO NOT READ LIST, MULTIPLE RESPONSES ALLOWED

- ☐ Ovarian
- ☐ Endometrial (i.e. of the uterus)
- ☐ Cervical
- ☐ Vulvar
- ☐ Oral or pharynx
- ☐ Thyroid
- ☐ Colon or Rectum
- ☐ Anal
- ☐ Lymphoma / leukemia
- ☐ Bladder
- ☐ Stomach or Small Bowel
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Breast
- ☐ Skin (melanoma, basal, squamous cells)
- ☐ Bone
- ☐ Kaposi Sarcoma
- ☐ Other, please specify: _____
- ☐ Don't know /no answer
- ☐ Prefer not to answer

Please specify "other"

_____

Have you ever undergone any cancer treatment?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Which cancer treatments have you undergone?
Select all that apply

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgery (cancer-related)
- ☐ Other
- ☐ Don't know
- ☐ Prefer not to answer

Specify 'Other'

_____

What part of your body had radiation?

_____

What was the surgery?

_____

The next section will ask about certain health diagnoses that your biological family may have/have had. Do you know your biological family, such as your biological mother/father/siblings?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

If you know your biological family, do you have a biological mother/father/siblings (i.e. brother or sister) with any of the following diagnoses?

	Yes	No	Don't know	Prefer not to answer
Diabetes	◯	◯	◯	◯
Insulin resistance / pre-diabetes / borderline diabetes	◯	◯	◯	◯
High cholesterol	◯	◯	◯	◯
*Myocardial infarction / heart attack	◯	◯	◯	◯
Cardiovascular disease	◯	◯	◯	◯
Stroke	◯	◯	◯	◯
Metabolic syndrome	◯	◯	◯	◯
Hypothyroidism (underactive thyroid)	◯	◯	◯	◯
Hyperthyroidism (overactive thyroid)	◯	◯	◯	◯
Adrenal insufficiency (not enough cortisol)	◯	◯	◯	◯
Cushing's disease (too much cortisol)	◯	◯	◯	◯
*Premature ovarian failure (< 40) / early menopause (< 45)	◯	◯	◯	◯
Dysfunctional uterine bleeding (abnormal bleeding with no clear problem, usually hormonal)	◯	◯	◯	◯
Polycystic ovary syndrome (PCOS) / Annovulatory androgen excess	◯	◯	◯	◯
Breast cancer	◯	◯	◯	◯
Kidney disease	◯	◯	◯	◯

Do you experience any of the following challenges?
Select all that apply

- ☐ Partial deafness
- ☐ Complete deafness
- ☐ Partial blindness
- ☐ Complete blindness
- ☐ Physical difficulty to walk - requiring assistive device like cane or walker on regular basis
- ☐ Physical difficulty to walk - requiring wheel chair on regular basis
- ☐ Speech difficulty
- ☐ Physical difficulty moving one or both arms
- ☐ Other, please specify:
- ☐ None
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

The following questions are related to mental health / mind wellbeing. Please indicate whether a health care provider has diagnosed you with any of the following mental health diagnoses. Please remember that your responses are confidential and private. If there is something you prefer not to answer, you are welcome to select "prefer not to answer".

Has a doctor ever told you that you have ADHD (attention deficit hyperactivity disorder)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have ADD (attention deficit disorder)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have anxiety?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have alcohol use disorder*?

*Also known as alcohol addiction
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have anorexia nervosa or bulimia nervosa?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have bipolar disorder?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have personality disorder?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have dementia?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have depression?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have a substance use disorder?

*Also known as drug addiction

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have obsessive-compulsive disorder (OCD)?

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have post traumatic stress disorder (PTSD)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has a doctor ever told you that you have schizophrenia?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you take medication to treat this?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever been diagnosed with any other health concerns? Please list any diagnoses that were not listed previously and state whether you are taking any medications for it, and if so, please list what medication are you taking.

_____

(Enter 9999 if none)

Which of the following applies to your current situation regarding hormones and/or surgery? Select one.	◯ I have fully medically/surgically transitioned ◯ I am in the process of medically/surgically transitioning ◯ I am planning to transition, but have not begun ◯ I am not planning to medically/surgically transition ◯ The concept of 'transitioning' does not apply to me ◯ I am not sure whether I am going to medically transition ◯ Other, please specify: _____ ◯ Don't know ◯ Prefer not to answer
Please specify other	_____
Are you currently taking Trans-related hormones? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you informed your HIV doctor that you are currently taking hormones? Select one.	◯ Yes ◯ No ◯ Not applicable - don't have an HIV doctor ◯ Don't know ◯ Prefer not to answer
Has your HIV doctor discussed with you the possible drug interactions between hormones and HIV medications? Select one.	◯ Yes ◯ No ◯ Not applicable - don't have an HIV doctor ◯ Don't know ◯ Prefer not to answer

BCC3 Reproductive Health

Please complete the survey below.

Thank you!

The following section asks about a wide variety of questions to help improve understanding of women's reproductive health and reproductive histories. Some topics may be applicable to you and others may not, depending on your age and/or menopausal status. We understand that some of these questions may feel personal or be difficult to answer. Please remember that your responses are completely confidential. Your experiences and responses are critical to help meet the project goals of better understanding the factors that affect women's reproductive health.

SKIP Reproduction Section if participant indicated trans-woman

---

How old were you when your first menstrual period (moon time) started?

Indicate age in years: _____

(Enter 8888 if "Have never had a menstrual period", 9999 if "Don't know" or 7777 if "Prefer not to answer")

The following question is part of a validated survey

When did you start your most recent menstrual period (moon time)?
Probe for best estimate.
Select one

- ◯ Within the last month
- ◯ More than 1 month ago, but within the last 3 months
- ◯ More than 3 months ago, but within the last 6 months
- ◯ More than 6 months ago, but within the last 9 months
- ◯ More than 9 months ago, but within the last year
- ◯ More than 1 year ago, but within the last 2 years
- ◯ More than 2 years ago, but less than 5 years
- ◯ More than 5 years ago, but less than 10 years
- ◯ More than 10 years ago
- ◯ Don't know
- ◯ Prefer not to answer

What was the date of your last period (first day of menstrual flow or bleeding)?

_____

(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

What was the date of your LAST menstrual period?

_____

(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

What was your age at your LAST menstrual period?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Is your menstrual period regular?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How often do they occur (in days)?	◯ < 23 ◯ 24 ◯ 25 ◯ 26 ◯ 27 ◯ 28 ◯ 29 ◯ 30 ◯ 31 ◯ 32 ◯ 33 ◯ 34 ◯ 35 ◯ >36 ◯ Too irregular to say ◯ Don't know ◯ Prefer not to answer
Which of the following describes your menstrual cycles lengths in the last six months as compared to the six months before that? Have they... Select one	◯ Stayed the same ◯ Become longer (periods farther apart) ◯ Become shorter (periods closer together) ◯ Too irregular to say (sometimes closer together and sometimes farther apart) ◯ Don't know ◯ Prefer not to answer
How would you describe your menstrual flow in the last six months? My menstrual bleeding has been or was: Select one	◯ Light ◯ Medium ◯ Heavy ◯ Very heavy ◯ Too irregular to say ◯ Don't know ◯ Prefer not to answer
How would you describe the heaviness of your flow in the last six months as compared to the six months before that? My menstrual flow has: Select one	◯ Stayed the same ◯ Become lighter ◯ Become heavier ◯ Too irregular to say ◯ Not Applicable - no menstrual period in the six months prior ◯ Don't know ◯ Prefer not to answer
With this increase in heavy flow, do you experience flooding or clotting so that you must change your pad/tampon every 1-2 hours?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How long does your menstrual flow usually last? (in days) Select one	◯ Less than 4 days ◯ Between 4-7 days ◯ Greater than 7 days ◯ Too variable to say ◯ Don't know ◯ Prefer not to answer

Which of the following describes the duration of your menstrual flow (days of bleeding) in the last six months as compared to the six months before that? My menstrual flow has: Select one	◯ Stayed the same ◯ Become longer ◯ Become shorter ◯ Too irregular to say ◯ Not Applicable - no menstrual period in the 6 months prior ◯ Don't know ◯ Prefer not to answer
In the last six months, did you have menstrual cramps or pains? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How would you describe how painful your menstrual pains have been in the last six months as compared to the six months before that? Select one	◯ More painful/uncomfortable ◯ Less painful/uncomfortable ◯ Same ◯ Too variable to say ◯ Don't know ◯ Prefer not to answer
In the past two years, has your menstrual period come late or early by more than a week for reasons other than pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
In the past 3 months, have you experienced any changes in how you feel before flow starts, such as breast tenderness or swelling, mood swings, fluid retention, or appetite changes?	◯ No changes ◯ Decreasing ◯ Increasing ◯ Never or rarely experience these symptoms ◯ Don't know ◯ Prefer not to answer
What was the longest single period of time (in months) without a menstrual period/flow in your life so far, during your menstruating years (not including during or following pregnancy or during breastfeeding, or menopause)? Indicate in months:	_____ (Enter 9999 "Don't know" or 7777 if "Prefer not to answer")
How many times have your menstrual periods EVER stopped for more than one year?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
At what age did your menstrual period stop for more than one year?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For what reasons do you think your menstrual periods stopped for more than one year?

- ☐ I've gone into natural menopause (more than 1 year without a period)
- ☐ I had surgery that induced menopause
- ☐ I had menopause due to chemotherapy or radiation therapy
- ☐ I was pregnant or breastfeeding
- ☐ I was engaged in long-term drug use
- ☐ I was taking Depo-Provera (injectable hormonal contraception) or have the levonorgestrel-releasing (Mirena) IUD
- ☐ I was taking methadone/methodose
- ☐ My weight was too low / lost weight quickly
- ☐ I was an extreme athlete training extremely hard
- ☐ Other medications
- ☐ Other please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Did your period stop more than one year any other time?

- ◯ Yes
- ◯ No

At what age did your menstrual period stop for more than one year?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For what reasons do you think your menstrual periods stopped for more than one year?

- ☐ I've gone into natural menopause (more than 1 year without a period)
- ☐ I had surgery that induced menopause
- ☐ I had menopause due to chemotherapy or radiation therapy
- ☐ I was pregnant or breastfeeding
- ☐ I was engaged in long-term drug use
- ☐ I was taking Depo-Provera (injectable hormonal contraception) or have the levonorgestrel-releasing (Mirena) IUD
- ☐ I was taking methadone/methodose
- ☐ My weight was too low / lost weight quickly
- ☐ I was an extreme athlete training extremely hard
- ☐ Other medications
- ☐ Other please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Did your period stop more than one year any other time?

- ◯ Yes
- ◯ No

At what age did your menstrual period stop for more than one year?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For what reasons do you think your menstrual periods stopped for more than one year?

- ☐ I've gone into natural menopause (more than 1 year without a period)
- ☐ I had surgery that induced menopause
- ☐ I had menopause due to chemotherapy or radiation therapy
- ☐ I was pregnant or breastfeeding
- ☐ I was engaged in long-term drug use
- ☐ I was taking Depo-Provera (injectable hormonal contraception) or have the levonorgestrel-releasing (Mirena) IUD
- ☐ I was taking methadone/methodose
- ☐ My weight was too low / lost weight quickly
- ☐ I was an extreme athlete training extremely hard
- ☐ Other medications
- ☐ Other please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Did your period stop more than one year any other time?

- ◯ Yes
- ◯ No

At what age did your menstrual period stop for more than one year?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For what reasons do you think your menstrual periods stopped for more than one year?

- ☐ I've gone into natural menopause (more than 1 year without a period)
- ☐ I had surgery that induced menopause
- ☐ I had menopause due to chemotherapy or radiation therapy
- ☐ I was pregnant or breastfeeding
- ☐ I was engaged in long-term drug use
- ☐ I was taking Depo-Provera (injectable hormonal contraception) or have the levonorgestrel-releasing (Mirena) IUD
- ☐ I was taking methadone/methodose
- ☐ My weight was too low / lost weight quickly
- ☐ I was an extreme athlete training extremely hard
- ☐ Other medications
- ☐ Other please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Did your period stop more than one year any other time?

- ◯ Yes
- ◯ No

At what age did your menstrual period stop for more than one year?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For what reasons do you think your menstrual periods stopped for more than one year?	☐ I've gone into natural menopause (more than 1 year without a period) ☐ I had surgery that induced menopause ☐ I had menopause due to chemotherapy or radiation therapy ☐ I was pregnant or breastfeeding ☐ I was engaged in long-term drug use ☐ I was taking Depo-Provera (injectable hormonal contraception) or have the levonorgestrel-releasing (Mirena) IUD ☐ I was taking methadone/methodose ☐ My weight was too low / lost weight quickly ☐ I was an extreme athlete training extremely hard ☐ Other medications ☐ Other please specify: ☐ Don't know ☐ Prefer not to answer
Please specify other	_____
Did your period stop more than one year any other time?	◯ Yes ◯ No
Please collect any other age(s) and details	_____
If you counted all the periods you have missed throughout your menstruating years, how many months would that be? (this question asks for the cumulative time including pregnancy and breastfeeding)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
How many of the [prd_missed_cumulative] months above are from pregnancy or breastfeeding?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Has it currently been >1 year since your last menstrual period?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has your menstrual period started to change?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, at what age?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

How would you describe your current menstrual status as it relates to menopause?
Select one

- ◯ Premenopausal - I have normal menstrual periods or would have if not for pregnancy, breastfeeding or taking hormones → Premenopausal refers to the time BEFORE menopause has occurred
- ◯ Perimenopausal - my menstrual periods have started to change or I've started to have night sweats or hot flushes → Perimenopause is the transition life phase as our body prepares for menopause. It is a gradual process, which may start with night sweats and other changes before varying menstrual cycle lengths begin, and then ends with year after the final menstrual period. → Menopausal refers to the time when one year has passed since your last menstrual flow occurred.
- ◯ Menopausal - I have not had a menstrual period for at least 12 months
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever taken any of the following medications/done any of the following to manage hot flushes and/or night sweats?
Select all that apply

- ☐ Hormone Therapy (HT) or menopausal hormone therapy (MHT) - ie. Estrogen or Progesterone or Progestins (synthetic drugs that act like progesterone)
- ☐ Anti-depressants (list examples): (e.g. paroxetine, citalopram, escitalopram, venlafaxine)
- ☐ Clonidine
- ☐ Gabapentin
- ☐ Oxybutynin
- ☐ Exercise
- ☐ Natural health products/alternative medicines
- ☐ None
- ☐ Other, please specify:
- ☐ Don't Know
- ☐ Prefer not to answer

Please specify other

_____

What natural health products/alternative therapies have you used to treat hot flushes and night sweats
Select all that apply

- ☐ Black cohosh
- ☐ Dong quai
- ☐ Chinese herbs
- ☐ Evening primrose oil
- ☐ Flax seed
- ☐ St. John's wort
- ☐ Exercise, yoga
- ☐ Breathing techniques/meditation
- ☐ Wild yam cream (natural progesterone product)
- ☐ Acupuncture
- ☐ Other, please specify
- ☐ Don't Know
- ☐ Prefer not to answer

Please specify other

_____

Have you ever used estrogen pills, patches, creams, sprays, gels or injections for symptoms in menopause or perimenopause? (Includes combined and estrogen-only options)

- ◯ Yes, currently
- ◯ Yes, but not currently
- ◯ No

Why do you take it?
Select all that apply

- ☐ To prevent hot flushes
- ☐ Night sweats
- ☐ To help me sleep
- ☐ To help with vaginal or urine symptoms
- ☐ For joint pain
- ☐ For mood
- ☐ For libido/sexual desire
- ☐ Other, specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

You indicated you use estrogen to help with vaginal or urine symptoms.

Please select all that apply

- ☐ To prevent urinary track infection
- ☐ To make it easier to have my pap test done
- ☐ To make sex more enjoyable/comfortable
- ☐ To help prevent leakage of urine/incontinence
- ☐ To treat vaginal dryness / itchiness / soreness
- ☐ To get rid of symptoms of pain on urination or feeling like I need to urinate frequently
- ☐ Don't know
- ☐ Prefer not to answer

Why did you take it?
Select all that apply

- ☐ To prevent hot flushes
- ☐ Night sweats
- ☐ To help me sleep
- ☐ To help with vaginal or urine symptoms
- ☐ For joint pain
- ☐ For mood
- ☐ For libido/sexual desire
- ☐ Other, specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

You indicated you used estrogen to help with vaginal or urine symptoms.

Please select all that apply

- ☐ To prevent urinary track infection
- ☐ To make it easier to have my pap test done
- ☐ To make sex more enjoyable/comfortable
- ☐ To help prevent leakage of urine/incontinence
- ☐ To treat vaginal dryness / itchiness / soreness
- ☐ To get rid of symptoms of pain on urination or feeling like I need to urinate frequently
- ☐ Don't know
- ☐ Prefer not to answer

What type(s) did you use?

- ☐ Estrogen Pill
- ☐ Injection
- ☐ Applied to your skin - patch, cream, gel or spray (not your vagina)

Have you used the estrogen pill in the last month?

- ◯ Yes
- ◯ No

Have you received the estrogen injection in the last 3 months?

- ◯ Yes
- ◯ No

Have you applied any estrogen patches, creams, gels, or sprays in the last month?	◯ Yes ◯ No
For how long have you taken estrogen in perimenopause/menopause? Indicate unit (days/weeks/months/years) in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long have you taken estrogen? Indicate unit (days/weeks/months/years)	◯ days ◯ weeks ◯ months ◯ years
For how long did you take estrogen? Indicate unit (days/weeks/months/years) in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you take estrogen? Indicate unit (days/weeks/months/years)	◯ days ◯ weeks ◯ months ◯ years
Have you used vaginal estrogen for symptoms in menopause or perimenopause?	◯ Yes, currently ◯ Yes, but not currently ◯ No
Have you used vaginal estrogen in the last month?	◯ Yes ◯ No
What type(s) do you use?	☐ VAGINAL ESTROGEN CREAM (estrace, premarin) ☐ Vaginal tablet (Vagifem) ☐ VAGINAL RING (EstringR) ☐ Don't know ☐ Prefer not to answer
What type(s) did you use?	☐ VAGINAL ESTROGEN CREAM (estrace, premarin) ☐ Vaginal tablet (Vagifem) ☐ VAGINAL RING (EstringR) ☐ Don't know ☐ Prefer not to answer
Why do you use vaginal estrogen? Select all that apply	☐ to make sex more enjoyable/comfortable ☐ to treat vaginal dryness / itchiness /soreness ☐ to make it easier to have my pap test done ☐ to prevent urinary tract infection ☐ to help prevent leakage of urine/incontinence ☐ to get rid of symptoms of pain on urination or feeling like I need to urinate frequently ☐ Other _____ ☐ Don't know ☐ Prefer not to answer
Please specify other	_____

Why did you use vaginal estrogen? Select all that apply	☐ to make sex more enjoyable/comfortable ☐ to treat vaginal dryness / itchiness /soreness ☐ to make it easier to have my pap test done ☐ to prevent urinary tract infection ☐ to help prevent leakage of urine/incontinence ☐ to get rid of symptoms of pain on urination or feeling like I need to urinate frequently ☐ Other _____ ☐ Don't know ☐ Prefer not to answer
Please specify other	_____
Do you or did you ever take progesterone for symptoms in menopause or perimenopause?	◯ Yes, currently ◯ Yes, but not now ◯ No
Why do you take progesterone?	◯ Same reason(s) for taking estrogen ◯ Other reason(s)
You indicated that you use progesterone for reasons different than estrogen. Select all that apply	☐ To prevent hot flushes ☐ Night sweats ☐ To help me sleep ☐ To help with vaginal or urine symptoms ☐ For joint pain ☐ For mood ☐ For libido/sexual desire ☐ Other, specify: _____ ☐ Don't know ☐ Prefer not to answer
Please specify other	_____
You indicated you use progesterone to help with vaginal or urine symptoms. Please select all that apply	☐ To prevent urinary track infection ☐ To make it easier to have my pap test done ☐ To make sex more enjoyable/comfortable ☐ To help prevent leakage of urine/incontinence ☐ To treat vaginal dryness / itchiness / soreness ☐ To get rid of symptoms of pain on urination or feeling like I need to urinate frequently ☐ Don't know ☐ Prefer not to answer
Why did you take progesterone?	◯ Same reason(s) for taking estrogen ◯ Other reason(s)
You indicated that you used progesterone for reasons different than estrogen. Select all that apply	☐ To prevent hot flushes ☐ Night sweats ☐ To help me sleep ☐ To help with vaginal or urine symptoms ☐ For joint pain ☐ For mood ☐ For libido/sexual desire ☐ Other, please specify: _____ ☐ Don't know ☐ Prefer not to answer

Please specify other	_____
You indicated you used progesterone to help with vaginal or urine symptoms. Please select all that apply	☐ To prevent urinary track infection ☐ To make it easier to have my pap test done ☐ To make sex more enjoyable/comfortable ☐ To help prevent leakage of urine/incontinence ☐ To treat vaginal dryness / itchiness / soreness ☐ To get rid of symptoms of pain on urination or feeling like I need to urinate frequently ☐ Don't know ☐ Prefer not to answer
What type(s) did you use? Select all that apply	☐ Pill ☐ Injection ☐ Patch or Cream ☐ Don't know ☐ Prefer not to answer
Have you used the progesterone pill in the last 1 month?	◯ Yes ◯ No
Have you received the progesterone injection in the last 3 months?	◯ Yes ◯ No
Have you used the progesterone patch or cream in the last 1 month?	◯ Yes ◯ No
For how long have you taken progesterone? Indicate unit (days/weeks/months/years) in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long have you taken progesterone? Indicate unit (days/weeks/months/years)	◯ days ◯ weeks ◯ months ◯ years
For how long did you take progesterone? Indicate unit (days/weeks/months/years) in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you take progesterone? Indicate unit (days/weeks/months/years)	◯ days ◯ weeks ◯ months ◯ years
Have you ever discussed phases of menopause with your healthcare provider? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Did you feel supported with these discussions?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

The following is a list of symptoms that may affect us from time to time in our daily lives. Thinking back over the past two weeks, please indicate how frequently you experienced any of the following and how much you were bothered by the symptom. If "not at all", then skip to next symptom.

This section is part of a validated survey.

		Almost every day / night / 5-7 times a week	Often / 3-4 times a week	Sometimes / 1-2 times a week	Never	Prefer not to answer
a	...Hot flashes or flushes	○	○	○	○	○
b	...Stiffness or soreness in joints, neck, or shoulders	○	○	○	○	○
c	...Cold sweats	○	○	○	○	○
d	...Night sweats	○	○	○	○	○
e	...Vaginal dryness	○	○	○	○	○
f	...Feeling blue or depressed	○	○	○	○	○
g	...Irritability or grouchiness	○	○	○	○	○
h	...Feeling tense or nervous / anxious	○	○	○	○	○
i	...Forgetfulness	○	○	○	○	○
j	...Frequent mood changes	○	○	○	○	○
k	...Heart pounding or racing	○	○	○	○	○
l	...Bladder leaks	○	○	○	○	○
m	...Skin is crawling or itching	○	○	○	○	○
n	...More tired than usual	○	○	○	○	○
p	...Lack desire or interest in sexual activities	○	○	○	○	○
r	...Breast tenderness	○	○	○	○	○
s	...Fluid retention/bloating	○	○	○	○	○
u	...Sleep problems	○	○	○	○	○
v	...Vaginal or vulvar pain (not during sex)	○	○	○	○	○

Now, please rate the severity of how much you were bothered by the symptom you indicated you experienced.

		A lot	Moderately	Very little	Not at all	Prefer not to answer
a	...Hot flashes or flushes	○	○	○	○	○
b	...Stiffness or soreness in joints, neck or shoulder	○	○	○	○	○
c	...Cold sweats	○	○	○	○	○
d						

	...Night sweats	◯	◯	◯	◯	◯
e	...Vaginal dryness	◯	◯	◯	◯	◯
f	...Feeling blue or depressed	◯	◯	◯	◯	◯
g	...Irritability or grouchiness	◯	◯	◯	◯	◯
h	...Feeling tense or nervous / anxiety	◯	◯	◯	◯	◯
i	...Forgetfulness	◯	◯	◯	◯	◯
j	...Frequent mood changes	◯	◯	◯	◯	◯
k	...Heart pounding or racing	◯	◯	◯	◯	◯
l	...Bladder leaks	◯	◯	◯	◯	◯
m	...Skin is crawling or itching	◯	◯	◯	◯	◯
n	...More tired than usual	◯	◯	◯	◯	◯
p	...Lack desire or interest in sexual activities	◯	◯	◯	◯	◯
r	...Breast tenderness	◯	◯	◯	◯	◯
s	... Fluid retention/bloating	◯	◯	◯	◯	◯
u	...Sleep problems	◯	◯	◯	◯	◯
v	...Vaginal or vulvar pain (not during sex)	◯	◯	◯	◯	◯

In the past 6 months, have you experienced weight gain?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

In the past 6 months, have you experienced unwanted hair growth?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

In the past 6 months, have you experienced pain during intercourse?

◯ Never
◯ Occasionally
◯ Often
◯ Always
◯ Not applicable - not having sex
◯ Don't know
◯ Prefer not to answer

In the past 3 months, have you noticed changes in breast tenderness or lumpiness (nodularity)?

◯ No changes
◯ Decreasing
◯ Increasing
◯ Never or rarely have breast tenderness or lumpiness
◯ Don't know
◯ Prefer not to answer

If you know your biological family, do you have a biological mother or biological sister who became menopausal (> one year without flow) "naturally" before the age of 40?
Select one

◯ Don't know biological family
◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

We will now be asking you about surgeries you may or may not have had in the past. This section also includes questions about abortions. If there is something you prefer not to answer, you are welcome to select "prefer not to answer". We can take a break at any time.

Have you had your uterus removed? When part of or all of your uterus is removed, that is referred to as a hysterectomy.
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

When did you undergo this surgery (specify, 'The first time' if you have undergone multiple surgeries)?
Please indicate your age at the time of surgery.

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

In which country was the uterus removal surgery(s)/hysterectomy performed?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Did you personally wish for the surgery (hysterectomy) or was it the procedure recommended to you, or forced upon you by another person?

- ☐ I wanted the procedure
- ☐ The procedure was recommended to me
- ☐ The procedure was forced upon me
- ☐ The procedure was medically necessary
- ☐ Don't know
- ☐ Prefer not to answer

Was the uterus removal surgery done because of your HIV status?
Select one

- ◯ No, the procedure occurred before I was diagnosed with HIV
- ◯ No, the procedure was done for reasons other than my HIV status
- ◯ Yes, the procedure was because of my HIV status
- ◯ Don't know
- ◯ Prefer not to answer

Have you had your cervix removed (alone or as part of a total hysterectomy)?
Select one.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you had one or both ovaries removed (alone or as part of a total hysterectomy)?
Select one.

- ◯ Yes, one ovary removed
- ◯ Yes, both ovaries removed
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

If yes, at what age?
First ovary

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

If yes, at what age?

Second ovary

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Was the ovary removal surgery due to your HIV status?
Select one

- ◯ No, the procedure occurred before I was diagnosed with HIV
- ◯ No, the procedure was done for reasons other than my HIV status
- ◯ Yes, the procedure was because of my HIV status
- ◯ Don't know
- ◯ Prefer not to answer

Have you had a tubal ligation or tube removal (called a salpingectomy or as part of a total hysterectomy)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

In which country was the tubal ligation/tubal removal performed?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Did you personally wish for the tubal ligation/tubal removal or was it the procedure forced or coerced upon you by another person?

- ☐ I wanted the procedure
- ☐ The procedure was forced upon me
- ☐ The procedure was medically necessary
- ☐ Don't know
- ☐ Prefer not to answer

Was the procedure forced or coerced upon you due to your HIV status?
Select one

- ◯ No, the procedure occurred before I was diagnosed with HIV
- ◯ No, the procedure was done for reasons other than my HIV status
- ◯ Yes, the procedure was because of my HIV status
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever terminated a pregnancy?

- ☐ Yes, and it was my choice
- ☐ Yes. and it was recommended to me
- ☐ Yes, and I was forced/coerced to do so
- ☐ No
- ☐ No, it was recommended to me, but I chose not to
- ☐ Don't know
- ☐ Prefer not to answer

This next section is about pregnancies in your life, and children, including those in your care and those that may not be. In this study, we are hoping to better understand the complex associations between women's health and their personal life experiences. We have tried to make these questions as respectful as possible, and they have been peer-reviewed. You can stop or take a break at any time.

Are you currently pregnant?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever been pregnant? This includes all pregnancies, whether the outcome was a live birth, miscarriage, stillbirth, termination of pregnancy (abortion), or an ectopic/tubal pregnancy.
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times have you ever been pregnant (excluding your current pregnancy, if applicable)?

Indicate number of pregnancies:

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

(First Pregnancy) What was the outcome?

◯ Single live birth
◯ Multiple live births
◯ Miscarriage
◯ Stillbirth
◯ Pregnancy termination
◯ Ectopic pregnancy
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) How many live births occurred?

◯ Two
◯ Three
◯ Other, please specify

Please specify other

_____

(First Pregnancy) Was this a planned pregnancy?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy?
Select one

◯ Diagnosed before
◯ Diagnosed during
◯ Diagnosed after
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant?

Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)?

Indicate number of weeks

_____
(Enter 9999 if "Don't know", 7777 if "Prefer not to answer" and 8888 if not applicable (did not receive ART during this pregnancy))

(First Pregnancy) When did you deliver?

Indicate month and year of delivery

Note to interviewer: Enter 15 for day

_____
(Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

(First Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?

◯ Yes
◯ No (Didn't have a preterm delivery)
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

(First Pregnancy) Was the baby born in Canada?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all?
In the case of multiple live births, this question would apply for the first baby.

Select one

◯ Yes, tested at birth
◯ Yes, tested within 10 years of birth
◯ Yes, but not within 10 years of birth
◯ No, not that I know of
◯ No, because I had not been diagnosed with HIV yet
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) What was the final result of the HIV test?

Select one

◯ HIV-Positive
◯ HIV-Negative
◯ Testing underway
◯ Don't know
◯ Prefer not to answer

(First pregnancy) What was the biological sex of the first child?

Select one

◯ Male
◯ Female
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) Did your first child ever become a biological parent?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) If yes, how many children? (regardless of whether always with the same partner)

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

(First Pregnancy) How many of these children were twins?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

(First Pregnancy) Was your second baby tested for HIV at birth, within 10 years of birth, or not at all?
Select one

◯ Yes, tested at birth
◯ Yes, tested within 10 years of birth
◯ Yes, but not within 10 years of birth
◯ No, not that I know of
◯ No, because I had not been diagnosed with HIV yet
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) What was the final result of the HIV test for the second baby?

Select one

◯ HIV-Positive
◯ HIV-Negative
◯ Testing underway
◯ Don't know
◯ Prefer not to answer

(First pregnancy) What was the biological sex of the second child?

Select one

◯ Male
◯ Female
◯ Don't know
◯ Prefer not to answer

(First Pregnancy) Did your second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(First Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(First Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(First Pregnancy) Was your third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(First Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(First pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(First Pregnancy) Did your third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(First Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(First Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(First Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(First Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(First Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(First Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 9999 if "Don't know", 7777 if "Prefer not to answer" or 8888 if "Not Applicable, (did not receive ART during this pregnancy)")
(First Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(First Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(First Pregnancy) Additional Notes	_____ (Leave blank if none)
Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Second Pregnancy ◯ Not applicable - No further pregnancies to report
(Second Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Second Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Second Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Second Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Did your this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

(Second Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) Was your second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Second pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) Was your third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer

(Second pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Second Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Second Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Second Pregnancy) Additional Notes	_____ (Leave blank if none)

Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Third Pregnancy ◯ Not applicable - No further pregnancies to report
(Third Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Third Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Third Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer

(Third Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) Did this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) Was the second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Third pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer

(Third Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) Was the third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Third pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Third Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Third Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Third Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Third Pregnancy) Additional Notes	_____ (Leave blank if none)
Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Fourth Pregnancy ◯ Not applicable - No further pregnancies to report
(Fourth Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Fourth Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Fourth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 9999 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Fourth Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Did this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

(Fourth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) Was the second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Fourth pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) Was the third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer

(Fourth pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fourth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Fourth Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fourth Pregnancy) Additional Notes	_____ (Leave blank if none)

Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Fifth Pregnancy ◯ Not applicable - No further pregnancies to report
(Fifth Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Fifth Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 9999 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Fifth Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) Was this pregnancy a preterm delivery	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer

(Fifth Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) Did this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 "Prefer not to answer")
(Fifth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 "Prefer not to answer")
(Fifth Pregnancy) Was the second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Fifth pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer

(Fifth Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) Was your third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Fifth pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Fifth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Fifth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Fifth Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Fifth Pregnancy) Additional Notes	_____ (Leave blank if none)
Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Sixth Pregnancy ◯ Not applicable - No further pregnancies to report
(Sixth Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Sixth Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Sixth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Sixth Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Did this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

(Sixth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) Was the second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Sixth pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) Was your third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer

(Sixth pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Sixth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Sixth Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Sixth Pregnancy) Additional Notes	_____ (Leave blank if none)

Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Seventh Pregnancy ◯ Not applicable - No further pregnancies to report
(Seventh Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Seventh Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Seventh Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer

(Seventh Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) Did this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) Was the second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Seventh pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer

(Seventh Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) Was the third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Seventh pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Seventh Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Seventh Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Seventh Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Seventh Pregnancy) Additional Notes	_____ (Leave blank if none)
Note to interviewer: Proceed to the next pregnancy if applicable	◯ Proceed to Eighth Pregnancy ◯ Not applicable - No further pregnancies to report
(Eighth Pregnancy) What was the outcome?	◯ Single live birth ◯ Multiple live births ◯ Miscarriage ◯ Stillbirth ◯ Pregnancy termination ◯ Ectopic pregnancy ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) How many live births occurred?	◯ Two ◯ Three ◯ Other, please specify
Please specify other	_____
(Eighth Pregnancy) Was this a planned pregnancy?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer

(Eighth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 9999 if "N/A, did not receive ART during this pregnancy, 7777 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) When did you deliver? Indicate month and year of delivery Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Eighth Pregnancy) Was the baby born in Canada? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Was this pregnancy a preterm delivery (< 37 weeks)?	◯ Yes ◯ No (Didn't have a preterm delivery) ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) If yes to preterm delivery (< 37 weeks), indicate number of weeks:	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) Was your baby tested for HIV at birth, within 10 years of birth, or not at all? In the case of multiple live births, this question would apply for the first baby. Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) What was the final result of the HIV test? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) What was the biological sex of this child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Did this child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

(Eighth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) Was this second baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) What was the final result of the HIV test for the second baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer
(Eighth pregnancy) What was the biological sex of the second child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Did the second child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) Was your third baby tested for HIV at birth, within 10 years of birth, or not at all? Select one	◯ Yes, tested at birth ◯ Yes, tested within 10 years of birth ◯ Yes, but not within 10 years of birth ◯ No, not that I know of ◯ No, because I had not been diagnosed with HIV yet ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) What was the final result of the HIV test for the third baby? Select one	◯ HIV-Positive ◯ HIV-Negative ◯ Testing underway ◯ Don't know ◯ Prefer not to answer

(Eighth pregnancy) What was the biological sex of the third child? Select one	◯ Male ◯ Female ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Did the third child ever become a biological parent? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) If yes, how many children? (regardless of whether always with the same partner)	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) How many of these children were twins?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) Was this a planned pregnancy? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Were you diagnosed with HIV before, during, or after this pregnancy? Select one	◯ Diagnosed before ◯ Diagnosed during ◯ Diagnosed after ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) Were you on HIV antiretroviral therapy (ART) before you became pregnant? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
(Eighth Pregnancy) How many weeks pregnant were you when you started antiretroviral therapy (ART)? Indicate number of weeks	_____ (Enter 8888 if "N/A, did not receive ART during this pregnancy, 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) When did the pregnancy end? Indicate month and year Note to interviewer: Enter 15 for day	_____ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
(Eighth Pregnancy) How many weeks had you been pregnant when the pregnancy ended? Indicate number of weeks	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
(Eighth Pregnancy) Additional Notes	_____ (Leave blank if none)

Note to Interviewer: If participant has more than 8 pregnancies, please collect information in the paragraph box

_____

Thank you for completing the questions on pregnancy history. We understand they can be very difficult to answer. Your answers are very valuable to help us learn more about and how to support the reproductive health of women.

The next section is about reproductive goals and access to reproductive services. Some of the questions may be applicable to you, and others may not be. You can select prefer not to answer if you do not want to answer anything. Your answers are important to help us learn more about women's reproductive choice and support.

Have you ever been diagnosed with or treated for infertility, or tried for 2 or more years and been unable to get pregnant?

- ◯ Yes
- ◯ No
- ◯ Don't Know
- ◯ Prefer not to answer

What was the reason?
Select all that apply

- ☐ Hormone or ovulation problem
- ☐ Tubal blockage or abdominal pain
- ☐ Problem with your partners fertility
- ☐ Other, please specify

Please specify other

_____

Did you access any fertility services to help you become pregnant?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Which fertility services did you use while trying to get pregnant?

Select all that apply

- ☐ Sperm or egg donation
- ☐ Fertility enhancing drugs prescribed by a doctor
- ☐ Artificial insemination or intrauterine insemination
- ☐ Assisted reproductive technology
- ☐ Male infertility treatment options
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Did you know whether the other biological parent (i.e. father, sperm donor) was HIV-negative, HIV-positive, or unknown HIV status before your current or most recent pregnancy?
Select one

- ◯ Other biological parent HIV-positive and participant diagnosed before pregnancy
- ◯ Other biological parent HIV-positive and participant diagnosed during or after pregnancy
- ◯ Other biological parent HIV-positive and control participant (HIV-negative)
- ◯ Other biological parent HIV-negative and participant diagnosed before pregnancy
- ◯ Other biological parent HIV-negative and participant diagnosed during or after pregnancy
- ◯ Other biological parent HIV status unknown and participant diagnosed before pregnancy
- ◯ Other biological parent HIV status unknown and participant diagnosed during or after pregnancy
- ◯ BOTH biological parent and participant (control) are HIV negative
- ◯ Not applicable - HIV was not yet discovered when I was last pregnant
- ◯ Don't know
- ◯ Prefer not to answer

Did you and/or the other biological parent do anything around the time you got pregnant to reduce the risk of the other biological parent from acquiring HIV?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Did you and/or the other biological parent do anything around the time you got pregnant to reduce the risk of you acquiring HIV?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Can you tell me what you did?
Select all that apply.

- ☐ Sperm washing
- ☐ Sperm donation
- ☐ Home, manual insemination (e.g., 'turkey baster method')
- ☐ Restricted condomless sex to most fertile times (e.g., 'timed ovulation')
- ☐ The HIV-negative sexual partner used pre-exposure prophylaxis with ART (PrEP)
- ☐ Waited to have condomless sex until HIV-positive sexual partner was on ART and virally suppressed (U=U)
- ☐ Artificial insemination or intrauterine insemination at a fertility clinic
- ☐ Used other assisted reproductive services from a fertility clinic, which may include in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or donor embryo transfer.
- ☐ Other, please specify:_____
- ☐ Don't know [exclusive]
- ☐ Prefer not to answer [exclusive]

Please specify other

_____

Are you aware of the Canadian HIV Pregnancy Planning Guidelines (published in 2012 and updated in 2018)? These are guidelines to support people living with or affected by HIV who want to become parents.

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Have you ever consulted these guidelines to inform your decisions around becoming a parent?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Did your provider ever discuss these guidelines with you to support your decisions around becoming a parent?"
Select one

- ◯ Yes
- ◯ No
- ◯ No, these guidelines were not available when I had my children
- ◯ Don't Know
- ◯ Prefer not to answer

Have you ever discussed your reproductive goals with a healthcare provider?
Select one

- ◯ Yes
- ◯ No
- ◯ Not applicable - unable / don't want to have children
- ◯ Don't know
- ◯ Prefer not to answer

Since knowing your HIV status, have you ever discussed your reproductive goals with a healthcare provider?
Select one

- ◯ Yes
- ◯ No
- ◯ Not applicable - unable / don't want to have children
- ◯ Don't know
- ◯ Prefer not to answer

Did this healthcare provider know your HIV status?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you currently have a healthcare provider with whom you feel comfortable talking to about your reproductive goals?
Select one

- ◯ Yes
- ◯ No
- ◯ Not applicable - unable / don't want to have children
- ◯ Don't know
- ◯ Prefer not to answer

When was the last time you discussed your reproductive goals with a healthcare provider?
Select one

- ◯ Within the last year
- ◯ 1 - 3 years ago
- ◯ 3 - 5 years ago
- ◯ 5 years ago or more
- ◯ Don't know
- ◯ Prefer not to answer

Thinking about the last time you discussed your reproductive goals with a healthcare provider, who initiated the conversation?
Select one

- ◯ You
- ◯ Your sexual partner
- ◯ Nurse
- ◯ Family doctor
- ◯ HIV specialist
- ◯ Obstetrics and gynecology doctor
- ◯ Counsellor
- ◯ Other please specify:
- ◯ Don't know
- ◯ Prefer not to answer

Please specify other

_____

Do you intend to become pregnant in the future?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

When in the future do you intend to become pregnant?
Select one

- ◯ I'd like to get pregnant now
- ◯ Not now, but within 1 year
- ◯ In 1 to 2 years from now
- ◯ In 3 to 4 years from now
- ◯ More than 4 years from now
- ◯ Don't know
- ◯ Prefer not to answer

Which of the following contraceptive methods have you ever used?
Select one response per line.

		Yes	No	Don't know	Prefer not to answer
a	an oral contraceptive, also known as 'the pill'	◯	◯	◯	◯
b	an injection, also known as 'Depo-provera'	◯	◯	◯	◯
c	NuvaRing, a vaginal ring containing hormone that you insert once a month	◯	◯	◯	◯
d	a contraceptive patch, also known as Ortho Evra and used once a week	◯	◯	◯	◯
e	an intrauterine device, also known as an "IUD" or "Copper IUD"	◯	◯	◯	◯
f	an Intrauterine System, also known as an "IUS" or "Mirena" (releases hormones)	◯	◯	◯	◯
g	an Implanon, also known as a "progestin implantable contraceptive under the skin	◯	◯	◯	◯
h					

	condoms (female and/or male)	◯	◯	◯	◯
i	any emergency contraception, commonly known as "Plan B", "the morning after pill"	◯	◯	◯	◯
j	Basal body temperature with other measures to know when you are fertile	◯	◯	◯	◯
k	Any other contraceptive methods (i.e. withdrawal; please specify: _____)	◯	◯	◯	◯
l	Other traditional methods (please specify:_____)	◯	◯	◯	◯

At what age did you start the oral contraceptive, also known as 'the pill'?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For how long did you use the oral contraceptive, also known as 'the pill'?

Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For how long did you use the oral contraceptive, also known as 'the pill'?

Specify unit (days/weeks/months/years) from drop-down list

◯ days
◯ weeks
◯ months
◯ years

What reasons did you use the oral contraceptive, also known as 'the pill' for?
Select all that apply

☐ contraception: to prevent pregnancy
☐ to treat premenstrual symptoms
☐ to treat heavy menstrual flow or abnormal bleeding
☐ to treat severe menstrual cramps (dysmenorrhea)
☐ to treat irregular or infrequent cramps
☐ to treat acne or unwanted facial or body hair
☐ to treat irregular or infrequent periods
☐ other, please specify

Please specify other

_____

At what age did you start the injection, also known as 'Depo-provera'?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For how long did you use the injection, also known as 'Depo-provera'?

Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For how long did you use the injection, also known as 'Depo-provera'? Specify unit (days/weeks/months/years) from drop-down list	◯ days ◯ weeks ◯ months ◯ years
What reasons did you use the injection, also known as 'Depo-provera' for? Select all that apply	☐ contraception: to prevent pregnancy ☐ to treat premenstrual symptoms ☐ to treat heavy menstrual flow or abnormal bleeding ☐ to treat severe menstrual cramps (dysmenorrhea) ☐ to treat irregular or infrequent cramps ☐ to treat acne or unwanted facial or body hair ☐ to treat irregular or infrequent periods ☐ other, please specify
Please specify other	_____
At what age did you start the NuvaRing?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the NuvaRing? Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the NuvaRing? Specify unit (days/weeks/months/years) from drop-down list	◯ days ◯ weeks ◯ months ◯ years
What reasons did you use the NuvaRing for? Select all that apply	☐ contraception: to prevent pregnancy ☐ to treat premenstrual symptoms ☐ to treat heavy menstrual flow or abnormal bleeding ☐ to treat severe menstrual cramps (dysmenorrhea) ☐ to treat irregular or infrequent cramps ☐ to treat acne or unwanted facial or body hair ☐ to treat irregular or infrequent periods ☐ other, please specify
Please specify other	_____
At what age did you start the contraceptive patch, also known as Ortho Evra?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the contraceptive patch, also known as Ortho Evra? Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For how long did you use the contraceptive patch, also known as Ortho Evra? Specify unit (days/weeks/months/years) from drop-down list	◯ days ◯ weeks ◯ months ◯ years
What reasons did you use the contraceptive patch, also known as Ortho Evra for? Select all that apply	☐ contraception: to prevent pregnancy ☐ to treat premenstrual symptoms ☐ to treat heavy menstrual flow or abnormal bleeding ☐ to treat severe menstrual cramps (dysmenorrhea) ☐ to treat irregular or infrequent cramps ☐ to treat acne or unwanted facial or body hair ☐ to treat irregular or infrequent periods ☐ other, please specify
Please specify other	_____
At what age did you start the intrauterine device, also known as an "IUD" or "Copper IUD"?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
What reasons did you use the intrauterine device, also known as an "IUD" or "Copper IUD" for? Select all that apply	☐ contraception: to prevent pregnancy ☐ to treat premenstrual symptoms ☐ to treat heavy menstrual flow or abnormal bleeding ☐ to treat severe menstrual cramps (dysmenorrhea) ☐ to treat irregular or infrequent cramps ☐ to treat acne or unwanted facial or body hair ☐ to treat irregular or infrequent periods ☐ other, please specify
Please specify other	_____
At what age did you start the Intrauterine System, also known as an "IUS" or "Mirena"?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the Intrauterine System, also known as an "IUS" or "Mirena"? Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the Intrauterine System, also known as an "IUS" or "Mirena"? Specify unit (days/weeks/months/years) from drop-down list	◯ days ◯ weeks ◯ months ◯ years

What reasons did you use the Intrauterine System, also known as an "IUS" or "Mirena"? for? Select all that apply	☐ contraception: to prevent pregnancy ☐ to treat premenstrual symptoms ☐ to treat heavy menstrual flow or abnormal bleeding ☐ to treat severe menstrual cramps (dysmenorrhea) ☐ to treat irregular or infrequent cramps ☐ to treat acne or unwanted facial or body hair ☐ to treat irregular or infrequent periods ☐ other, please specify
Please specify other	_____
At what age did you start the Implanon?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the Implanon? Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
For how long did you use the Implanon? Specify unit (days/weeks/months/years) from drop-down list	◯ days ◯ weeks ◯ months ◯ years
What reasons did you use the Implanon? Select all that apply	☐ contraception: to prevent pregnancy ☐ to treat premenstrual symptoms ☐ to treat heavy menstrual flow or abnormal bleeding ☐ to treat severe menstrual cramps (dysmenorrhea) ☐ to treat irregular or infrequent cramps ☐ to treat acne or unwanted facial or body hair ☐ to treat irregular or infrequent periods ☐ other, please specify
Please specify other	_____
At what age did you start using condoms?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
At what age did you start the emergency contraception, commonly known as "Plan B", "the morning after pill"?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
How many times did you use the emergency contraception, commonly known as "Plan B", "the morning after pill"?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
At what age did you consider your basal body temperature with other measures to know when you are fertile?	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

What is the "other" contraceptive method you mentioned you used?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

At what age did you start [contra_hxk_specify]?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Please specify the traditional method

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

At what age did you start the [contra_hxl_specify]?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Have you ever been sufficiently bothered by severe acne and/or unwanted face or body hair to consult a physician for treatment?

◯ Yes
◯ No

At what age did you consult a physician for treatment?

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

In the past six months have you used any of the following?
Select all that apply.

☐ NONE
☐ Oral contraceptive (e.g,. "the pill")
☐ Injection - Depo-provera
☐ Implanon - progesting implantable contraception
☐ Male condoms
☐ Female condoms
☐ Conscious abstinence from biological male partners for past 6 months
☐ Rhythm method/Withdrawal method
☐ Intrauterine Device (e.g., "IUD", "Copper IUD")
☐ Intrauterine System (e.g., "IUS", Mirena)
☐ Diaphragm (i.e., cervical cap)
☐ Vaginal cream/Jellies/Foams
☐ The sponge
☐ NuvaRing (i.e., a vaginal ring containing hormone that you insert once a month)
☐ Contraceptive patch (also known as Ortho Evra and used once a week)
☐ Emergency contraception (e.g., "Plan B", "The morning after pill", Ovral, Preven)
☐ Male sterilization/Vasectomy
☐ Hysterectomy
☐ Tubal ligation
☐ Spermicides / lube-lubricant
☐ Not currently having sex
☐ Other, please specify: _____
☐ Don't know [exclusive]
☐ Prefer not to answer [exclusive]

Have you used the oral contraceptive (eg. "the pill") in the past 1 month?

◯ Yes
◯ No

Are you currently using the oral contraceptive (e.g. "the pill)?

- ◯ Yes
- ◯ No

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Are you currently using Depo-provera?

- ◯ Yes
- ◯ No

When was your last Depo Provera injection?

_____

(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Have you used the implanon in the past 1 month?

- ◯ Yes
- ◯ No

Are you currently using the implanon?

- ◯ Yes
- ◯ No

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

In the past six months, how often did your male partner use condoms during sex?
Select one

- ◯ Always (100% of the time)
- ◯ Usually (Over 75% of the time)
- ◯ Sometimes (Between 25% and 75% of the time)
- ◯ Occasionally (Less than 25% of the time)
- ◯ None of the time (0% of the time)
- ◯ Don't know
- ◯ Prefer not to answer

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

In the past six months, how often were female condoms used during sex?
Select one

- ◯ Always (100% of the time)
- ◯ Usually (Over 75% of the time)
- ◯ Sometimes (Between 25% and 75% of the time)
- ◯ Occasionally (Less than 25% of the time)
- ◯ None of the time (0% of the time)
- ◯ Don't know
- ◯ Prefer not to answer

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

Are you currently using the Intrauterine System (e.g., "IUS", Mirena)?

- ◯ Yes
- ◯ No

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Have you used the NuvaRing in the past 1 month?

◯ Yes
◯ No

Are you currently using the NuvaRing?

◯ Yes
◯ No

For which of the following reasons did you use this method?

Select all that apply

☐ Birth control
☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
☐ To control acne or unwanted facial or body hair
☐ To control my menstrual period
☐ To treat heavy menstrual flow or abnormal bleeding
☐ To treat severe menstrual cramps (dysmenorrhea)
☐ To treat irregular or infrequent cramps
☐ For treatment of perimenopausal symptoms
☐ Other, please specify:
☐ Don't know
☐ Prefer not to answer

Please specify other

_____

Have you used the contraceptive patch in the past 1 month?

◯ Yes
◯ No

Are you currently using the contraceptive patch?

◯ Yes
◯ No

For which of the following reasons did you use this method?

Select all that apply

☐ Birth control
☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
☐ To control acne or unwanted facial or body hair
☐ To control my menstrual period
☐ To treat heavy menstrual flow or abnormal bleeding
☐ To treat severe menstrual cramps (dysmenorrhea)
☐ To treat irregular or infrequent cramps
☐ For treatment of perimenopausal symptoms
☐ Other, please specify:
☐ Don't know
☐ Prefer not to answer

Please specify other

_____

Have you used the emergency contraception (e.g. Plan B, the morning after pill) in the past 1 month?

◯ Yes
◯ No

How many times have you taken emergency contraception (Plan B or the morning after pill) during the last 6 months?

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

For which of the following reasons did you use hysterecomy as a method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

For which of the following reasons did you use tubal ligation as a method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

For which of the following reasons did you use this method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Please specify the "other" contraception method

_____

For which of the following reasons did you use [contraothspecify] as a method?

Select all that apply

- ☐ Birth control
- ☐ To avoid getting or giving sexually transmitted infections (e.g., to practice safer sex)
- ☐ To control acne or unwanted facial or body hair
- ☐ To control my menstrual period
- ☐ To treat heavy menstrual flow or abnormal bleeding
- ☐ To treat severe menstrual cramps (dysmenorrhea)
- ☐ To treat irregular or infrequent cramps
- ☐ For treatment of perimenopausal symptoms
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

Overall, how satisfied are you with your current contraceptive or safer sex method(s)?

Select one

- ◯ Extremely satisfied
- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied
- ◯ Extremely dissatisfied
- ◯ Don't know
- ◯ Prefer not to answer

Would you prefer to use different contraceptive or safer sex method(s) other than the one(s) you are currently using?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What method(s) would you prefer to use?
Select all that apply.

- ☐ Oral contraceptive (e.g,. "the pill")
- ☐ Injection (i.e., Depo-provera)
- ☐ Implanon (i.e., progestin implantable contraceptive)
- ☐ Male condoms
- ☐ Female condoms
- ☐ Conscious abstinence from biological male partners for past 6 months
- ☐ Rhythm method/Withdrawal method
- ☐ Intrauterine Device (e.g., "IUD", "Copper IUD")
- ☐ Intrauterine System (e.g., "IUS", Mirena)
- ☐ Diaphragm (i.e., cervical cap)
- ☐ Vaginal cream/Jellies/Foams
- ☐ The sponge
- ☐ NuvaRing (i.e., a vaginal ring containing hormone that you insert once a month)
- ☐ Contraceptive patch (also known as Ortho Evra and used once a week)
- ☐ Emergency contraception (e.g., "Plan B", "The morning after pill", Ovral, Preven)
- ☐ Male sterilization/Vasectomy
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Spermicides / lube-lubricant
- ☐ Other, please specify: _____
- ☐ Don't know [exclusive]
- ☐ Prefer not to answer [exclusive]

Please specify other

_____

What is the most important reason you do not use your preferred method?
Select one

- ◯ Doctor will not prescribe it
- ◯ Cost
- ◯ Not available/difficult to access/unreliable source
- ◯ Spouse or partner objects to it
- ◯ Religious reasons
- ◯ Fear of side effects
- ◯ Still thinking about it/have not made up my mind
- ◯ Difficult to use
- ◯ Fear of the procedure (IUD, tubal ligation, Norplant)
- ◯ Other, please specify: _____
- ◯ Don't know
- ◯ Prefer not to answer

Please specify other

_____

What are the main reasons that you have not used contraception in the past 6 months? Select all that apply, even if the reasons have changed over the past 6 months.	☐ I am currently pregnant ☐ I am trying to become pregnant ☐ I don't mind becoming pregnant ☐ I don't believe in using birth control ☐ I don't think I would become pregnant ☐ I cannot become pregnant ☐ I cannot become pregnant because my sexual partner is infertile ☐ I use the withdrawal or rhythm method ☐ I don't like using contraception ☐ I don't use contraception for religious reasons ☐ My sexual partner doesn't like using contraception ☐ My sexual partner refuses to use/will not let me use contraception ☐ I am not having sex with a biological man (e.g., my sexual partner is a woman, transman, etc.) ☐ I am not having any sex ☐ I am in a mutually faithful sexual relationship ☐ I knew my partner and I had the same HIV status (e.g., "we are both HIV-positive") ☐ I am undetectable / adherent to meds and I didn't think I could transmit HIV to others ☐ I thought my partner(s) was/were at low risk of getting HIV or AIDS ☐ Other, please specify: _____ ☐ Don't know ☐ Prefer not to answer
Please specify other	_____

BCC3 Substance Use

Please complete the survey below.

Thank you!

This section will ask about your potential use of alcohol, tobacco, cannabis, and other substances. This includes prescription medications used differently than for which they were prescribed.

Your lived experiences are very valuable in helping us understand the factors that affect women's health and aging. We understand that some of these questions may be sensitive or difficult to answer. Please know that your responses are completely confidential.

Have you EVER used cigarettes/tobacco, alcohol, or drugs recreationally (non-medicinally)? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you ever smoked cigarettes regularly? If so, did you smoke cigarettes within the past 3 months?	◯ Yes, within the last 3 months ◯ Yes, more than 3 months ago ◯ Never

How old were you when you first started smoking cigarettes?

- ◯ Don't know
- ◯ Prefer not to answer
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10
- ◯ 11
- ◯ 12
- ◯ 13
- ◯ 14
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◯ 97
◯ 98
◯ 99
◯ 100
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Please specify the frequency of current cigarette use.
Select one

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Don't know
◯ Prefer not to answer

Please specify the quantity of current cigarettes smoked [prsnt_freq_pack_yrs].

*In BC, most packs sold have 20 cigarettes.

◯ 1
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◯ 3
◯ 4
◯ 5
◯ 6
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◯ 8
◯ 9
◯ 10
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◯ 12
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(cigarettes)

For how long have you smoked [prsnt_qty_pack_yrs] cigarettes [prsnt_freq_pack_yrs] for?

Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question

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	◯ 70 ◯ 71 ◯ 72 ◯ 73 ◯ 74 ◯ 75 ◯ 76 ◯ 77 ◯ 78 ◯ 79 ◯ 80 ◯ 81 ◯ 82 ◯ 83 ◯ 84 ◯ 85 ◯ 86 ◯ 87 ◯ 88 ◯ 89 ◯ 90 ◯ 91 ◯ 92 ◯ 93 ◯ 94 ◯ 95 ◯ 96 ◯ 97 ◯ 98 ◯ 99 ◯ 100 (Specify days/weeks/months/years in the next question)
Please specify the units (days/weeks/months/years) for the previous question from drop-down list	◯ days ◯ weeks ◯ months ◯ years
Looking at your entire smoking history as a whole, how many times did you abstain from smoking cigarettes for a period of more than 3 months?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6-10 ◯ >10 ◯ 0 ◯ Don't know ◯ Prefer not to Answer

Considering all of your years smoking since the age that you started, the following questions will ask you for an average of cigarettes daily, weekly, monthly or yearly, whichever applies to you. We're looking for one number that represents your best estimate over this period of time.

Please specify the average frequency of total cigarette use. Select one	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Don't know ◯ Prefer not to answer

Please specify the average quantity of total [pstfreq_pack_yrs1] cigarettes smoked.

*In Canada, most packs sold have 20 cigarettes.

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(cigarettes)

How many total years have you smoked cigarettes?

This does not include years that you stopped or quit smoking.

_____

How many years has it been since you stopped smoking cigarettes?

_____

Any additional information not captured above in regards to cigarette smoking?

_____

End of smoking questions.

Have you ever drank alcohol? If so, did you drink alcohol within the last 3 months?

◯ Yes, within 3 months
◯ Yes, but more than 3 months ago
◯ No, never

How old were you when you first started drinking?

- ◯ Don't know
- ◯ Prefer not to answer
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- ◯ 100

Please specify the frequency of current alcohol use
Select one

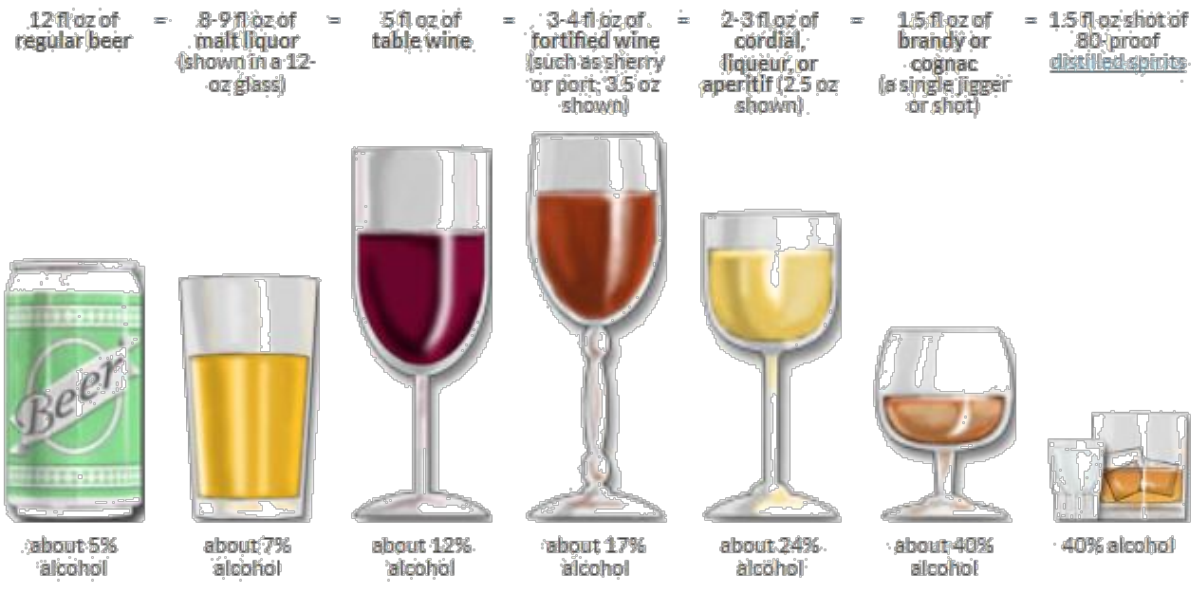
- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Yearly
- ◯ Don't know
- ◯ Prefer not to answer

What's a "standard" drink?

Although the drinks pictured here are different sizes, each contains approximately the same amount of alcohol and counts as one U.S. standard drink or one alcoholic drink-equivalent.

Bottle of Wine = 5 drinks

Bottle of Spirits = 17 drinks



Please specify the quantity of current [prsnt_freq_drnk_yrs] alcohol use

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(drinks)

For how long have you drank [prsnt_qty_drnk_yrs] drinks of alcohol [prsnt_freq_drnk_yrs] for?

Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
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	◯ 70 ◯ 71 ◯ 72 ◯ 73 ◯ 74 ◯ 75 ◯ 76 ◯ 77 ◯ 78 ◯ 79 ◯ 80 ◯ 81 ◯ 82 ◯ 83 ◯ 84 ◯ 85 ◯ 86 ◯ 87 ◯ 88 ◯ 89 ◯ 90 ◯ 91 ◯ 92 ◯ 93 ◯ 94 ◯ 95 ◯ 96 ◯ 97 ◯ 98 ◯ 99 ◯ 100 (Specify days/weeks/months/years in the next question)
Please specify the units (days/weeks/months/years) for the previous question from drop-down list	◯ days ◯ weeks ◯ months ◯ years

Considering all of your years drinking alcohol between now and the age that you started, we'd like to ask you for an average of drinks daily, weekly, monthly or yearly whichever is accurate for you. We're looking for one number that represents your best estimate over your entire drinking history.

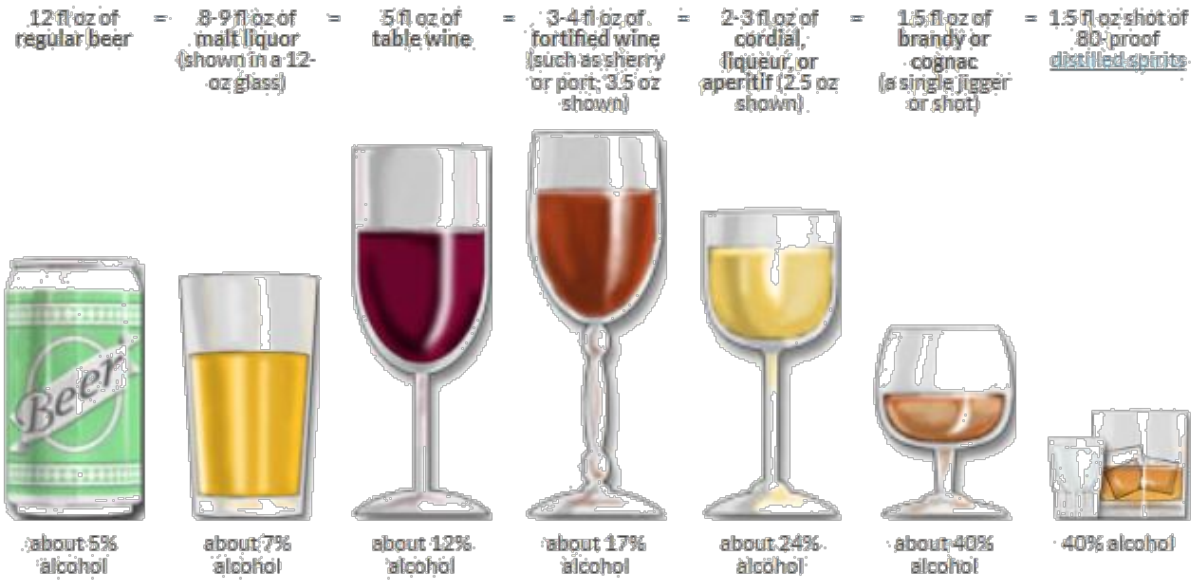
Please specify the average frequency of total alcohol use? Select one	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Don't know ◯ Prefer not to answer

What's a "standard" drink?

Although the drinks pictured here are different sizes, each contains approximately the same amount of alcohol and counts as one U.S. standard drink or one alcoholic drink-equivalent.

Bottle of Wine = 5 drinks

Bottle of Spirits = 17 drinks



Please specify the average quantity of total [pstfreq_drnk_yrs1] alcohol use

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(drinks)

How many total years have you drank alcohol?

_____

How many years has it been since you stopped drinking alcohol?

_____

Any additional information not captured above in regards to alcohol use

_____

Are you currently using or have you ever used any of the following substances? Select all that apply.

	Daily	Weekly	Monthly	Yearly	Less than once a year	No current use (past 3 months), but has used and quit in the past	No current use, but tried once in the past	Never - no current or past use	Don't know	Prefer not to answer

Tobacco (ALTERNATE forms other than smoking cigarettes)	○	○	○	○	○	○	○	○	○	○
CBD (oils, edible, topical)	○	○	○	○	○	○	○	○	○	○
Cannabis (THC, joints, edibles)	○	○	○	○	○	○	○	○	○	○
Heroin (dust, horse, junk, down, or downtown)	○	○	○	○	○	○	○	○	○	○
Heroin + Cocaine (speedballs)	○	○	○	○	○	○	○	○	○	○
Cocaine alone (uptown, up)	○	○	○	○	○	○	○	○	○	○
Crack (rock, freebase cocaine)	○	○	○	○	○	○	○	○	○	○
Methamphetamine (crystal meth, ice, jib, gak)	○	○	○	○	○	○	○	○	○	○
Benzodiazepine	○	○	○	○	○	○	○	○	○	○
Dilaudid (hydromorphone, hydrochloride)	○	○	○	○	○	○	○	○	○	○
OxyContin/OxyCodone/OxyNeo	○	○	○	○	○	○	○	○	○	○
Morphine	○	○	○	○	○	○	○	○	○	○
Methadone (methadose)	○	○	○	○	○	○	○	○	○	○
Talwin & Ritalin (T&Rs)	○	○	○	○	○	○	○	○	○	○
T3s T4s (codeine) or any over-the-counter drug containing codeine not as prescribed.	○	○	○	○	○	○	○	○	○	○
Ecstasy equivalent (x-tasy, E.X)	○	○	○	○	○	○	○	○	○	○
Gabapentin	○	○	○	○	○	○	○	○	○	○
MDA (Sassafras, Sally)	○	○	○	○	○	○	○	○	○	○
Speed (amphetamines, uppers)	○	○	○	○	○	○	○	○	○	○
Acid (LSD, PCP, angel dust)	○	○	○	○	○	○	○	○	○	○
Mushrooms (magic mushrooms, mush)	○	○	○	○	○	○	○	○	○	○
Ketamine (special K)	○	○	○	○	○	○	○	○	○	○
Sleeping pills	○	○	○	○	○	○	○	○	○	○
Fentanyl or Carfentanil	○	○	○	○	○	○	○	○	○	○
Other	○	○	○	○	○	○	○	○	○	○

The next section will ask about current frequency or past duration of use for each individual substance indicated above. We are looking for numbers that represent your best estimate.

Please specify the frequency of your past tobacco use (alternate forms other than smoking cigarettes).

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Yearly
- ○ Less than once a year
- ○ Don't know
- ○ Prefer not to answer

How many years has it been since you stopped using tobacco (alternate forms other than smoking cigarettes).	_____
How many total years have you used tobacco (alternate forms other than smoking cigarettes)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past marijuana (CBD) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using CBD?	_____
How many total years have you used marijuana (CBD)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past marijuana (THC) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using marijuana (THC)?	_____
How many total years have you used marijuana (THC)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past heroin use	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using heroin?	_____
How many total years have you used heroin?	_____ (This does not include years where you stopped or quit.)

Please specify the frequency of your past heroin + cocaine (speedballs) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using heroin + cocaine (speedballs)?	_____
How many total years have you used heroin + cocaine (speedballs)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past cocaine use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using cocaine?	_____
How many total years have you used cocaine?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past crack use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using crack?	_____
How many total years have you used crack?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past methamphetamine (crystal meth, ice, jib, gak) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using methamphetamine (crystal meth, ice, jib, gak)?	_____

How many total years have you used methamphetamine (crystal meth, ice, jib, gak)?

_____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past benzodiazepine use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using benzodiazepine?

_____

How many total years have you used benzodiazepine?

_____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past dilaudid (hydromorphone, hydrochloride) use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using dilaudid (hydromorphone, hydrochloride)?

_____

How many total years have you used dilaudid (hydromorphone, hydrochloride)?

_____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past OxyContin/ OxyCodone/ OxyNeo use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using OxyContin/ OxyCodone/ OxyNeo?

_____

How many total years have you used OxyContin/ OxyCodone/ OxyNeo?

_____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past morphine use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using morphine?	_____
How many total years have you used morphine?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past methadone (methadose) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using methadone (methadose)?	_____
How many total years have you used methadone (methadose)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past talwin & ritalin (T&Rs) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using talwin & ritalin (T&Rs)?	_____
How many total years have you used talwin & ritalin (T&Rs)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past use of T3s, T4s (codeine) or any other over-the-counter drug containing codeine not as prescribed.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using T3s, T4s (codeine) or any other over-the-counter drug containing codeine not as prescribed?	_____

How many total years have you used T3s, T4s (codeine) or any other over-the-counter drug containing codeine not as prescribed?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past ecstasy equivalent x-tasy, E.X) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using ecstasy equivalent x-tasy, E.X)?	_____
How many total years have you used ecstasy equivalent x-tasy, E.X)?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past gabapentin use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using gabapentin?	_____
How many total years have you used gabapentin?	_____ (This does not include years where you stopped or quit.)
Please specify the frequency of your past MDA (Sassafras, Sally) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using MDA (Sassafras, Sally)?	_____
How many total years have you used MDA (Sassafras, Sally)?	_____ (This does not include years where you stopped or quit.)

Please specify the frequency of your past speed (amphetamines, uppers) use.

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Yearly
- ◯ Less than once a year
- ◯ Don't know
- ◯ Prefer not to answer

How many years has it been since you stopped using speed (amphetamines, uppers)?

_____

How many total years have you used speed (amphetamines, uppers)?

_____

(This does not include years where you stopped or quit.)

Please specify the frequency of your past acid (LSD, PCP, angel dust) use.

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Yearly
- ◯ Less than once a year
- ◯ Don't know
- ◯ Prefer not to answer

How many years has it been since you stopped using acid (LSD, PCP, angel dust)?

_____

How many total years have you used acid (LSD, PCP, angel dust)?

_____

(This does not include years where you stopped or quit.)

Please specify the frequency of your past mushrooms (magic mushrooms, mush) use.

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Yearly
- ◯ Less than once a year
- ◯ Don't know
- ◯ Prefer not to answer

How many years has it been since you stopped using mushrooms (magic mushrooms, mush)?

_____

How many total years have you used mushrooms (magic mushrooms, mush)?

_____

(This does not include years where you stopped or quit.)

Please specify the frequency of your past ketamine (special K) use.

- ◯ Daily
- ◯ Weekly
- ◯ Monthly
- ◯ Yearly
- ◯ Less than once a year
- ◯ Don't know
- ◯ Prefer not to answer

How many years has it been since you stopped using ketamine (special K)?

_____

How many total years have you used ketamine (special K)?

_____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past sleeping pills use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using sleeping pills?

_____

How many total years have you used sleeping pills?

_____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past fentanyl or carfentanil use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using fentanyl or carfentanil?

_____

How many total years have you used fentanyl or carfentanil?

_____
(This does not include years where you stopped or quit.)

Please specify the "other" drug, you indicated you use

_____

Please specify the frequency of your past [substothspec] use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using [substothspec]?

_____

How many total years have you used [substothspec]?

_____
(This does not include years where you stopped or quit.)

Do you vape (also known as smoking e-cigarettes)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Please select the substance(s) in your e-liquid or e-juice	☐ Nicotine ☐ THC ☐ CBD ☐ Other ☐ Don't know ☐ prefer not to answer
Please specify other	_____
How often do you use your e-cigarette / vape?	◯ Daily ◯ Weekly ◯ Monthly ◯ Less than once a month, but more than once a year ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
Did your use of e-cigarette/vape change due to the COVID-19 pandemic?	◯ Yes, increased ◯ Yes, increased then returned to usual use ◯ Yes, increased initially and then decreased below usual use ◯ Yes, decreased ◯ Yes, decreased then returned to usual use ◯ Yes, decreased initially and then increased above usual use ◯ No, stayed the same ◯ Don't know ◯ Prefer not to answer
Have you ever experienced an overdose? Select on	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

How many overdoses have you experienced in the last 6 months?
Indicate number:

- ◯ Don't know
- ◯ Prefer not to answer
- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
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- ◯ 98
- ◯ 99
- ◯ 100

These next questions ask about your experiences of discrimination in your day-to-day life due to your use of illegal drugs (i.e., heroin, cocaine) or legal drugs (i.e. prescription) not in the manner they were prescribed. Please think carefully, and do your best to answer each question.

Select one per row.

The following nine questions are part of a validated survey.

	Not at all	Just a little	Somewhat	Very much	Prefer not to answer
a. How much do you feel that you need to hide your drug use?	◯	◯	◯	◯	◯
b. How much do you feel ashamed of using drugs?	◯	◯	◯	◯	◯
c. How much do you feel people avoid you because you use drugs?	◯	◯	◯	◯	◯

d. How much do you fear you will lose your friends because you use drugs?	○	○	○	○	○
e. How much do you fear family will reject you because you use drugs?	○	○	○	○	○
f. How much do you think drug use is a punishment for something?	○	○	○	○	○
g. How much do you feel that people do not want you around their children because you use drugs?	○	○	○	○	○
h. How much do you think other people are uncomfortable being around you because you use drugs?	○	○	○	○	○
i. How much do you think health care providers are uncomfortable treating you because you use drugs?	○	○	○	○	○

Any additional information not captured above about substance use?

_____

Confirmed Current Opiate User

BCC3 Demographics - Community

Please complete the survey below.

Thank you!

Welcome back to the BCC3 study! The survey you will complete today is a continuation of the survey you completed in your clinical study visit. We will ask you questions about your food security, incarceration, sleep, oral health, physical health, sexual health, experiences of discrimination and violence, social support, emotional wellbeing, and resilience. Please remember that your answers are confidential and private. If there are any questions that you would prefer not to answer, you are welcome to select "prefer not to answer".

Your answers are very important to allow us to better understand the holistic health and wellbeing of women. Thank you for your time!

Today's Date (date of community visit):

_____

This first section will ask you questions related to social determinants of health such as food security, how many children are under your care, and incarceration.

The following four questions are part of a validated survey.

Which of the following statements best describes the food eaten in your household in the past 12 months, that is since the current month of last year?
Select one

- ◯ In the past 12 months, you and other household members always had enough of the kinds of food you wanted to eat
- ◯ In the past 12 months, you and other household members had enough to eat, but not always the kinds of food you want
- ◯ Sometimes you and other household members did not have enough to eat
- ◯ Often you and other household members didn't have enough to eat
- ◯ Don't know
- ◯ Prefer not to answer

Now I'm going to read you several statements that may be used to describe the food situation for your household. Please tell me if the statement was often true, sometimes true, or never true for you and other household members in the past 12 months.
Select one per row

	Often True	Sometimes True	Never True	Prefer not to answer
In the past 12 months, you and other household members worried that food would run out before you got money to buy more.	◯	◯	◯	◯

In the past 12 months, the food that you and other household members bought just didn't last, and there wasn't any money to get more.	◯	◯	◯	◯
In the past 12 months, you and other household members couldn't afford to eat balanced meals.	◯	◯	◯	◯

This next section is about your children, including those in your care and those that may not be. In this study, we are hoping to better understand the complex associations between women's health and their personal life experiences. There is no disrespect or discrimination intended with these questions. You can stop or take a break at any time.

How many children do you have?

Please include all living children, biological and adopted, whether they live with you or not.

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

How many children under the age of 18 are currently under your care?

Please include all children under your care, whether they are related to you or otherwise. This includes children that live with you and those who may not live with you but you financially support

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

The following questions are in regards to incarceration.

Have you ever been incarcerated*, or held in custody overnight or longer, in Canada?
Select one

*incarceration refers to the state of being confined in prison/jail; imprisonment.

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

In the last year, have you been incarcerated, or held in custody overnight or longer, in Canada?
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

The last time you were incarcerated, how long were you incarcerated for (in total)?
Select one

ONLY indicate THE NUMBER of days/weeks/months/years & then specify units in the next question

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

The last time you were incarcerated, how long were you incarcerated for (in total)?
Select one

Indicate unit days/weeks/months/years

◯ Year(s)
◯ Month(s)
◯ Week(s)
◯ Day(s)
◯ Don't know [Exclusive]
◯ Prefer not to answer

Do you currently have any "Red Zones"* or restrictions that affect where you can go?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

*A Red Zone is a region that is forbidden, or in which a particular activity is prohibited.

Have these restrictions affected where you can access healthcare services?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

BCC3 Sleep and Oral Health

Please complete the survey below.

Thank you!

The following section includes a series of questions about your sleep and oral health.

Night sweats are hot flushes which occur during sleep. How often in the last TWO WEEKS, have you experienced hot flushes during the time when you were sleeping?
Select one

- ◯ Never
- ◯ Once or twice
- ◯ Three to five times
- ◯ More than fives times but less than every night
- ◯ Once a night
- ◯ More than once most nights
- ◯ Don't know
- ◯ Prefer not to answer

If you have experienced any night sweats or night time hot flushes in the last two weeks, please grade their usual severity

Select one

- ◯ 1. mild warm feeling
- ◯ 2. moderate hot feeling, sweat or flush
- ◯ 3. moderately severe hot feeling often with sweating on half of your body
- ◯ 4. a major hot feeling often with sweating on most of your body
- ◯ Don't know
- ◯ Prefer not to answer

How much are you usually bothered by night sweats?

- ◯ A lot
- ◯ Moderately
- ◯ A little
- ◯ Not at all
- ◯ Don't know
- ◯ Prefer not to answer

Do they (night sweats or night time hot flushes) come at any particular
time in your menstrual cycle?

- ◯ Yes
- ◯ No, not timed with menstrual cycle
- ◯ No, menstrual cycle is irregular
- ◯ Not applicable (don't menstruate)
- ◯ Don't know
- ◯ Prefer not to answer

If yes, when?

Select all that apply

- ☐ During flow
- ☐ Before flow
- ☐ After flow
- ☐ At the time of ovulation
- ☐ Don't know
- ☐ Prefer not to answer

How satisfied or dissatisfied are you with your current sleep pattern?
Select one

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Neutral
- ◯ Dissatisfied
- ◯ Very dissatisfied
- ◯ Don't know
- ◯ Prefer not to answer

During the past month, on average, how many hours of actual sleep did you get at night?

(This may be different than the numbers of hours you spend in bed.)

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

In the past 3 months, have you noticed changes in your sleep? If yes, please indicate which of the following is MOST changed.	◯ No changes ◯ Yes, waking early ◯ Yes, mid-sleep awakening ◯ Yes, problems falling asleep ◯ Yes, getting more sleep
Has a doctor ever told you that you have a sleep disorder (i.e. sleep apnea, restless legs, insomnia)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take/use anything for sleep? Please select all that apply.	☐ NONE ☐ Melatonin ☐ Teas ☐ Cannabis ☐ Music ☐ Yoga ☐ Meditation ☐ Sleeping pills ☐ Other ☐ Don't know ☐ Prefer not to answer
Please specify other	_____
In general, would you say the health of your mouth is excellent, very good, good, fair or poor? Select one	◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor ◯ Don't know ◯ Prefer not to answer
Do you use a CPAP or mouthguard/mouth devices*? Select one *sleeping devices for sleep apnea	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you have one or more of your own original teeth? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you wear dentures or false teeth? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

In the past 12 months have you experienced any of the following?
Select all that apply

- ☐ Toothache
- ☐ Cannot chew adequately
- ☐ Swelling in your mouth
- ☐ Tooth-decay (caries)/cavities
- ☐ Natural tooth loose
- ☐ Natural tooth broken
- ☐ Gums around natural teeth are sore
- ☐ Lost or stolen dentures
- ☐ Thrush
- ☐ Canker sores
- ☐ Herpes (cold sores)
- ☐ None
- ☐ Other (please specify)
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Has your dentist ever checked you for oral cancer?

During an oral cancer screening exam, your dentist looks in your mouth to check for patches or mouth sores. Using gloved hands, your dentist also feels the tissues in your mouth to check for lumps or other abnormalities. The dentist may also examine your throat and neck for lumps.

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

BCC3 Women's Sexual Health

Please complete the survey below.

Thank you!

The next section includes some personal questions about your sexuality, which may apply whether you are currently in a sexual relationship, having sex, or not. Please remember that your responses are confidential and anonymous. Nobody will know these are YOUR answers. I can guide you through these questions or you can complete them on your own. If there is something you prefer not to answer, you are welcome to select "prefer not to answer".

Is it okay if I continue guiding you through the questions in this section? If you would like to complete this section by yourself, that's okay too. How would you like to proceed?
Select one

- ◯ I'd prefer to complete this section myself
- ◯ I'd prefer to complete this section together
- ◯ I'd prefer to skip this entire section

Have you ever had consensual sex? This includes any type of sexual intercourse you willingly engaged in, including getting or giving oral sex, vaginal sex, and/or anal sex with people of any gender.
Select one

- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

How old were you the first time you had consensual sex?

Indicate age in years.

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

In the past 6 months, have you been involved in any type of intimate relationship, whether it included sex or not?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Which of the following best describes the relationship(s) you have been involved in, in the past 6 months?

Please note:
• If you've had more than one romantic or intimate relationship in the past 6 months, please think about your relationship with the person you consider your primary partner.
• If you think multiple terms apply, please select the one you feel represents your relationship the best (e.g., think about how you would talk about it to others or yourself).

Select one

- ◯ Married or common-law* relationship (Husband/wife/spouse/partner relationship)
- ◯ "Partner" relationship but not married or common-law*
- ◯ "Boyfriend/girlfriend" relationship
- ◯ Dating but not officially in a relationship
- ◯ "On and off again" relationship
- ◯ "Friend with benefits" relationship (i.e., sex/intimacy between friends without monogamy/commitment)
- ◯ "Booty call" relationship (i.e., a late-night sexual encounter arranged for the purpose of sex/intimacy)
- ◯ One-night stand (i.e., a sexual relationship lasting only one night without expectations of further relations, often a stranger such as someone you meet at a bar)
- ◯ Casual sexual relationship (i.e., distinct from a one-night stand, with more regular sexual relations but no romantic involvement/commitment, and not necessarily just at night or with a friend)
- ◯ Transactional relationship (i.e., refers to sexual relationships where the giving of gifts, money, shelter, drugs, food, clothes, or services in return for sex/intimacy is an important factor)
- ◯ Polyamory (i.e., an intimate relationship involving multiple partners, all of whom are aware/consenting)
- ◯ Swinging/open relationship (i.e., a committed relationship with non-monogamous behaviour, where singles or partners are allowed to have sex with other people as a recreational or social activity)
- ◯ Affair relationship
- ◯ Other, please specify

  _____
- ◯ Don't know
- ◯ Prefer not to answer

Please specify "other"

_____

Have you had consensual sex* in the past 6 months? This includes any type of sexual intercourse you willingly engaged in, including getting or giving oral sex, vaginal sex, and/or anal sex with people of any gender. This also includes regular partners, casual partners, or paying sex partners / clients.
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Has your abstinence or avoidance of sex (including oral, vaginal and/or anal sex with people of any gender) been intentional? (i.e., as in, you are actively deciding not to have sex right now)

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What are your reasons for not having sex?

Select all that apply

- ☐ I am worried about transmitting HIV
- ☐ I am worried about disclosing my HIV status to a sexual partner
- ☐ I am worried about contracting other sexually transmitted infections
- ☐ I am worried about issues of HIV-related criminalization
- ☐ I have a reduced or absent sex drive (i.e., no/low sexual desire)
- ☐ I have reduced or absent sexual arousal (i.e., no/low physical response)
- ☐ No sexual partner
- ☐ My partner has a reduced or absent sex drive (i.e., no/low sexual desire)
- ☐ My partner has reduced or absent sexual arousal (i.e., no/low physical response or impotent)
- ☐ My partner is sick/not well
- ☐ My partner is abusive/violent
- ☐ Don't need sex/Satisfied without sex
- ☐ Abstinence due to religious beliefs
- ☐ Everyday stressors (e.g., work, kids, tired)
- ☐ Depression
- ☐ Other, please specify:
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

For how many consecutive months have you abstained from sex?
Select one

- ◯ 6-12 months
- ◯ 13-24 months
- ◯ 25 or more months
- ◯ Don't know
- ◯ Prefer not to answer

What is the most important thing that would need to change for you to become sexually active?

Select one

- ◯ A sexual partner
- ◯ An HIV-positive sexual partner
- ◯ Feeling more healthy
- ◯ Higher sex drive
- ◯ Partner needs a higher sex drive
- ◯ Nothing
- ◯ Other, please specify:
- ◯ Don't know
- ◯ Prefer not to answer

Please specify 'Other'

_____

How many consensual regular sexual partner(s)* have you had in the past six months?

For the purposes of this question, a regular sexual partner* is someone (1) with whom you've had multiple sexual encounters, (2) who has filled this role for a longer period of time, and (3) with whom you do not trade goods and/or services for sexual encounters. Examples may include, but are not limited to, spouses, common law partners, long term relationships, friends with benefits, or partners who you've seen on and off for some time.

Please note, this question refers to all regular sexual relationships that have existed in the past six months, even if the relationship has since ended. It does NOT refer to casual sexual partners* or paying sexual partners/clients*.

Indicate number of partners:

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

We're now going to ask you some questions about your last 5 consensual sex partners that you had in the last 6 months (if applicable). Let's begin with your current or most recent consensual sex partner, then we will ask the same questions about your 2nd, 3rd, 4th and 5th partner (if applicable). Remember that the information you are providing us is very important and completely confidential.

What gender* does your current or most recent sexual partner* currently identify with?
Select all that apply

- ☐ Man
- ☐ Woman
- ☐ Trans man (Female to Male), including those in transition
- ☐ Trans woman (Male to Female), including those in transition
- ☐ Two-spirited
- ☐ Intersex
- ☐ Gender queer
- ☐ Other, please specify
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

What was this sex partner's HIV status at your last sexual encounter?
Select one

- ◯ HIV-positive
- ◯ HIV-negative
- ◯ Don't know
- ◯ Prefer not to answer

How long have/had you been in this sexual relationship?

ONLY indicate THE NUMBER of (days/months/years) & then specify units in the next question

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

How long have/had you been in this sexual relationship?

Indicate unit (days/months/years)

- ◯ Months
- ◯ Years
- ◯ Days
- ◯ Don't know
- ◯ Prefer not to answer

In the last 6 months what strategies have you and your partner(s) used to reduce the risk of sexual transmission of HIV?
Select all that apply

- ☐ Adhering to ARVs* to suppress my viral load
- ☐ Male condom use
- ☐ Female condom use
- ☐ PrEP (pre-exposure prophylaxis)*
- ☐ PEP (post-exposure prophylaxis)*
- ☐ HIV-positive partner (sero-sorting)
- ☐ No penetrative sex (i.e., avoided anal and vaginal sex)
- ☐ Other, please specify
- ☐ None
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

How much do/did you worry about transmitting HIV to your partner? (This may include HIV if your partner is negative, your/their strain of HIV if your partner is positive)
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about acquiring other STIs from your partner?

Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about transmitting other STIs to your partner?
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

What gender* does your 2nd most recent sexual partner* currently identify with?
Select all that apply

- ☐ Man
- ☐ Woman
- ☐ Trans man (Female to Male), including those in transition
- ☐ Trans woman (Male to Female), including those in transition
- ☐ Two-spirit
- ☐ Intersex
- ☐ Gender queer
- ☐ Other, please specify
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

What was this sex partner's HIV status at your last sexual encounter?
Select one

- ◯ HIV-positive
- ◯ HIV-negative
- ◯ Don't know
- ◯ Prefer not to answer

How long have/had you been in this sexual relationship? ONLY indicate THE NUMBER of (days/months/years) & then specify units in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
How long have/had you been in this sexual relationship? Indicate unit (days/months/years)	◯ Months ◯ Years ◯ Days ◯ Don't know ◯ Prefer not to answer
In the last 6 months what strategies have you and your partner(s) used to reduce the risk of sexual transmission of HIV? Select all that apply	☐ Adhering to ARVs* to suppress my viral load ☐ Male condom use ☐ Female condom use ☐ PrEP (pre-exposure prophylaxis)* ☐ PEP (post-exposure prophylaxis)* ☐ HIV-positive partner (sero-sorting) ☐ No penetrative sex (i.e., avoided anal and vaginal sex) ☐ Other, please specify ☐ None ☐ Don't know ☐ Prefer not to answer
Please specify "other"	_____
How much do/did you worry about transmitting HIV to your partner? (This may include HIV if your partner is negative, your/their strain of HIV if your partner is positive) Select one	◯ I worry a lot ◯ I worry a little ◯ I don't really worry ◯ Not worried at all ◯ Don't know ◯ Prefer not to answer
How much do/did you worry about acquiring other STIs from your partner? Select one	◯ I worry a lot ◯ I worry a little ◯ I don't really worry ◯ Not worried at all ◯ Don't know ◯ Prefer not to answer
How much do/did you worry about transmitting other STIs to your partner? Select one	◯ I worry a lot ◯ I worry a little ◯ I don't really worry ◯ Not worried at all ◯ Don't know ◯ Prefer not to answer

What gender* does your 3rd most recent sexual partner* currently identify with? Select all that apply	☐ Man ☐ Woman ☐ Trans man (Female to Male), including those in transition ☐ Trans woman (Male to Female), including those in transition ☐ Two-spirit ☐ Intersex ☐ Gender queer ☐ Other, please specify ☐ Don't know ☐ Prefer not to answer
Please specify "other"	_____
What was this sex partner's HIV status at your last sexual encounter? Select one	◯ HIV-positive ◯ HIV-negative ◯ Don't know ◯ Prefer not to answer
How long have/had you been in this sexual relationship? ONLY indicate THE NUMBER of (days/months/years) & then specify units in the next question	_____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
How long have/had you been in this sexual relationship? Indicate unit (days/months/years)	◯ Months ◯ Years ◯ Days ◯ Don't know ◯ Prefer not to answer
In the last 6 months what strategies have you and your partner(s) used to reduce the risk of sexual transmission of HIV? Select all that apply	☐ Adhering to ARVs* to suppress my viral load ☐ Male condom use ☐ Female condom use ☐ PrEP (pre-exposure prophylaxis)* ☐ PEP (post-exposure prophylaxis)* ☐ HIV-positive partner (sero-sorting) ☐ No penetrative sex (i.e., avoided anal and vaginal sex) ☐ Other, please specify ☐ None ☐ Don't know ☐ Prefer not to answer
Please specify "other"	_____
How much do/did you worry about transmitting HIV to your partner? (This may include HIV if your partner is negative, your/their strain of HIV if your partner is positive) Select one	◯ I worry a lot ◯ I worry a little ◯ I don't really worry ◯ Not worried at all ◯ Don't know ◯ Prefer not to answer

How much do/did you worry about acquiring other STIs from your partner?

Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about transmitting other STIs to your partner?
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

What gender* does your 4th most recent sexual partner* currently identify with?
Select all that apply

- ☐ Man
- ☐ Woman
- ☐ Trans man (Female to Male), including those in transition
- ☐ Trans woman (Male to Female), including those in transition
- ☐ Two-spirit
- ☐ Intersex
- ☐ Gender queer
- ☐ Other, please specify
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

What was this sex partner's HIV status at your last sexual encounter?
Select one

- ◯ HIV-positive
- ◯ HIV-negative
- ◯ Don't know
- ◯ Prefer not to answer

How long have/had you been in this sexual relationship?

ONLY indicate THE NUMBER of (days/months/years) & then specify units in the next question

_____

(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

How long have/had you been in this sexual relationship?

Indicate unit (days/months/years)

- ◯ Months
- ◯ Years
- ◯ Days
- ◯ Don't know
- ◯ Prefer not to answer

In the last 6 months what strategies have you and your partner(s) used to reduce the risk of sexual transmission of HIV?
Select all that apply

- ☐ Adhering to ARVs* to suppress my viral load
- ☐ Male condom use
- ☐ Female condom use
- ☐ PrEP (pre-exposure prophylaxis)*
- ☐ PEP (post-exposure prophylaxis)*
- ☐ HIV-positive partner (sero-sorting)
- ☐ No penetrative sex (i.e., avoided anal and vaginal sex)
- ☐ Other, please specify
- ☐ None
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

How much do/did you worry about transmitting HIV to your partner? (This may include HIV if your partner is negative, your/their strain of HIV if your partner is positive)
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about acquiring other STIs from your partner?

Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about transmitting other STIs to your partner?
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

What gender* does your 5th most recent sexual partner* currently identify with?
Select all that apply

- ☐ Man
- ☐ Woman
- ☐ Trans man (Female to Male), including those in transition
- ☐ Trans woman (Male to Female), including those in transition
- ☐ Two-spirit
- ☐ Intersex
- ☐ Gender queer
- ☐ Other, please specify
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

What was this sex partner's HIV status at your last sexual encounter?
Select one

- ◯ HIV-positive
- ◯ HIV-negative
- ◯ Don't know
- ◯ Prefer not to answer

How long have/had you been in this sexual relationship?

ONLY indicate THE NUMBER of (days/months/years) & then specify units in the next question

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

How long have/had you been in this sexual relationship?

Indicate unit (days/months/years)

- ◯ Months
- ◯ Years
- ◯ Days
- ◯ Don't know
- ◯ Prefer not to answer

In the last 6 months what strategies have you and your partner(s) used to reduce the risk of sexual transmission of HIV?
Select all that apply

- ☐ Adhering to ARVs* to suppress my viral load
- ☐ Male condom use
- ☐ Female condom use
- ☐ PrEP (pre-exposure prophylaxis)*
- ☐ PEP (post-exposure prophylaxis)*
- ☐ HIV-positive partner (sero-sorting)
- ☐ No penetrative sex (i.e., avoided anal and vaginal sex)
- ☐ Other, please specify
- ☐ None
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

How much do/did you worry about transmitting HIV to your partner? (This may include HIV if your partner is negative, your/their strain of HIV if your partner is positive)
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about acquiring other STIs from your partner?

Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

How much do/did you worry about transmitting other STIs to your partner?
Select one

- ◯ I worry a lot
- ◯ I worry a little
- ◯ I don't really worry
- ◯ Not worried at all
- ◯ Don't know
- ◯ Prefer not to answer

These next questions are specific to sex partners from whom you have received money, drugs, shelter, goods, or services in exchange for sex. Remember that the information you are providing us is completely confidential.

In the past 6 months, have you been provided with any of the following in exchange for sex?
Select all that apply.

- ☐ No (Have not been provided with anything in exchange for sex in the past 6 months)
- ☐ Money
- ☐ Drugs (e.g., alcohol, cannabis, illegal drugs)
- ☐ Shelter
- ☐ Food
- ☐ Gifts
- ☐ Clothes
- ☐ Services
- ☐ Other, please specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Thinking back over the last 6 months, how many clients / johns have you seen on average a week? This includes exchanging sex for money, drugs, shelter, food, gifts, clothes, services, or other items.

Indicate average number of clients per week:

_____

_____
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

This next section includes questions on violence. This information is important to educate the public about experiences of violence and to advocate for better programs and policies to prevent violence and support survivors. We are also hoping to better understand how women's experiences of violence impact their current health. We know this can be a very hard thing to read and talk about; we can stop or take a break at any time.

Have you experienced violence from a sex work client in the last six months?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

If you are comfortable answering this, can I ask you what kinds of violence you have experienced? This information is important to educate the public about experiences of violence and advocate for better programs and policies to prevent violence and support survivors.
Select all that apply.

- ☐ No, prefer not to answer the type of violence
- ☐ Verbal harassment
- ☐ Physical assault or beating
- ☐ Rape or sexual assault
- ☐ Assault with a weapon
- ☐ Strangling
- ☐ Abduction or kidnap
- ☐ Attempted sexual assault
- ☐ Thrown out of a moving car
- ☐ Robbed
- ☐ Other [Please specify]
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Did you report the abuse or violence you experienced over the past 6 months to the police?
Select one

- ☐ Yes, all of the time
- ☐ Yes, some of the time
- ☐ No
- ☐ Too scared to report
- ☐ Don't trust the police or authorities
- ☐ Don't know
- ☐ Prefer not to answer

For the following questions please respond by indicating "yes", "no", or "sometimes":
Select one per row

	Yes	No	Sometimes	Don't Know	Prefer not to answer
Do you hide involvement in sex work from family and friends?	◯	◯	◯	◯	◯
Do you hide involvement in sex work from your doctor or health care provider?	◯	◯	◯	◯	◯

Do you believe that sex work is shameful?	○	○	○	○	○

The following questions ask about your relationship with your current (or most recent) sexual partner. If you currently have more than one sexual partner, please think about the person you consider your primary sexual partner. Please indicate whether you Strongly Agree, Agree, Disagree, or Strongly Disagree with each of the following statements.
Select one answer per line

	Strongly Agree	Agree	Disagree	Strongly Disagree	Prefer not to answer
If I asked my partner(s) to use a condom, s/he/they would get violent.	○	○	○	○	○
If I asked my partner(s) to use a condom, s/he/they would get angry.	○	○	○	○	○
Most of the time, we do what my partner wants to do.	○	○	○	○	○
My partner won't let me wear certain things.	○	○	○	○	○
When my partner and I are together, I'm pretty quiet.	○	○	○	○	○
My partner has more say than I do about important decisions that affect us.	○	○	○	○	○
My partner tells me who I can spend time with.	○	○	○	○	○
If I asked my partner to use a condom, s/he/they would think I'm having sex with other people.	○	○	○	○	○
I feel trapped or stuck in our relationship.	○	○	○	○	○
My partner does what s/he/they wants, even if I do not want her/him/them to.	○	○	○	○	○
I am more committed to our relationship than my partner is.	○	○	○	○	○
When my partner and I disagree, s/he/they get her/his/their way most of the time.	○	○	○	○	○
My partner gets more out of our relationship than I do.	○	○	○	○	○

My partner always wants to know where I am.	◯	◯	◯	◯	◯
My partner might be having sex with someone else.	◯	◯	◯	◯	◯

The remaining questions in this section are about your sexuality as a woman, which may apply whether you are having sex with a partner or not. Your answers are confidential.

In the past 6 months, have you ever masturbated alone (stimulated your body for sexual pleasure, whether or not you had an orgasm)?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

In the past 6 months, have you ever used a vibrator or other sex toys?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

During the past ONE month, have you felt pleasure from any forms of sexual experience (including self-pleasure or masturbation)?
Please select the one most appropriate response.

- ◯ Always felt pleasure from sexual experiences
- ◯ Usually, about 75% of the time
- ◯ Sometimes, about 50% of the time
- ◯ Seldom, less than 25% of the time
- ◯ Have not felt any pleasure
- ◯ Have had no sexual experience (solo or partnered) during the past month
- ◯ Don't know
- ◯ Prefer not to answer

Overall, how important a part of your life is your sexual activity?
Select the most appropriate response

- ◯ Very important
- ◯ Somewhat important
- ◯ Neither important nor unimportant
- ◯ Somewhat unimportant
- ◯ Not at all important
- ◯ Not applicable - do not engage in sexual activity
- ◯ Don't know
- ◯ Prefer not to answer

How satisfied are you with the overall appearance of your body?
Please select the one most appropriate response

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied
- ◯ Don't know
- ◯ Prefer not to answer

How much do you agree or disagree with the following statement:
Select one.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Prefer not to answer

I often feel I don't have enough emotional closeness in my sex life.	○	○	○	○	○	○
I feel content with how often I have sexual intimacy (kissing, intercourse, etc.) in my life.	○	○	○	○	○	○

Overall, how satisfactory or unsatisfactory is your present sex life?
Select one

- ○ Completely satisfactory
- ○ Very satisfactory
- ○ Reasonably satisfactory
- ○ Not very satisfactory
- ○ Not at all satisfactory
- ○ Don't know
- ○ Prefer not to answer

Since knowing your HIV status, have you ever experienced any concerns about your sexual wellbeing?
Select all that apply

- ☐ Sexual self-esteem (e.g., feeling dirty, sexually unattractive, poor body image, shame, guilt)
- ☐ Emotional aspects of sex (e.g., anxieties, inhibitions, lack of pleasure, dissatisfaction)
- ☐ Physical aspects of sex (e.g., kissing, touching, behaviours, practices, techniques)
- ☐ Sexual function (e.g., loss of desire, difficulties with orgasm, pain during sex)
- ☐ Relationships (e.g., not finding a partner, abusive partner)
- ☐ Other, please specify
- ☐ I have not experienced any concerns
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

How much distress, if any, did this concern cause you?

	No distress	Mild distress	Moderate distress	Severe distress	Don't know	Prefer not to answer
a. Sexual self-esteem (e.g., feeling dirty, sexually unattractive, poor body image, shame, guilt)	○	○	○	○	○	○
b. Emotional aspects of sex (e.g., anxieties, inhibitions, lack of pleasure, dissatisfaction)	○	○	○	○	○	○
c. Physical aspects of sex (e.g., kissing, touching, behaviours, practices, techniques)	○	○	○	○	○	○
d. Sexual function (e.g., loss of desire, difficulties with orgasm, pain during sex)	○	○	○	○	○	○

e. Relationships (e.g., not finding a partner, abusive partner)	○	○	○	○	○	○
f. [hiv_sexual_wellbeing_a_oth]	○	○	○	○	○	○

Since knowing your HIV status, have you ever talked to anyone about the impact of living with HIV on your sexual wellbeing? This may include partners, friends, or healthcare providers.

For the purposes of this question, this does NOT include discussions about safer sex strategies to minimize HIV transmission like condom use or having a low viral load.

If yes, please indicate what areas of concern were discussed.
Select all that apply.

- ☐ Sexual self-esteem (e.g., feeling dirty, sexually unattractive, poor body image, shame, guilt)
- ☐ Emotional aspects of sex (e.g., anxieties, inhibitions, lack of pleasure, dissatisfaction)
- ☐ Physical aspects of sex (e.g., kissing, touching, behaviours, practices, techniques)
- ☐ Sexual function (e.g., loss of desire, difficulties with orgasm, pain during sex)
- ☐ Relationships (e.g., not finding a partner, abusive partner)
- ☐ Other, please specify:
- ☐ I have never talked to anyone about these aspects of sexuality
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Which of the following people did you talk to about these concerns?
Select all that apply

- ☐ Partner
- ☐ Peers/women living with HIV
- ☐ Other friends (not living with HIV)
- ☐ HIV physician
- ☐ Family doctor
- ☐ Nursing staff
- ☐ Counsellor
- ☐ Social worker
- ☐ Peer worker
- ☐ Community worker
- ☐ Therapist who specializes in women's sexuality
- ☐ Therapist who specializes in trauma
- ☐ Family
- ☐ Elder
- ☐ Other, please specify
- ☐ No one
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Of the people you talked to, how useful were they in helping you cope with your experience?
Select one per line

	Very helpful	A little bit helpful	Not at all helpful	Don't know	Prefer not to answer
a. Partner	○	○	○	○	○
b. Peers/women living with HIV	○	○	○	○	○

c. Other friends (not living with HIV)	○	○	○	○	○
d. HIV physician	○	○	○	○	○
e. Family doctor	○	○	○	○	○
f. Nursing staff	○	○	○	○	○
g. Counsellor	○	○	○	○	○
h. Social worker	○	○	○	○	○
i. Peer worker	○	○	○	○	○
j. Community worker	○	○	○	○	○
k. Therapist who specializes in women's sexuality	○	○	○	○	○
l. Therapist who specializes in trauma	○	○	○	○	○
m. Family	○	○	○	○	○
n. Elder	○	○	○	○	○
o. [hiv_sxlwllbngcoth]	○	○	○	○	○

Who (if anyone) would you feel most comfortable talking to about concerns related to your sexual wellbeing? (This is applicable whether you have previously experienced any concerns or not)

Select all that apply

- ☐ Partner
- ☐ Peers/women living with HIV
- ☐ Other friends (not living with HIV)
- ☐ Family member living with HIV
- ☐ Family member not living with HIV
- ☐ Elder
- ☐ Peer worker (e.g., peer navigator, peer counsellor)
- ☐ HIV physician
- ☐ Family doctor
- ☐ Nursing staff
- ☐ Counsellor
- ☐ Social worker
- ☐ Community worker
- ☐ Therapist who specializes in women's sexuality
- ☐ Therapist who specializes in trauma
- ☐ Other, please specify:
- ☐ No one
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

BCC3 Stigma and Discrimination

Please complete the survey below.

Thank you!

This next section is about stigma and discrimination as it pertains to HIV, race, and gender. We know that this can also be a very difficult subject to talk or hear about. We can go through the questions together or you can answer these questions by yourself. You can select "prefer not to answer" at any time. We can stop or take a break at any time.
Is it okay if I continue guiding you through the questions in this section?

- ◯ I'd prefer to complete this section myself
- ◯ I'd prefer to complete this section together
- ◯ I'd prefer to skip this entire section

This next section is about stigma and discrimination as it pertains to race and gender. We know that this can also be a very difficult subject to talk or hear about. We can go through the questions together or you can answer these questions by yourself. You can select "prefer not to answer" at any time. We can stop or take a break at any time.
Is it okay if I continue guiding you through the questions in this section?

- ◯ I'd prefer to complete this section myself
- ◯ I'd prefer to complete this section together
- ◯ I'd prefer to skip this entire section

All of the scales in the following section are validated.

For each of the following items, please indicate how often have people treated you this way in the past because of your HIV status. These questions can refer to your entire life.

The following questions are part of a validated HIV stigma scale.

Select one per line.

Because of your HIV status...

	Never	Not Often	Somewhat Often	Often	Very Often	N/A, i.e. have never disclosed	Prefer not to answer
a. Family members have avoided me.	◯	◯	◯	◯	◯	◯	◯
b. Family members have looked down on me.	◯	◯	◯	◯	◯	◯	◯
c. Family members have treated me differently.	◯	◯	◯	◯	◯	◯	◯
d. Community/social workers have not taken my needs seriously.	◯	◯	◯	◯	◯	◯	◯

e. Community/social workers have discriminated against me.	○	○	○	○	○	○	○
f. Community/social workers have denied me services.	○	○	○	○	○	○	○
g. Healthcare workers have not listened to my concerns.	○	○	○	○	○	○	○
h. Healthcare workers have avoided touching me.	○	○	○	○	○	○	○
i. Healthcare workers have treated me with less respect.	○	○	○	○	○	○	○

For the following questions please say if you strongly agree, agree, neither agree or disagree, disagree, or strongly disagree with the following statements:

Select one per row

In the past month, would you say...

	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree	Prefer not to answer
a. I've limited what I tell others about myself	○	○	○	○	○	○
b. I've been afraid to tell other people that I have HIV	○	○	○	○	○	○
c. I've been worried about my family members finding out that I have HIV	○	○	○	○	○	○
d. I've been worried about people at my job/routine daily activities finding out that I have HIV	○	○	○	○	○	○
e. I've been worried that I'll lose my source of income if other people find out that I have HIV	○	○	○	○	○	○
f. I've been worried that I'll lose access to health services or care if people find out that I have HIV	○	○	○	○	○	○

For each of the following items, please indicate whether you: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree.
These questions can refer to your entire life.

Select one per line

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Prefer not to answer
a. I have been hurt by how people reacted to learning I have HIV.	○	○	○	○	○	○
b. I have stopped socializing with some people because of their reactions of me having HIV.	○	○	○	○	○	○
c. I have lost friends by telling them I have HIV.	○	○	○	○	○	○
d. I am very careful who I tell that I have HIV.	○	○	○	○	○	○
e. I worry that people who know I have HIV will tell others.	○	○	○	○	○	○
f. I feel that I am not as good a person as others because I have HIV.	○	○	○	○	○	○
g. Having HIV makes me feel unclean.	○	○	○	○	○	○
h. Having HIV makes me feel that I'm a bad person.	○	○	○	○	○	○
i. Most people think that a person with HIV is disgusting.	○	○	○	○	○	○
j. Most people with HIV are rejected when others find out	○	○	○	○	○	○

These next questions ask about your experiences of racism. Please think carefully, and do your best to answer each question.

In your day-to-day life how often have any of the following things happened to you because of your race?

Select one per row.

	Almost Everyday	Frequently	Sometimes	Not that Often	Almost Never	Never	Prefer not to answer

a. You are treated with less courtesy	○	○	○	○	○	○	○
b. You are treated with less respect	○	○	○	○	○	○	○
c. You receive poorer service	○	○	○	○	○	○	○
d. People act as if you are not as smart	○	○	○	○	○	○	○
e. People act as if they are afraid of you	○	○	○	○	○	○	○
f. People act as if you are dishonest	○	○	○	○	○	○	○
g. People act as if they are better	○	○	○	○	○	○	○
h. You are called names or insulted	○	○	○	○	○	○	○
i. You are threatened or harassed	○	○	○	○	○	○	○

These next questions ask about your experiences of sexism. Please think carefully, and do your best to answer each question.

In your day-to-day life how often have any of the following things happened to you because you are a woman?
Select one per row.

	Almost Everyday	Frequently	Sometimes	Not that often	Almost Never	Never	Prefer not to answer
a. You are treated with less courtesy	○	○	○	○	○	○	○
b. You are treated with less respect	○	○	○	○	○	○	○
c. You receive poorer service	○	○	○	○	○	○	○
d. People act as if you are not as smart	○	○	○	○	○	○	○
e. People act as if they are afraid of you	○	○	○	○	○	○	○
f. People act as if you are dishonest	○	○	○	○	○	○	○
g. People act as if they are better	○	○	○	○	○	○	○
h. You are called names or insulted	○	○	○	○	○	○	○
i. You are threatened or harassed	○	○	○	○	○	○	○

These next questions ask about your experiences of sexism. Please think carefully, and do your best to answer each question.

In your day-to-day life how often have any of the following things happened to you because of your gender?

Select one per row.

	Almost Everyday	Frequently	Sometimes	Not that often	Almost Never	Never	Prefer not to answer
You are treated with less courtesy	○	○	○	○	○	○	○
You are treated with less respect	○	○	○	○	○	○	○
You receive poorer service	○	○	○	○	○	○	○
People act as if you are not as smart	○	○	○	○	○	○	○
People act as if they are afraid of you	○	○	○	○	○	○	○
People act as if you are dishonest	○	○	○	○	○	○	○
People act as if they are better	○	○	○	○	○	○	○
You are threatened or harassed	○	○	○	○	○	○	○

In your experience...

	Many times	Sometimes	Once/Twice	Never	Prefer not to answer
Have you been made fun of or called names for your Trans identity or experience?	○	○	○	○	○
Have you been hit or beaten up for your Trans identity or experience?	○	○	○	○	○
Have you heard that Trans people are not normal?	○	○	○	○	○
Have you been objectified or fetishized sexually because you're Trans?	○	○	○	○	○
Have you felt that being Trans hurt and embarrassed your family?	○	○	○	○	○
Have you had to try to pass as non-Trans to be accepted?	○	○	○	○	○
How often do you suspect you have been turned down for a job because of your Trans identity?	○	○	○	○	○

Have you had to move away from your family or friends because you're Trans?	○	○	○	○	○
Have you experienced some form of police harassment for being Trans?	○	○	○	○	○

BCC3 Physical Activity

Please complete the survey below.

Thank you!

1313) During the past month , which statement best describes the kinds of physical activity you usually did? Do not include the time you spent working at a job.

Please read all six statements before selecting one.

- ◯ 1. I did not do much physical activity. I mostly did things like watching television, reading, playing cards, or playing computer games. Only occasionally, no more than once or twice a month, did I do anything more active such as going for a walk or playing tennis.
- ◯ 2. Once or twice a week, I did light activities such as getting outdoors on the weekends for an easy walk or stroll. Or once or twice a week, I did chores around the house such as sweeping floors or vacuuming.
- ◯ 3. About three times a week, I did moderate activities such as brisk walking, swimming, or riding a bike for about 15-20 minutes each time. Or about once a week, I did moderately difficult chores such as raking or mowing the lawn for about 45-60 minutes. Or about once a week, I played sports such as softball, basketball, or soccer for about 45-60 minutes.
- ◯ 4. Almost daily, that is five or more times a week, I did moderate activities such as brisk walking, swimming, or riding a bike for 30 minutes or more each time. Or about once a week, I did moderately difficult chores or played sports for 2 hours or more.
- ◯ 5. About three times a week, I did vigorous activities such as running or riding hard on a bike for 30 minutes or more each time.
- ◯ 6. Almost daily, that is, five or more times a week, I did vigorous activities such as running or riding hard on a bike for 30 minutes or more each time.

BCC3 Chronic Pain

Please complete the survey below.

Thank you!

The following section includes a series of questions about chronic pain as it relates to your overall health.

How much bodily pain have you had during the last week?

- ◯ none
- ◯ very mild
- ◯ mild
- ◯ moderate
- ◯ severe
- ◯ very severe

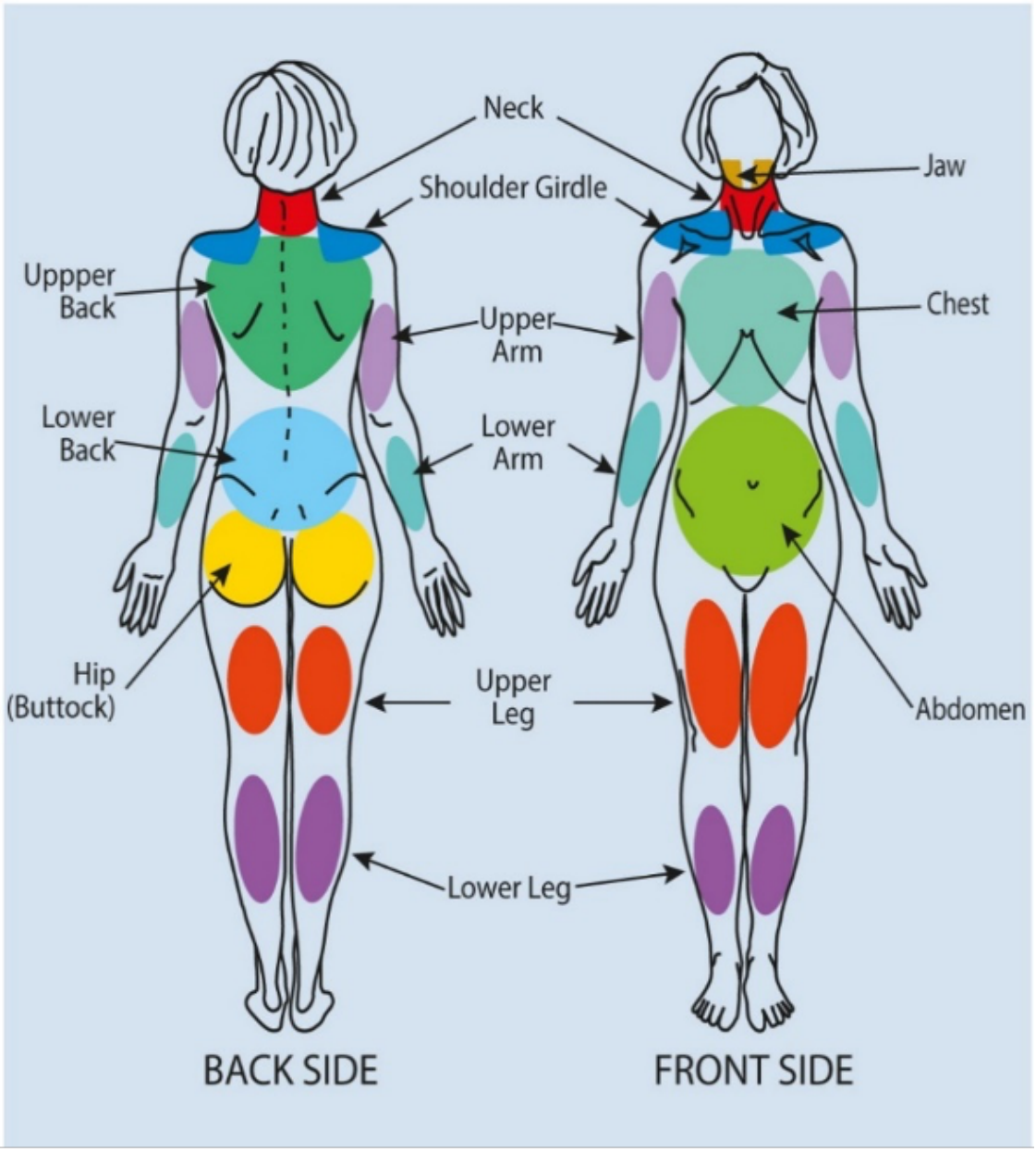
Do you have bodily pain that has lasted for more than 3 months?

- ◯ Yes
- ◯ No

The following questions will ask you to rate your pain on a scale of one to ten with respect to how it interfeferes with your life.
0 indicates that pain does not interfere and 10 indicates that pain completely interferes.

	Does not interfere, 0	1	2	3	4	5	6	7	8	9	Completely interferes, 10
What number best describes your pain on average in the past week?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
What number best describes how, during the past week, pain has interfered with your enjoyment of life?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
What number best describes how, during the past week, pain has interfered with your general activity?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

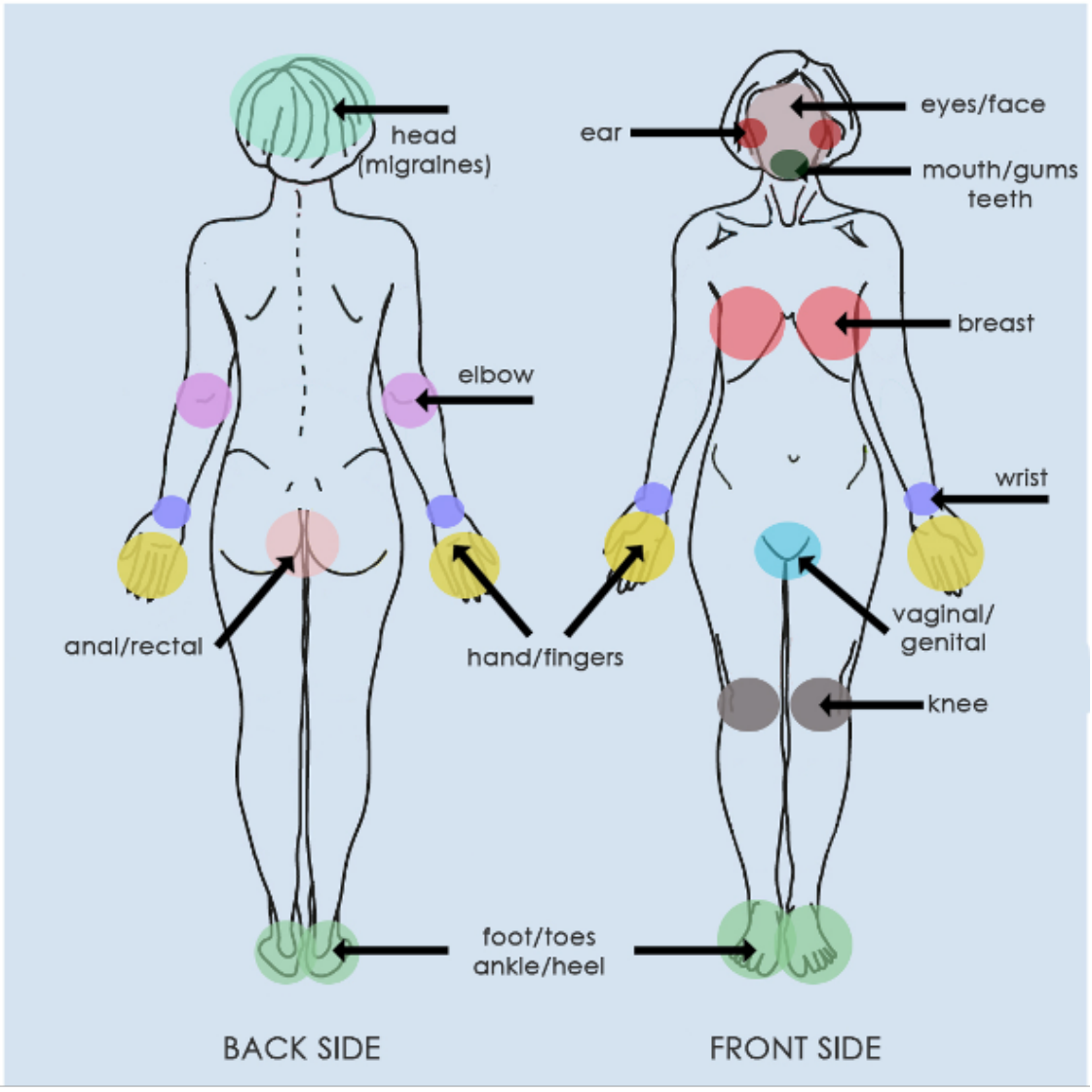
Please use this image to help localize your pain in the following question



Please check each area you have felt pain in over the past week. This list may not cover your pain, so please select other and a second list will open.

- ☐ Shoulder girdle, left
- ☐ Shoulder girdle, right
- ☐ Upper arm, left
- ☐ Upper arm, right
- ☐ Lower arm, left
- ☐ Lower arm, right
- ☐ Hip (buttock) left
- ☐ Hip (buttock) right
- ☐ Upper leg left
- ☐ Upper leg right
- ☐ Lower leg left
- ☐ Lower leg right
- ☐ Jaw left
- ☐ Jaw right
- ☐ Chest
- ☐ Abdomen
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ Other/None of these areas, see next image

Please use this image to help localize your pain in the following question.



Additional areas of pain. Please check each area you have felt pain in over the past week

- ☐ Foot/ankle/heel left
- ☐ Foot/ankle/heel right
- ☐ Knee left
- ☐ Knee right
- ☐ Elbow left
- ☐ Elbow right
- ☐ Wrist left
- ☐ Wrist right
- ☐ Hand/fingers left
- ☐ Hand/fingers right
- ☐ Head (migraines)
- ☐ Eyes/face
- ☐ Mouth/gums/teeth
- ☐ Ear
- ☐ Vaginal/genital
- ☐ Anal/rectal
- ☐ Breast
- ☐ Other

Please specify 'Other'

_____

Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer, select one of the options on the scale under each item, from "not at all confident" to "completely confident".

	Not at all confident, 0	1	2	3	4	5	6	7	8	9	Completely confident, 10
I can cope with my pain in most situations.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
I can still accomplish most of my goals in life, despite the pain.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
I can live a normal lifestyle, despite the pain.	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Do you experience stigma, isolation, and/or discrimination due to your chronic pain?

- ◯ Extremely
- ◯ Quite a bit
- ◯ Moderately
- ◯ Very little/Occasionally
- ◯ Not at all
- ◯ Don't know
- ◯ Prefer not to answer

Do you ever use medications (prescribed or over the counter) to cope with your chronic pain?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you ever use substances (alcohol, marijuana, cigarettes, or other substances) to cope with your chronic pain?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If you experience any mental health diagnoses (ie. depression, anxiety, etc.), do you think they are related to your chronic pain?	◯ Yes ◯ Maybe ◯ No ◯ No, I do not have any mental health diagnoses ◯ Don't know ◯ Prefer not to answer
Does your chronic pain interfere with your quality of sleep? Please select all that apply.	☐ Yes, I have difficulty falling asleep ☐ Yes, I wake in the night ☐ Yes, I wake early ☐ No ☐ Don't know ☐ Prefer not to answer
How much do you agree or disagree with the following statement: “I feel resilient and strong because I cope with chronic pain.”	◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree ◯ Don't know ◯ Prefer not to answer
I have support in place to help me navigate my chronic pain journey.	◯ Yes ◯ No ◯ No, and I would like some support ◯ Don't know ◯ Prefer not to answer

BCC3 Violence and Abuse

Please complete the survey below.

Thank you!

This next section deals with violence and abuse. The questions may be personal and sensitive in nature. These questions will be used to better address the health care needs of women living with HIV. Please remember that your responses are completely confidential and private. I'd like to guide you through these questions. If there is something you prefer not to answer, you are welcome to select "prefer not to answer".

This next section deals with violence and abuse. The questions may be personal and sensitive in nature. Please remember that your responses are completely confidential and private. I'd like to guide you through these questions. If there is something you prefer not to answer, you are welcome to select "prefer not to answer".

Is it okay if I continue guiding you through the questions in this section? If you would like to complete this section by yourself, that's okay too. How would you like to proceed?
Select one

- ◯ I prefer to do the violence section myself
- ◯ I prefer to do the violence section together
- ◯ I prefer to skip the violence section → skip to next section

This first series of questions are about experiences you had as an adult. For our purposes, adult is defined as 16 years of age or older.

As an adult, has someone ever physically hurt you?

Please note, this only includes if someone has intentionally hurt you. It does not include accidents.

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times did this happen?
Select one

- ◯ All the time
- ◯ Frequently
- ◯ Fairly often
- ◯ Rarely / Sometimes
- ◯ Don't know
- ◯ Prefer not to answer

Has this happened in the last 3 months?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

As an adult, has someone ever insulted, threatened, screamed, or cursed at you?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times did this happen?
Select one

- ◯ All the time
- ◯ Frequently
- ◯ Fairly often
- ◯ Rarely / Sometimes
- ◯ Don't know
- ◯ Prefer not to answer

Has this happened in the last 3 months?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

As an adult, has someone ever restricted your actions by controlling where you can go and what you can do? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How many times did this happen? Select on	◯ All the time ◯ Frequently ◯ Fairly often ◯ Rarely / Sometimes ◯ Don't know ◯ Prefer not to answer
Has this happened in the last 3 months? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
As an adult, has someone ever sexually forced themselves on you, or forced you to have sex? This can include the fondling of your private parts, oral sex, vaginal sex, and anal intercourse. It can be either forced or with your consent because you feared the consequences of resisting the person. Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How many times did this happen? Select one	◯ All the time ◯ Frequently ◯ Fairly often ◯ Rarely / Sometimes ◯ Don't know ◯ Prefer not to answer
Has this happened in the last 3 months? Select one	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Were any of these experiences from an intimate partner? For example, someone who currently is or was a spouse or boyfriend/girlfriend?	◯ No ◯ Yes, but not in the last 3 months ◯ Yes, in the last 3 months ◯ Don't know ◯ Prefer not to answer
Were any of these experiences from a person who IS NOT or WAS NOT your intimate partner? For instance, an acquaintance, family member, care provider, or stranger?	◯ No ◯ Yes, but not in the last 3 months ◯ Yes, in the last 3 months ◯ Don't know ◯ Prefer not to answer

Have you ever experienced violence upon disclosure of your HIV status to a sexual partner?
Select all that apply.

- ☐ Yes, verbal violence
- ☐ Yes, physical violence
- ☐ Yes, sexual violence
- ☐ No
- ☐ Never disclosed my HIV status to a sexual partner
- ☐ Don't know
- ☐ Prefer not to answer

In the last three months, have you experienced any type of violence (including verbal, physical, or sexual violence) upon disclosure of your HIV status to a sexual partner?
Select all that apply.

- ☐ Yes, verbal violence
- ☐ Yes, physical violence
- ☐ Yes, sexual violence
- ☐ No
- ☐ Never disclosed my HIV status to a sexual partner
- ☐ Don't know
- ☐ Prefer not to answer

Pandemics are known to increase stress and experiences of violence. Thinking about your experiences of violence over the course of the COVID-19 pandemic compared to before the pandemic controls were implemented in mid-March 2020, would you say that you have experienced an increase in violence, a decrease, or there was no change?

- ◯ Increase
- ◯ Decrease
- ◯ No change
- ◯ Don't know
- ◯ Prefer not to answer

This second series of questions are about experiences you had as a child. For our purposes, child is defined as less than 16 years of age.

During your childhood, did an adult ever physically hurt you?

Interviewer explanation: in some cultures, physical discipline of children is common; for our purposes, we are including such physical discipline.

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times did this happen?
Select one

- ◯ All the time
- ◯ Frequently
- ◯ Fairly often
- ◯ Rarely / Sometimes
- ◯ Don't know
- ◯ Prefer not to answer

During your childhood, did an adult ever insult, threaten or verbally degrade you?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times did this happen?
Select one

- ◯ All the time
- ◯ Frequently
- ◯ Fairly often
- ◯ Rarely / Sometimes
- ◯ Don't know
- ◯ Prefer not to answer

During your childhood, did someone ever sexually force themselves on you, or force you to have sex?

This can include the fondling of your private parts, oral sex, vaginal sex, and anal intercourse. It can be either forced or with your consent because you feared the consequences of resisting the person.

Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times did this happen?

Select one

- ◯ All the time
- ◯ Frequently
- ◯ Fairly often
- ◯ Rarely / Sometimes
- ◯ Don't know
- ◯ Prefer not to answer

Did you ever seek help, such as medical treatment, counselling, or social support to cope with the violence?
Select one

This applies to both adulthood and childhood violence.

- ◯ All of the time
- ◯ Some of the time
- ◯ None of the time

BCC3 Social Support

Please complete the survey below.

Thank you!

I would now like to move on to discuss your relationships with other people, outside of any relationships with a partner(if applicable).

I will read some statements to you; please indicate whether you are able to do the activities mentioned in the statements as much as you would like, less than you would like, much less than you would like, or never.

	As much as I would like	Less than I would like	Much less than I would like	Never	Prefer not to answer
a. I get visits from friends and relatives.	○	○	○	○	○
b. I get useful advice about important things in my life.	○	○	○	○	○
c. I get chances to talk to someone about problems at work (or with my housework).	○	○	○	○	○
d. I get chances to talk to someone I trust about my personal and family problems.	○	○	○	○	○
e. I have people who care what happens to me.	○	○	○	○	○
f. I get love and affection.	○	○	○	○	○
g. I get help around the house.	○	○	○	○	○
h. I get help with money in an emergency.	○	○	○	○	○
i. I get help when I need transportation	○	○	○	○	○
j. I get help when I am sick.	○	○	○	○	○

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? Select one response per line

How often do you have available...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Prefer not to answer
a. Someone to turn to for suggestions about how to deal with a personal problem.	○	○	○	○	○	○	○

b. Someone to help with daily chores if you were sick.	◯	◯	◯	◯	◯	◯	◯
c. Someone to love and make you feel wanted.	◯	◯	◯	◯	◯	◯	◯
d. Someone to do something enjoyable with.	◯	◯	◯	◯	◯	◯	◯

Approximately how many women living with HIV do you know personally, including friends and colleagues? Please try to provide your best estimate.
Select one.

◯ None
◯ 1 person
◯ 2 to 4 people
◯ 5 to 9 people
◯ 10 to 19 people
◯ 20 to 49 people
◯ 50 to 99 people
◯ 100 or more
◯ Don't know
◯ Prefer not to answer

In your life, do you have someone living with HIV who you get support from? For this question, please think about friends or family living with HIV who you can call on in times of need, rather than someone who you only know in a formal role, such as a peer navigator. This person can be a friend or a peer.
Select one

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

How much do you agree or disagree with the following statement: "As a woman living with HIV in my community, I feel isolated".
Select one.

◯ Strongly agree
◯ Agree
◯ Neither agree or disagree
◯ Disagree
◯ Strongly disagree
◯ Prefer not to answer

How much do you agree or disagree with the following statement: "I don't reach out to friends or stay in touch, because I can't explain my life living with HIV to them".
Select one.

◯ Strongly agree
◯ Agree
◯ Neither agree or disagree
◯ Disagree
◯ Strongly disagree
◯ Prefer not to answer

BCC3 Emotional and Social Wellbeing and Health

Please complete the survey below.

Thank you!

The following section includes a series of questions about emotional wellbeing and quality of life as it relates to your overall mental and physical health.

Have you ever been diagnosed with a mental health condition by a care provider?
Select one

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Which, if any, of the following mental health conditions are you currently living with? Please only include conditions that have been diagnosed by a healthcare provider.
Select all that apply.

- ☐ Alcohol Addiction
- ☐ Anxiety
- ☐ Anorexia Nervosa or Bulimia Nervosa
- ☐ ADD/ADHD (i.e., Attention deficit (hyperactivity) disorder)
- ☐ Bipolar Disorder
- ☐ Personality Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Drug Addiction/Substance Use Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Post Traumatic Stress Disorder
- ☐ Schizophrenia
- ☐ Sleep disorder
- ☐ Other, please specify:
- ☐ None
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "other"

_____

Below is a list of the ways you might have felt or behaved during the past week. Please tell me how often you have felt this way during the past week.
Select one per line.

	Most or all of the time (5-7 days)	Occasionally or a moderate amount of the time (3-4 days)	Some or a little of the time (1-2 days)	Rarely or none of the time (less than 1 day)	Don't know	Prefer not to answer
a. I was bothered by things that usually don't bother me.	◯	◯	◯	◯	◯	◯
b. I had trouble keeping my mind on what I was doing.	◯	◯	◯	◯	◯	◯
c. I felt depressed	◯	◯	◯	◯	◯	◯

d. I felt that everything I did was an effort.	○	○	○	○	○	○
e. I felt hopeful about the future.	○	○	○	○	○	○
f. I felt fearful.	○	○	○	○	○	○
g. My sleep was restless.	○	○	○	○	○	○
h. I was happy.	○	○	○	○	○	○
i. I felt lonely.	○	○	○	○	○	○
j. I could not get "going".	○	○	○	○	○	○

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and check the box to indicate how much you have been bothered by that problem in the last month.
The following six questions are part of a validated scale.
Select one response per line.

	Extremely	Quite a bit	Moderately	A little bit	Not at all	Prefer not to answer
a. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	○	○	○	○	○	○
b. Feeling very upset when something reminded you of a stressful experience from the past?	○	○	○	○	○	○
c. Avoid activities or situations because they remind you of a stressful experience from the past?	○	○	○	○	○	○
d. Feeling distant or cut off from other people?	○	○	○	○	○	○
e. Feeling irritable or having angry outbursts?	○	○	○	○	○	○
f. Having difficulty concentrating?	○	○	○	○	○	○

During the past 30 days, about how often did you feel ...
Select one per line.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Prefer not to answer
a. Nervous?	○	○	○	○	○	○	○
b. Hopeless?	○	○	○	○	○	○	○
c. Restless or fidgety?	○	○	○	○	○	○	○
d. That everything was an effort?	○	○	○	○	○	○	○

e. So depressed that nothing could cheer you up?	○	○	○	○	○	○	○
f. Worthless?	○	○	○	○	○	○	○

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
a. Feeling nervous, anxious, or on edge	○	○	○	○
b. Not being able to stop or control worrying	○	○	○	○
c. Worrying too much about different things	○	○	○	○
d. Trouble relaxing	○	○	○	○
e. Being so restless that it's hard to sit still	○	○	○	○
f. Becoming easily annoyed or irritable	○	○	○	○
g. Feeling afraid as if something awful might happen	○	○	○	○

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?
Please select one

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
Select one per line

	Yes, limited a lot	Yes, limited a little	No, not limited at all	Prefer not to answer
a. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	○	○	○	○
b. Climbing several flights of stairs.	○	○	○	○

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
Select one per line

	Yes	No	Prefer not to answer
a. Accomplished less than you would like	○	○	○
b. Were limited in the kind of work or other activities	○	○	○

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
Select one per line.

	Yes	No	Prefer not to answer
a. Accomplished less than you would like	◯	◯	◯
b. Didn't do work or other activities as carefully as usual	◯	◯	◯

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
Select one

◯ Extremely
◯ Quite a bit
◯ Moderately
◯ A little bit
◯ Not at all
◯ Prefer not to answer

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...
Select one per line.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Prefer not to answer
a. Have you felt calm and peaceful?	◯	◯	◯	◯	◯	◯
b. Did you have a lot of energy?	◯	◯	◯	◯	◯	◯
c. Have you felt downhearted and blue?	◯	◯	◯	◯	◯	◯

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
Select one

◯ All of the time
◯ Most of the time
◯ Some of the time
◯ A little of the time
◯ None of the time
◯ Prefer not to answer

In general, would you say your health is:
Select one.

◯ Excellent
◯ Very Good
◯ Good
◯ Fair
◯ Poor
◯ Prefer not to answer

Compared to one year ago, how would you rate your health in general now?

◯ Much better now than one year ago
◯ Somewhat better now than one year ago
◯ About the same as one year ago
◯ Somewhat worse now than one year ago
◯ Much worse now than one year ago

Does spirituality/traditional spirituality/culture play a role in your life?
Select one.

- ◯ Yes
- ◯ No
- ◯ Not applicable (do not have spirituality/traditional spirituality/culture)
- ◯ Don't know
- ◯ Prefer not to answer

Throughout your life, which of the following best describes your engagement in spiritual/traditional/cultural practices?
Select one.

- ◯ Not applicable - I do not have spiritual/traditional practices.
- ◯ Spiritual/traditional practices have always been a part of my life.
- ◯ I have reconnected to my people's spiritual/traditional practices.
- ◯ I am finding out more about my spiritual/traditional practices.
- ◯ I have not yet learned about my spiritual/traditional practices.
- ◯ I used to engage in spiritual/traditional practices, but I do not anymore.
- ◯ I have never engaged in my spiritual/traditional practices.
- ◯ Don't know
- ◯ Prefer not to answer

In the last year, how would you describe the role of spirituality/traditional spirituality/culture on your health?
Select all that apply.

- ☐ Not applicable - Religion and spirituality do not play a role in my health
- ☐ One that supports my health (going to the doctors, taking my medication)
- ☐ One that supports my overall wellbeing
- ☐ One that supports my social support systems (friends, family, community)
- ☐ One that supports my coping abilities
- ☐ One that supports my experience of gender based stigma and discrimination
- ☐ One that worsens my experience of gender based stigma and discrimination
- ☐ One that worsens my experience of HIV related stigma and discrimination (HIV-positive participants only)
- ☐ One that worsens barriers to health (going to the doctors, taking my medication)
- ☐ Other, please specify _____ [Other specify required]
- ☐ Don't know
- ☐ Prefer not to answer

Please specify other

_____

How connected do you feel to your culture?
Select one.

- ◯ Very connected
- ◯ Somewhat connected
- ◯ Not very connected
- ◯ Not connected at all
- ◯ Not applicable (I do not have a culture I identify with)
- ◯ Don't know
- ◯ Prefer not to answer

For mental health and wellbeing purposes, do you seek out or use any of the following? Select all that apply.	☐ Counselling ☐ Peer support ☐ Support from a spiritual healer ☐ Support from a spiritual leader (ie. priest, church member, etc.) ☐ Support from an Elder(s) (Indigenous community leader) ☐ Traditional methods of healing (ie. smudge, sweat lodge, dancing, praying, etc.) ☐ Other, specify ☐ None of the above ☐ Don't know ☐ Prefer not to answer
Please specify other	_____

BCC3 COVID-19 Impacts

Please complete the survey below.

Thank you!

This next section is about the COVID-19 pandemic and how it has impacted your emotional, mental, and physical health and wellbeing. We know that this can be a difficult subject to talk or hear about, and we can take a break at any time. Please remember that all of your responses are confidential and private. Your answers are very important in determining the unique effects of the pandemic on women!

Are you more or less likely to consult a healthcare provider about any medical concerns now compared to before the COVID-19 restrictions came into place in mid-March 2020?

- ◯ Much more likely to consult a health care provider now compared to before the restrictions came into place
- ◯ More likely to consult a healthcare provider now
- ◯ Equally likely (no change)
- ◯ Less likely to consult a healthcare provider now
- ◯ Much less likely to consult a healthcare provider now
- ◯ Don't Know
- ◯ Prefer not to Answer

Since the COVID-19 restrictions came into place in mid-March 2020,

Have you NEEDED any of the following health services or social support services, including those from healthcare providers, AIDS Service Organizations, or other community services? (please select all that apply)

	Yes	No	Don't Know	Prefer not to answer
HIV medical care. Refers to any care you received from a physician, nurse, or nurse practitioner about your HIV.	◯	◯	◯	◯
Antiretroviral therapy (ART)	◯	◯	◯	◯
ART adherence support (e.g., MAT program)	◯	◯	◯	◯
Routine health check-ups	◯	◯	◯	◯
Allied health or specialist appointments (e.g., radiology, physiotherapy, optometrist)	◯	◯	◯	◯
Emergency medical services	◯	◯	◯	◯
Home medical care services (e.g., wound care)	◯	◯	◯	◯
Planned surgeries	◯	◯	◯	◯
Cervical screening	◯	◯	◯	◯
Breast screening	◯	◯	◯	◯

Colorectal screening	○	○	○	○
Bone density screening	○	○	○	○
Mental health services	○	○	○	○
Contraception services	○	○	○	○
Sexual health services (e.g., STI testing & treatment, advice for sexual concerns, relationship support/advice)	○	○	○	○
Violence prevention and/or support services (including domestic, intimate partner, sexual, physical, emotional, and/or controlling violence)	○	○	○	○
Pregnancy planning and/or fertility support	○	○	○	○
Pregnancy termination services	○	○	○	○
Prenatal and/or postnatal care	○	○	○	○
Menopause care	○	○	○	○
Vaccinations (not related to COVID-19)	○	○	○	○
Dental care	○	○	○	○
Accessing prescribed medications	○	○	○	○
Substance use services, including harm reduction services (e.g., supervised consumption facilities), support services, and/or treatment services	○	○	○	○
Peer support and/or peer navigation services	○	○	○	○
Food bank or grocery program support	○	○	○	○
Other, please specify	○	○	○	○

Please specify 'Other'

_____

If Needed, have you ACCESSED this service and HOW have you accessed this service (i.e., in person or virtually, including via phone or video-based consultation)? Please respond for each health service you identified as needing.

	Yes, in person	Yes, virtually	Yes, both in person and virtually	No	Don't know	Prefer not to answer

HIV medical care. Refers to any care you received from a physician, nurse, or nurse practitioner about your HIV.	○	○	○	○	○	○
Antiretroviral therapy (ART)	○	○	○	○	○	○
ART adherence support (e.g., MAT program)	○	○	○	○	○	○
Routine health check-ups	○	○	○	○	○	○
Allied health or specialist appointments (e.g., radiology, physiotherapy, optometrist)	○	○	○	○	○	○
Emergency medical services	○	○	○	○	○	○
Home medical care services (e.g., wound care)	○	○	○	○	○	○
Planned surgeries	○	○	○	○	○	○
Cervical screening	○	○	○	○	○	○
Breast screening	○	○	○	○	○	○
Colorectal screening	○	○	○	○	○	○
Bone density screening	○	○	○	○	○	○
Mental health services	○	○	○	○	○	○
Contraception services	○	○	○	○	○	○
Sexual health services (e.g., STI testing & treatment, advice for sexual concerns, relationship support/advice)	○	○	○	○	○	○
Violence prevention and/or support services (including domestic, intimate partner, sexual, physical, emotional, and/or controlling violence)	○	○	○	○	○	○
Pregnancy planning and/or fertility support	○	○	○	○	○	○
Pregnancy termination services	○	○	○	○	○	○
Prenatal and/or postnatal care	○	○	○	○	○	○
Menopause care	○	○	○	○	○	○
Vaccinations (not related to COVID-19)	○	○	○	○	○	○
Dental care	○	○	○	○	○	○
Accessing prescribed medications	○	○	○	○	○	○

Substance use services, including harm reduction services (e.g., supervised consumption facilities), support services, and/or treatment services	○	○	○	○	○	○
Peer support and/or peer navigation services	○	○	○	○	○	○
Food bank or grocery program support	○	○	○	○	○	○
[srvcs_need_oth]	○	○	○	○	○	○

If Needed, have you experienced any DIFFICULTIES accessing any of the health services that you needed? Please respond for each health service you identified as needing.

	Yes	No	Don't know	Prefer not to answer
HIV medical care. Refers to any care you received from a physician, nurse, or nurse practitioner about your HIV.	○	○	○	○
Antiretroviral therapy (ART)	○	○	○	○
ART adherence support (e.g., MAT program)	○	○	○	○
Routine health check-ups	○	○	○	○
Allied health or specialist appointments (e.g., radiology, physiotherapy, optometrist)	○	○	○	○
Emergency medical services	○	○	○	○
Home medical care services (e.g., wound care)	○	○	○	○
Planned surgeries	○	○	○	○
Cervical screening	○	○	○	○
Breast screening	○	○	○	○
Colorectal screening	○	○	○	○
Bone density screening	○	○	○	○
Mental health services	○	○	○	○
Contraception services	○	○	○	○
Sexual health services (e.g., STI testing & treatment, advice for sexual concerns, relationship support/advice)	○	○	○	○

Violence prevention and/or support services (including domestic, intimate partner, sexual, physical, emotional, and/or controlling violence)	○	○	○	○
Pregnancy planning and/or fertility support	○	○	○	○
Pregnancy termination services	○	○	○	○
Prenatal and/or postnatal care	○	○	○	○
Menopause care	○	○	○	○
Vaccinations (not related to COVID-19)	○	○	○	○
Dental care	○	○	○	○
Accessing prescribed medications	○	○	○	○
Substance use services, including harm reduction services (e.g., supervised consumption facilities), support services, and/or treatment services	○	○	○	○
Peer support and/or peer navigation services	○	○	○	○
Food bank or grocery program support	○	○	○	○
[srvcs_need_oth]	○	○	○	○

What are the main reasons for the difficulties you experienced accessing any of the health services that you needed (please select all that apply)?

- ☐ I am worried about being exposed to COVID-19 while travelling to see a care provider in person
- ☐ I am worried about being exposed to COVID-19 in the care setting
- ☐ I have difficulties with transportation (e.g., limited transportation options)
- ☐ The provider and/or clinic had limited hours and/or restricted access
- ☐ The service was closed
- ☐ My doctor or clinic was not accepting in-person appointments
- ☐ My healthcare needs were considered non-urgent
- ☐ Receiving care virtually is difficult for me (limited access to phone, computer, internet, other access challenges)
- ☐ I did not feel safe to discuss health issues in a virtual consultation rather in person
- ☐ I did not feel there was sufficient privacy to discuss health issues in a virtual consultation rather than in person
- ☐ I had difficulties getting a referral to this care
- ☐ Peer supports (e.g., peer navigation, peer support) were not available
- ☐ I had no time to access the service (e.g., workload demands, childcare demands)
- ☐ Other reasons
- ☐ Don't know
- ☐ Prefer Not to Answer

Please specify 'Other'

_____

How satisfied were you with the medical care provided virtually (i.e., online and/or via video or telephone consultation)?

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied
- ◯ Don't Know
- ◯ Prefer not to Answer

Do you prefer to receive at least some medical care through virtual consultation or in-person?

- ◯ I very much prefer receiving care through virtual consultation
- ◯ I prefer receiving care through virtual consultation
- ◯ I have no preference for virtual or in-person medical care
- ◯ I prefer receiving in-person care
- ◯ I very much prefer receiving in-person-care
- ◯ Both. I prefer to receive some care in-person and other care virtually.
- ◯ Not Applicable (e.g., I have not received medical care)
- ◯ Don't know
- ◯ Prefer not to answer

Now I'd like to ask you about self-care practices within the context of your sexual and reproductive health. According to the World Health Organization (WHO), "Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider.

For sexual and reproductive health, this might include at-home testing (e.g., for pregnancy or for HIV), at-home treatment (e.g., self-injection with fertility drugs, taking a medical abortion pill), and self-education using online health and medical resources. Other innovative types of self-care interventions may be on the horizon.

To what degree do you agree or disagree with the following statements:

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't Know	Prefer not to Answer	Other, please specify
I would feel comfortable performing self-care tests and treatments for sexual and reproductive health at home.	○	○	○	○	○	○	○	○
If recommended for me, I would prefer to perform self-care tests and treatments vs having my healthcare provider perform them.	○	○	○	○	○	○	○	○
Providing options for self-care increases my feeling of empowerment in healthcare encounters.	○	○	○	○	○	○	○	○
Since the COVID-19 public health measures were implemented in mid-March 2020, I have been more likely to use self-care tests and treatments?	○	○	○	○	○	○	○	○
Since the COVID-19 public health measures were implemented in mid-March 2020, I have been more likely to use online health resources for information about sexual and reproductive health?	○	○	○	○	○	○	○	○

Section 2. Direct Experiences with COVID-19

Now I'd like to ask you questions about your direct experience with COVID-19.

Have you ever been tested for COVID-19?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you ever had a positive COVID-19 test result?	◯ Yes ◯ No ◯ Results not yet available ◯ Don't know ◯ Prefer not to answer
Do you believe that you've had COVID-19 even though you haven't received a positive COVID-19 test?	◯ Yes ◯ No ◯ Prefer not to answer
Have you ever had antibody testing for COVID-19? This test looks for COVID-19 antibodies in your blood to determine whether you've previously been infected with COVID-19.	◯ Yes ◯ No ◯ Don't Know/No Answer ◯ Prefer not to answer
Have you ever had a positive COVID-19 antibody test?	◯ Yes ◯ No ◯ Results not yet available ◯ Don't know ◯ Prefer not to answer
Have you been offered the COVID-19 vaccine?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you received the COVID-19 vaccine?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Which vaccine did you receive?	◯ Pfizer-BioNTech ◯ Moderna ◯ AstraZeneca/COVISHIELD ◯ Janssen ◯ Other ◯ Don't Know ◯ Prefer not to answer
If yes, approximately when did you receive dose 1?	_____ (please input the day as 15)

If YES, approximately when did you receive dose 2?	◯ I have received dose 2 and know the month and year when I received it (please specify). ◯ Haven't received dose 2 yet ◯ Not applicable - choosing not to receive dose 2 ◯ Not applicable - only one dose recommended with the vaccine I received ◯ Don't Know ◯ Prefer not to answer (please input the day as 15)
When did you receive dose 2?	_____ (please input the day as 15)
When the COVID-19 vaccine is recommended for you, how likely are you to receive it?	◯ Very unlikely ◯ Unlikely ◯ Neutral ◯ Somewhat likely ◯ Very likely ◯ Don't know ◯ Prefer not to answer
How much does your HIV status affect your fear of acquiring COVID-19? Does it make you:	◯ Much more fearful ◯ More fearful ◯ It makes no difference ◯ Less fearful ◯ Much less fearful
Do you consider yourself an essential worker?	◯ No ◯ Yes, health worker ◯ Yes, other essential worker (e.g., first responder, social worker, transportation worker, grocery or other retail worker) ◯ Don't know ◯ Prefer not to answer

Section 3. COVID-19 Impacts

In this final section, we would like to ask you some questions about the way that COVID-19 may have impacted various aspects of your life.

How well would you describe yourself as coping during ....

	Not able to cope	Find it a challenge to cope	Neutral	Coping a little successfully	Coping very successfully	Prefer not to answer
The three months prior to when BC implemented social distancing guidelines (December 2019 - mid March 2020),	◯	◯	◯	◯	◯	◯

During the time between mid-March 2020 and three months ago?	◯	◯	◯	◯	◯	◯
Recently, during the last 3 months?	◯	◯	◯	◯	◯	◯

Has your relationship status changed as a result of the COVID-19 pandemic?

- ◯ No change: I had a partner before the pandemic and have the same partner now.
- ◯ No change: I didn't have a partner before and don't have a partner now.
- ◯ Yes: I have a new partner or started a new relationship since the pandemic
- ◯ Yes: I now live with my partner.
- ◯ Yes: I no longer live with my partner.
- ◯ Yes: My relationship ended.
- ◯ Other, please specify
- ◯ Prefer not to answer

Please specify 'Other'

_____

In what ways has the COVID-19 pandemic affected your intimate relationship and/or sexual well-being since the COVID-19 restrictions were introduced? (select all that apply)

- ☐ It's more difficult to meet new partners
- ☐ I have not tried to meet new partners.
- ☐ I have participated in online dating to a greater extent
- ☐ I have deliberately not had sexual contact with new partners due to COVID-19 restrictions.
- ☐ I have ended/not pursued a relationship due to COVID-19 restrictions.
- ☐ I have experienced challenges accessing sexual health services
- ☐ I have experienced challenges accessing contraception
- ☐ The COVID-19 pandemic has not affected my intimate relationships
- ☐ The COVID-19 pandemic has not affected my sex life
- ☐ The COVID-19 pandemic has improved my sex life
- ☐ The COVID-19 pandemic has worsened my sex life
- ☐ Other, please specify: _____
- ☐ Not applicable
- ☐ Don't know
- ☐ Prefer not to answer

Please specify 'Other'

_____

In what ways has the COVID-19 pandemic affected your intimate relationship and/or sexual well-being since the COVID-19 restrictions were introduced? (select all that apply)

- ☐ I see my partner more
- ☐ I see my partner less
- ☐ I have experienced violence within my relationship
- ☐ I have experienced challenges accessing sexual health services
- ☐ I have experienced challenges accessing contraception
- ☐ My relationship with my intimate partner has improved
- ☐ My relationship with my intimate partner has worsened
- ☐ The COVID-19 pandemic has not affected my intimate relationships
- ☐ The COVID-19 pandemic has improved my sex life
- ☐ The COVID-19 pandemic has worsened my sex life
- ☐ The COVID-19 pandemic has not affected my sex life
- ☐ Other, please specify
- ☐ Don't know
- ☐ Prefer not to answer

Please specify 'Other'

_____

Thinking about your activities over the course of the pandemic compared to before the pandemic controls were implemented in mid-March 2020, would you say that you have increased, decreased, or that there was no change in this activity?

	Increased	Decreased	No change	Don't know	Prefer not to answer
Exercise regularly	○	○	○	○	○
Eat healthy	○	○	○	○	○
Get enough good quality sleep	○	○	○	○	○
Drink alcohol	○	○	○	○	○
Smoke tobacco/vape	○	○	○	○	○
Use cannabis	○	○	○	○	○
Use illicit substances	○	○	○	○	○
Spend time on social media	○	○	○	○	○
Screen time (e.g., watch TV/movies, play video games)	○	○	○	○	○
Read for enjoyment	○	○	○	○	○
Socialize with family (in-person or virtually)	○	○	○	○	○
Socialize with friends (in-person or virtually)	○	○	○	○	○

If any, what aspects of your life have gotten better under COVID-19 public health restrictions?

_____

Thank you so much for answering these questions. Is there anything else you'd like to let us know about the impacts of COVID-19 on your health and well-being?

_____

BCC3 Resilience

Please complete the survey below.

Thank you!

This is the final section of the survey, it contains some important questions about resiliency*. Please go through the questions carefully. There will then be an opportunity to offer any feedback or comments on the survey.

*Resilience is the inner strength that helps individuals bounce back and carry on in the face of adversity.

Please read the following statements and indicate how characteristic each item is of yourself. Options range from 1 (Strongly Disagree) to 5 (Strongly Agree).

The following four questions are part of a validated scale.

	1 - Strongly Disagree	2 - Moderately Disagree	3 - More or Less	4 - Moderately Agree	5 - Strongly Agree	Prefer not to answer
a. There is a direction in my life.	○	○	○	○	○	○
b. My plans for the future match with my true interests and values.	○	○	○	○	○	○
c. I know which direction I am going to follow in my life.	○	○	○	○	○	○
d. My life is guided by a set of clear commitments.	○	○	○	○	○	○

Please read the following statements regarding resiliency*. To the right of each, you will find seven options, ranging from Strongly Agree on the left to Strongly Disagree on the right. Please select the option which best indicates your feelings about that statement.
Select one per line

***Resilience is the inner strength that helps individuals bounce back and carry on in the face of adversity.**

The following questions are part of a validated scale.

	Strongly Agree	Moderately Agree	Slightly Agree	Neither agree or disagree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Prefer not to answer
a. I usually manage one way or another	○	○	○	○	○	○	○	○
b. I feel proud that I have accomplished things in life	○	○	○	○	○	○	○	○
c. I usually take things in stride	○	○	○	○	○	○	○	○
d. I am friends with myself	○	○	○	○	○	○	○	○

e. I feel that I can handle many things at a time	○	○	○	○	○	○	○	○
f. I am determined	○	○	○	○	○	○	○	○
g. I can get through difficult times because I've experienced difficulty before	○	○	○	○	○	○	○	○
h. I have self-discipline	○	○	○	○	○	○	○	○
i. I keep interested in things	○	○	○	○	○	○	○	○
j. I can usually find something to laugh about	○	○	○	○	○	○	○	○
k. My belief in myself gets me through hard times	○	○	○	○	○	○	○	○
l. In an emergency, I'm someone people can generally rely on	○	○	○	○	○	○	○	○
m. My life has meaning	○	○	○	○	○	○	○	○
n. When I'm in a difficult situation, I can usually find my way out of it	○	○	○	○	○	○	○	○

You have completed the survey!!!

Thank you for taking the time to complete the survey. If you have any final comments, please indicate them here.

_____

Note to Interviewer: Please record participant visit information in the Participant Database.

How did you find out about this study?

- ☐ At Oak Tree Clinic
- ☐ Poster
- ☐ Social media post
- ☐ Through healthcare provider
- ☐ Through a friend
- ☐ Email list
- ☐ Other

Please specify other

_____

Thank you for participating in our study!