



REACH

Thank you for agreeing to complete this confidential survey. Please answer all the questions as fully as you can. **You are free to leave out any question you do not want to answer.**

Please do NOT write your name or clinic number on this survey. Your answers will NOT be seen by doctors and nurses in the clinic, and your answers will NEVER be recorded in your clinic notes.

If you have any questions or need any help, please ask the person who gave you this survey.

Please place your completed survey in the envelope, seal the envelope and give it back to the staff member who gave it to you.

Thank you for your help!

Date: ____ / ____ / ____

Unique study number: _____

SECTION A: GENERAL INFORMATION

A1. Are you:

- Male
- Transgender male
- Female
- Transgender female

A2. What is your date of birth?

Month: _____ Year: _____

A3. What is your ethnic group? Choose one section from A to E, then tick one box to best describe your ethnic group or background

A White

- English / Welsh / Scottish / Northern Irish / British
- Irish
- Gypsy or Irish Traveller
- Any other White background

B Mixed / multiple ethnic groups

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed / multiple ethnic background

C Asian / Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

D Black / African / Caribbean / Black British

- African
- Caribbean
- Any other Black / African / Caribbean background

E Other ethnic group

- Arab
- Hispanic / Latino
- Any other ethnic group

A4. Were you born in the UK?

- Yes → IF YES, PLEASE GO TO QUESTION A5
 No

If NO, which country were you born in? _____

In which year did you first arrive in the UK? _____

What is your immigration status in the UK?

- | | |
|--|--|
| <input type="checkbox"/> British citizen | <input type="checkbox"/> Student visa |
| <input type="checkbox"/> Citizen of another European Union country | <input type="checkbox"/> Refugee / seeking asylum |
| <input type="checkbox"/> Right to stay for an indefinite amount of time (Indefinite Leave to Remain - ILR) | <input type="checkbox"/> No papers to be in the UK |
| <input type="checkbox"/> Right to stay for a fixed amount of time (Exceptional Leave to Remain – ELR) | <input type="checkbox"/> Work permit |
| | <input type="checkbox"/> Other |

A5. What is your main language?

- English
 Other (please write in): _____

A6. Are you currently in an ongoing relationship with a partner (wife / husband or civil partner or girlfriend / boyfriend)?

- No, I am not currently in an ongoing relationship with a partner
→ IF NO, PLEASE GO TO QUESTION A7
 Yes, I am in a relationship and living with my partner
 Yes, I am in a relationship but not living with my partner

If YES, how long have you been in this relationship? (please write in)

Years: _____ Months: _____

If YES, does your partner have HIV?

- Yes No Don't know / unsure

A7. Do you have any children from current or previous relationships?

- Yes No

If YES, how many children do you have? 1 2 3 or more

A8. FOR WOMEN ONLY: are you currently pregnant?

- Yes No Don't know / unsure

A9. FOR WOMEN ONLY: have you had a baby in the last 12 months?

- Yes No

A10. What is your current work situation?

- Employed or self-employed FULL-TIME (at least 30 hours per week)
 Employed or self-employed PART-TIME (less than 30 hours per week)
 Full-time student / education / training
 Unemployed and registered for benefits
 Unemployed, NOT registered for benefits
 Permanently sick / disabled (for 3 months or more)
 Temporarily sick / disabled (for less than 3 months)
 Looking after home / family / dependents full-time
 Retired
 Other (please specify): _____

A11. How many years in full-time education have you had since you were 16?

- None
 Up to 2 years
 3 years or more

A12. What is your religion?

- No religion → **PLEASE GO TO QUESTION A13**
- Christian
- Hindu
- Muslim
- Buddhist
- Jewish
- Sikh
- Any other religion

- How important is religion in your life?**
- Very
 - Somewhat
 - Not very
 - Not at all

A13. Which of the following options best describes how you think of yourself?

- Heterosexual or straight → **PLEASE GO TO QUESTION A14**
- Gay or lesbian
- Bisexual
- Other
- Prefer not to say

- How open are you about your sexuality?**
- Completely open
 - Open to most people
 - Open to some people
 - Not open

A14. Do you currently have enough money to cover your basic needs (eg food, clothes, heating, accommodation)?

- All of the time
- Most of the time
- Some of the time
- No

A15. Which of the following describes your current accommodation? (please tick all that apply)

Own my own home (including mortgage / loan / shared ownership)

Renting ...

Renting from the council / a housing association

Renting from a private landlord

Rent paid by housing benefit

Temporary accommodation (eg hostel, shelter, bed & breakfast)

Staying with partner / friend(s) / family

Homeless → **PLEASE GO TO QUESTION A16**

Other

How long have you lived or stayed in your current accommodation?

Less than 6 months

6 months to 1 year

1 to 5 years

5 years or more

What is your postcode? (please write in): _____

A16. Thinking back over the past FOUR weeks ...

... was there ever no food to eat of any kind in your house because of lack of resources (eg money, vouchers etc)?

Never

Sometimes

Often

Rather not say

... did you go to sleep at night hungry because there was not enough food?

Never

Sometimes

Often

Rather not say

... did you go a whole night and day without eating anything at all because there was not enough food?

Never

Sometimes

Often

Rather not say

SECTION B: LIFE WITH HIV

B1. When did you first find out you were HIV positive?

If you are unsure of the month, please give the year only:

Month: _____ Year: _____

B2. FOR WOMEN ONLY: did you find out you were HIV positive during pregnancy?

- Yes No

B3. Where were you first diagnosed with HIV?

- | | |
|---|---|
| <input type="checkbox"/> GP / family doctor | <input type="checkbox"/> While donating blood |
| <input type="checkbox"/> Doctor in private practice | <input type="checkbox"/> Community venue |
| <input type="checkbox"/> Sexual health clinic | <input type="checkbox"/> Used a home testing / sampling kit |
| <input type="checkbox"/> Antenatal clinic | <input type="checkbox"/> HIV testing service |
| <input type="checkbox"/> Hospital as an in-patient | <input type="checkbox"/> Prison |
| | <input type="checkbox"/> Elsewhere |

B4. At your last test, what was your CD4 count?

- Less than 200
 200 - 350
 351 - 500
 More than 500
 Don't know / can't remember

B5. At your last test, was your viral load undetectable?

- Yes No Don't know / can't remember

B6. Does your HIV affect your day-to-day activities?

No

Yes, a little

Yes, a lot

B7. Apart from health care staff, have you told anyone that you have HIV?

Yes

No → IF NO, PLEASE GO TO QUESTION B8

If YES, who have you told that you have HIV?

I have told my partner / wife / husband

Yes

No

Not applicable

**I have told other family members
(eg children, parents, brothers or sisters)**

Most or all

Some

None

Not applicable

I have told my friends

Most or all

Some

None

Not applicable

I have told my employer

Yes

No

Not applicable

**B8. In the last 12 months, have you experienced any of the following feelings because of your HIV status:
(please tick all that apply)**

I feel ashamed

I feel guilty

I blame myself

I blame others

I have low self-esteem

I feel I should be punished

I feel suicidal

None of these

B13. Here is a list of some things that other people do or use that may be helpful or supportive. Please tick the column that is closest to your situation:

	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
I have people who care what happens to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get love and affection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get chances to talk to someone I trust about my personal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get invitations to go out and do things with other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get help when I am sick in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B14. Has anyone at an HIV clinic ever given you information about support groups for people who have HIV?

- Yes No Don't know / can't remember

B15. Have you been to a support group for people who have HIV in your local area?

- Yes, more than once
 Yes, but only once
 No, but I would like to → PLEASE GO TO QUESTION B16
 No, and I do not want to → PLEASE GO TO QUESTION B16
 I am not aware of a local support group → PLEASE GO TO QUESTION B16

If YES, have you found it helpful?

- Yes, definitely Yes, to some extent No

B16. Have you ever injected yourself with non-prescribed drugs or other substances?

Yes

No → IF NO, PLEASE GO TO QUESTION B17

If YES, when was the last time you injected yourself with non-prescribed drugs or other substances?

- In the last 7 days
- Between 7 days and 4 weeks ago
- Between 4 weeks and 1 year ago
- Between 1 year and 5 years ago
- Longer than 5 years ago

B17. In the last five years, have you taken any recreational drugs?
(this includes drugs such as heroin, cocaine, crystal meth, amphetamines, marijuana or steroids, but does not include any drug taken under a doctor's instructions)

Yes

No → IF NO, PLEASE GO TO QUESTION C1

If YES, in the last 12 months, have you used...
(please tick all that apply)

- Crystal meth
- Crack cocaine
- Heroin
- Ketamine
- GBL
- Mephedrone
- Other

SECTION C: YOUR HEALTH AND HEALTH CARE

C1. Overall, how would you rate your health during the past 4 weeks?

- Excellent Very good Good Fair Poor

C2. Over the past 2 weeks, have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C3. In the last 12 months, have you received support from any of the following, to help you cope with your HIV?
(please tick all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Specialist HIV doctor | <input type="checkbox"/> GP / family doctor |
| <input type="checkbox"/> Specialist HIV nurse | <input type="checkbox"/> Counsellor or psychologist |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Health adviser |
| <input type="checkbox"/> Community nurse | <input type="checkbox"/> Patient representative |
| <input type="checkbox"/> Social worker | <input type="checkbox"/> Peer mentor |
| <input type="checkbox"/> Telephone helpline | <input type="checkbox"/> Other |

C4. Has the doctor ever told you that you have any of the following?
(please tick all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Asthma (as an adult) | <input type="checkbox"/> High blood pressure (hypertension) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Diabetes (any type) | <input type="checkbox"/> Stroke (any form) |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Sickle cell anaemia |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> None of these |

C5. Do you have a long-standing condition that causes you difficulty with accessing buildings, streets or vehicles?

- Yes No

C6. Do you experience frequent memory loss (eg do you forget the occurrence of special events even the more recent ones, appointments etc)?

- Never Hardly ever Yes, definitely

C7. Do you feel that you are slower when reasoning, planning activities or solving problems?

- Never Hardly ever Yes, definitely

C8. Do you have difficulties paying attention (eg to a conversation, a book or a movie)?

- Never Hardly ever Yes, definitely

C9. Are you currently registered with a GP / family doctor in the UK?

- Yes No → IF NO, PLEASE GO TO QUESTION C10

If YES, have you told your GP that you have HIV?

- Yes No

C10. When was the last time you attended a GP's surgery in the UK (for your own health needs)?

- In the last year
 1 to 5 years ago
 More than 5 years ago
 I have never attended a GP's surgery in the UK
 Don't know / can't remember

C11. Have you ever stayed in a hospital in the UK as an in-patient?

- Yes No → IF NO, PLEASE GO TO QUESTION C12

If YES, when was the last time you stayed in a hospital in the UK?

- In the last year 1 to 5 years ago More than 5 years ago Don't know / can't remember

C12. Thinking about your health care, please indicate your degree of agreement with the following sentences:

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
I can figure out how and where to get the information I need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I am in control over how and what I learn about my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: YOUR HIV CARE

D1. Since your HIV diagnosis, have there been any periods of a year or more when you have not seen a doctor about your HIV?

- No
- Yes
- Don't know / can't remember
- I have been diagnosed for less than a year

D2. Since your HIV diagnosis, how often have you missed your appointments at the HIV clinic because you:

	Never	Rarely	Sometimes	Often
Simply forgot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt too sick or ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt too tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt depressed / overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Didn't want to think about being HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Didn't have enough money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Didn't have transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were afraid of being seen at the clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Didn't think a doctor could help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had not followed the doctor's advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had enough medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Couldn't get time off work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D3. Have you ever missed an appointment at the HIV clinic because of drinking alcohol?

- Yes
- No
- Don't know / can't remember

D4. Have you ever missed an appointment at the HIV clinic because of taking recreational drugs?

- Yes No Don't know / can't remember

D5. Since your HIV diagnosis, have you attended more than one HIV clinic in the UK?

- Yes No → IF NO, PLEASE GO TO QUESTION D6

If YES, how many HIV clinics have you attended in the UK?

(please write in):

Thinking about the HIV clinic that you currently attend ...

D6. When did you last see a doctor or nurse at this clinic?

- Today
 In the last month
 Between 1 and 6 months ago
 Between 6 months and 1 year ago
 Longer than 1 year ago

D7. How long was the gap between the last time you saw a doctor or nurse at this clinic and the time before that?

- 1 month or less
 Between 1 and 6 months
 Between 6 months and 1 year
 Longer than 1 year
 I have not previously seen a doctor or nurse at this clinic

D8. How long have you been receiving medical care at this HIV clinic?
(please write in)

Years: _____ Months: _____

D9. In the last 12 months, how many appointments have you missed at this HIV clinic?

Please write in: _____

D10. How do you usually travel to the clinic? Tick the box for the longest part, by distance, of your usual journey to the HIV clinic:

- | | |
|---|---|
| <input type="checkbox"/> Public transport | <input type="checkbox"/> Hospital transport |
| <input type="checkbox"/> Car | <input type="checkbox"/> Bicycle |
| <input type="checkbox"/> Motorcycle, scooter, moped | <input type="checkbox"/> On foot |
| <input type="checkbox"/> Taxi, minicab | <input type="checkbox"/> Other |

D11. If you usually travel by car, have you ever had difficulty with finding a parking space near the clinic?

- Never
- Rarely
- Sometimes
- Often
- Not applicable

D12. How long does it usually take you to get to the clinic?

- Up to 30 minutes
- 30 – 60 minutes
- 1 – 2 hours
- More than 2 hours

D13. How convenient for you are the opening hours at the clinic?

- Very convenient
- Fairly convenient
- Not very convenient
- Not at all convenient

D14. What additional opening hours would be convenient for you?
(please tick all that apply)

- Early morning opening (Monday to Friday)
- Evening opening (Monday to Friday)
- Saturday opening
- Sunday opening
- Other (please specify): _____

D15. In the past, have you had consultations with a doctor or nurse at this clinic using ... (please tick all that apply)

- Face-to-face communication
- Telephone
- SMS / text messaging
- Email
- Skype or other web-based communication

D16. In the future, would you like to have consultations with a doctor or nurse at this clinic using ... (please tick all that apply)

- Face-to-face communication
- Telephone
- SMS / text messaging
- Email
- Skype or other web-based communication

D17. How often do you expect to have a routine consultation with a doctor or nurse at this clinic?

- Every month
- Every 3 months
- Every 4 months
- Every 6 months
- Every year
- Other (please specify): _____

D18. How likely are you to recommend this HIV clinic to friends and family if they needed similar care or treatment?

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely
- Extremely unlikely
- Don't know

D19. The last time you made an appointment at this HIV clinic, how did you book your appointment?

- In person
- By telephone
- By SMS / text message
- By email
- Online booking system
- Don't know / can't remember → **PLEASE GO TO QUESTION D20**

How easy was it for you to book your last appointment at this clinic?

- Very easy
- Fairly easy
- Not very easy
- Not at all easy

Thinking about the last time you came to see a doctor or nurse at this clinic ...

D20. Were the reception staff friendly and approachable?

- Yes, definitely Yes, to some extent No Don't know / can't remember

D21. Last time you came to see a doctor or nurse at this clinic ...

- ... did you book an appointment before you came? Yes No
... was it a routine consultation? Yes No
... did you feel sick or ill? Yes No

D22. Please indicate how important each of the following reasons were for you the last time you came to see a doctor or nurse at this clinic:

	Very important	Somewhat important	Not at all important
I wanted advice / information on my HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted advice / information on something other than my HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I needed practical support (eg letter for housing, benefits etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I needed more HIV medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D23. Did the doctor or nurse explain the reasons for any treatment or action in a way that you could understand?

- Yes, completely
 Yes, to some extent
 No
 Did not need an explanation
 No treatment or action was needed
 Don't know / can't remember

Thinking about the last time you saw a doctor at this clinic...

D24. Was the doctor you saw friendly and approachable?

- Yes, definitely Yes, to some extent No Don't know / can't remember

D25. Did the doctor listen to what you had to say?

- Yes, definitely Yes, to some extent No Don't know / can't remember

D26. Did you have confidence and trust in the doctor?

- Yes, definitely Yes, to some extent No Don't know / can't remember

Thinking about the last time you saw a nurse at this clinic...

D27. Was the nurse you saw friendly and approachable?

- Yes, definitely Yes, to some extent No Don't know / can't remember

D28. Did the nurse listen to what you had to say?

- Yes, definitely Yes, to some extent No Don't know / can't remember

D29. Did you have confidence and trust in the nurse?

- Yes, definitely Yes, to some extent No Don't know / can't remember

SECTION E: MEDICINES

E1. Please indicate your degree of agreement with the following sentences:

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
Medicines help many people to live better lives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines help many people to live longer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctors use too many medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies are safer than medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctors place too much trust in medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If doctors had more time with patients they would prescribe fewer medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E2. Are you currently taking HIV medicine (HIV treatment / antiretroviral therapy / HAART)?

<input type="checkbox"/> Yes → IF YES, PLEASE GO TO SECTION F	
<input type="checkbox"/> No – but I have taken HIV medicine previously	→ IF NO, PLEASE GO TO SECTION G
<input type="checkbox"/> No – I have never taken HIV medicine	

SECTION F: FOR PEOPLE WHO ARE CURRENTLY TAKING HIV MEDICINE

F1. Does your HIV clinic have an HIV medicine delivery service?

Some HIV clinics provide a service which delivers HIV medicine (HIV treatment / antiretroviral therapy / HAART) to a patient's home, work place or a local business for collection

- Yes - I am currently using it
- Yes - I have used it but I am not currently using it
- Yes - but I haven't used it
- No
- Don't know / can't remember

F2. Many people find a way of using their medicines which suits them. For each of the following statements, please tick the box which best applies to you:

	Always	Often	Sometimes	Rarely	Never
I forget to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I alter the dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I stop taking them for a while	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I decide to miss out a dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take less than instructed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F3. During the past 7 days, on how many days have you missed taking any of your pills?

- None
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

F4. Thinking about taking HIV medicine, please indicate your degree of agreement with the following sentences:

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
My health, at present, depends on these medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health in the future will depend on these medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
These medicines are my best hope for the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
These medicines keep me alive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having to take these medicines worries me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I sometimes worry about becoming too dependent on these medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
These medicines give me unpleasant side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The taste of this medicine makes me feel unwell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

You have finished all the questions for you, please go to Section H

SECTION G: FOR PEOPLE WHO ARE NOT CURRENTLY TAKING HIV MEDICINE

G1. Has your doctor advised you to take HIV medicine?

Yes → IF YES, PLEASE GO TO QUESTION G2

No → IF NO, PLEASE GO TO SECTION H

G2. If your doctor has advised you to take HIV medicine, how important were the following factors in deciding not to take HIV medicine at this time?

	Very important	Somewhat important	Not at all important
Side effects of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling depressed or overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't want to think about being HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using alcohol or recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't want anyone to see the medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking alternative or complementary medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication is too complicated to take	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication is harmful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information from friends or support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information from media (eg TV, newspapers, internet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION H: Please use the space below for any further comments or information that you feel may be relevant to the survey

A large, empty rectangular box with a thin black border, intended for providing additional comments or information relevant to the survey.



REACH

Thank you very much for completing this survey

Please seal the survey in the envelope provided and give it back to the staff member who gave it to you.

Thank you

Support, advice and information about living with HIV is available from:

THT Direct [REDACTED]

10am to 8pm - Monday to Friday

Information can also be found on the Terrence Higgins Trust website at:

www.tht.org.uk

This project is run by

Research Department of Infection and Population Health

University College London