

# Appendix 1. Kiribati STEPS Survey Questionnaire



## The WHO STEPwise Approach to Surveillance of Noncommunicable Diseases (STEPS)

Check if the following are completed (to be checked by:)		Yes	No
Fasting status	(Step 2&3 Registration Station)	<input type="checkbox"/>	<input type="checkbox"/>
Checkout	(Step 2&3 Check-out Station)	<input type="checkbox"/>	<input type="checkbox"/>
EpiData data entry	(Data entry personnel)	<input type="checkbox"/>	<input type="checkbox"/>
Epilinfo data entry	(Data entry personnel)	<input type="checkbox"/>	<input type="checkbox"/>
Data entry irregularities	(Data entry personnel)	<input type="checkbox"/>	<input type="checkbox"/>

Identification Information:			
V 1	Is the respondent on the participation list for the survey?	Yes, on the original list 1 Yes, on the replacement list 2 No (if "No", then END) 3	<input type="checkbox"/>
I 1	Island code		<input type="checkbox"/>
I 2	Village name:		
I 3	Village code: (SEE NOTE BELOW)		<input type="text"/> <input type="text"/>
I 4	Interviewer code		<input type="text"/> <input type="text"/>
I 5	Date of completion of the questionnaire		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> /2004 Day Month Year

Respondent ID Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
	Consent		
I 6	Consent has been read out to respondent	Yes 1 No 2	<input type="checkbox"/> If NO, read consent
I 7	Consent has been obtained (verbal or written)	Yes 1 No 2	<input type="checkbox"/> If NO, END
I 8	Interview Language	English 1 Kiribati 2	<input type="checkbox"/>
I 9	Time of interview (24 hour clock)		<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
I 10	Family Name		
I 11	First Name		

**Note:** Identification information I6 to I13 should be stored separately from the questionnaire because it contains confidential information. Please note Village Code is required as part of main instrument for data analyses.  
Date of interview is required to calculate age

## Step 1 Demographic Information

			Coding Column
C1	Sex ( <i>Record Male / Female as observed</i> )	Male 1 Female 2	<input type="checkbox"/>
C2	What is your date of birth? <i>If Don't Know, See Note* below and Go to C3</i>	Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> Year 19 <input type="text"/> <input type="text"/>	
C3	How old are you?	Years	<input type="text"/> <input type="text"/>
C4	In total, how many years have you spent at school or in full-time study (excluding pre-school)?	Years	<input type="text"/> <input type="text"/>
C5	What is your <i>ethnic background</i> ?	Kiribati 1 Other 2 Refused 3	<input type="checkbox"/>
C6	What is the highest level of education you have completed?	No formal schooling 1 Less than primary school 2 Primary school completed 3 Secondary school completed 4 College/University completed 5 Post graduate degree 6	<input type="checkbox"/>
C7	Which of the following best describes your <u>main</u> work status over the last 12 months?	Government employee 1 Non-government employee 2 Self-employed 3 Non-paid 4 Student 5 Homemaker 6 Retired 7 Unemployed (able to work) 8 Unemployed (unable to work) 9	<input type="checkbox"/>
C8	How many people older than 18 years, including yourself, live in your household?	Number of people	<input type="text"/> <input type="text"/>
C9	Taking the <b>past year</b> , can you tell me what the average earnings of the household have been?	Per week <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR per month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> OR per year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Refused 1 <input type="checkbox"/>	

**Note\*:** 1) Missing values are not permissible for Village code, Date of Interview and Sex.

2) The **Date of Birth** (C2) or the **age** (C3) or **both** (C2 and C3) have to be filled. CODE "DK" FOR DON'T KNOW or DON'T REMEMBER.

## Step 1 Behavioural Measures

Tobacco Use (Section S)			
Now I am going to ask you some questions about various health behaviours. This includes things like smoking, drinking alcohol, eating fruits and vegetables and physical activity. Let's start with smoking.			
		<b>Response</b>	<b>Coding Column</b>
S 1a	Do you currently smoke any <b>tobacco products</b> , such as cigarettes, cigars or pipes?  (NOTE: CURRENTLY = past 12 months)	Yes 1 No 2	<input type="checkbox"/> If No, go to S4
S 1b	<u>If Yes,</u> Do you currently smoke tobacco products <b>daily</b> ?	Yes 1 No 2	<input type="checkbox"/> If No, go to S4
S 2a	How old were you when you <b>first started</b> smoking daily?	Age (years) Don't remember DK	<input type="text"/> <input type="text"/> If Known, go to S 3

<b>S 2b</b>	Do you remember how long ago it was?  <i>(CODE DK FOR DON'T REMEMBER)</i>	In Years  OR in Months  OR in Weeks	Years <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Weeks <input type="text"/> <input type="text"/>		
<b>S 3</b>	On average, <b>how many</b> of the following do you smoke each day? <i>(RECORD FOR EACH TYPE)</i>	Manufactured cigarettes  Hand-rolled cigarettes  Hand-rolled rauara  ← Other (please specify): _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	} <i>Go to A1a</i>	
<b>S 4</b>	In the past, did you ever smoke <b>daily</b> ?	Yes 1 No 2	<input type="text"/>		<i>If No, go to A1a</i>
<b>S 5a</b>	<u>If Yes,</u> How old were you when you <b>stopped</b> smoking <b>daily</b> ?	Age (years) Don't remember DK	<input type="text"/> <input type="text"/>		<i>If Known, go to A1a</i> <i>If DK, go to S 5b</i>
<b>S 5b</b>	How <b>long ago</b> did you stop smoking daily?	Years ago  OR Months ago  OR Weeks ago	Years <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Weeks <input type="text"/> <input type="text"/>		

Alcohol Consumption (Section A)				
The next questions ask about the consumption of alcohol.				
		<b>Response</b>	<b>Coding Column</b>	
<b>A 1a</b>	Have you <b>ever consumed</b> a drink that contains alcohol such as beer, wine, spirit, fermented toddy or yeast?	Yes 1 No 2	<input type="text"/>	<i>If No, Go to K1</i>
<b>A 1b</b>	Have you consumed alcohol within the <b>past 12 months</b> ?	Yes 1 No 2	<input type="text"/>	<i>If No, Go to K1</i>
<b>A 2</b>	In the past 12 months, <b>how frequently</b> have you had at least one drink? <i>(READ RESPONSES)</i> <i>USE SHOWCARD</i>	5 or more days a week 1 1-4 days per week 2 1-3 days a month 3 Less than once a month 4	<input type="text"/>	
<b>A 3</b>	When you drink alcohol, <b>on average</b> , how many drinks do you have during one day?	Number	<input type="text"/> <input type="text"/>	
<b>A 4</b>	During each of the <b>past 7 days</b> , how many standard drinks of any alcoholic drink did you have each day? <i>(RECORD FOR EACH DAY)</i> <i>USE SHOWCARD</i>	Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

**Note:** Code **DK** for "Don't know" or "Don't remember".



P 4	Does your work involve moderate-intensity activity, like brisk walking <i>or carrying light loads</i> for at least 10 minutes at a time? <i>INSERT EXAMPLES &amp; USE SHOWCARD</i>	Yes No	1 2	<input type="checkbox"/>	If No, go to P6
P 5a	In a typical week, on how many days do you do moderate-intensity activities as part of your work?	Days a week		<input type="checkbox"/>	
P 5b	On a typical day on which you did moderate-intensity activities, how much time do you spend doing such work?	In hours and minutes	hrs <input type="text"/> <input type="text"/> : mins <input type="text"/> <input type="text"/>		
		OR in Minutes only	or minutes <input type="text"/> <input type="text"/> <input type="text"/>		
P 6	How long is your typical work day?	Number of hours	hrs <input type="text"/> <input type="text"/>		
Other than activities that you've already mentioned, I would like to ask you about the way you travel to and from places. For example to work, for shopping, to market, to church.					
P 7	Do you walk or use a bicycle ( <i>pedal cycle</i> ) for at least 10 minutes continuously to get to and from places?	Yes No	1 2	<input type="checkbox"/>	If No, go to P9
P 8a	In a typical week, on how many days do you walk or bicycle for at least 10 minutes to get to and from places?	Days a week		<input type="checkbox"/>	
P 8b	How much time would you spend walking or bicycling for travel on a typical day?	In hours and minutes	hrs <input type="text"/> <input type="text"/> : mins <input type="text"/> <input type="text"/>		
		OR in Minutes only	or minutes <input type="text"/> <input type="text"/> <input type="text"/>		
The next questions ask about activities you do in your leisure time. Think about activities you do for recreation, fitness or sports. Do not include the physical activities you do at work or for travel mentioned already.					
P 9	Does your <i>leisure time</i> involve mostly sitting, reclining, or standing, with no physical activity lasting more than 10 minutes at a time?	Yes No	1 2	<input type="checkbox"/>	If Yes, go to P 14
P 10	In your <i>leisure time</i> , do you do any vigorous activities like <i>running or strenuous sports, weight lifting</i> for at least 10 minutes at a time? <i>INSERT EXAMPLES &amp; USE SHOWCARD</i>	Yes No	1 2	<input type="checkbox"/>	If No, go to P 12
P 11a	If Yes, In a typical week, on how many days do you do vigorous activities as part of your <i>leisure time</i> ?	Days a week		<input type="checkbox"/>	
P 11b	How much time do you spend doing this on a typical day?	In hours and minutes	hrs <input type="text"/> <input type="text"/> : mins <input type="text"/> <input type="text"/>		
		OR in Minutes only	or minutes <input type="text"/> <input type="text"/> <input type="text"/>		
P 12	In your <i>leisure time</i> , do you do any moderate-intensity activities like brisk walking, <i>cycling or swimming</i> for at least 10 minutes at a time? <i>INSERT EXAMPLES &amp; USE SHOWCARD</i>	Yes No	1 2	<input type="checkbox"/>	If No, go to P 14
P 13a	If Yes In a typical week, on how many days do you do moderate-intensity activities as part of [ <i>leisure time</i> ]?	Days a week		<input type="checkbox"/>	
P 13b	How much time do you spend doing this on a typical day?	In hours and minutes	hrs <input type="text"/> <input type="text"/> : mins <input type="text"/> <input type="text"/>		
		OR in Minutes only	or minutes <input type="text"/> <input type="text"/> <input type="text"/>		
The following question is about sitting or reclining. Think back over the past 7 days, to time spent at work, at home, in <i>leisure</i> , including time spent sitting at a desk, visiting friends, reading, or watching television, but do not include time spent sleeping.					
P 14	Over the past 7 days, how much time did you spend sitting or reclining on a typical day?	In hours and minutes	hrs <input type="text"/> <input type="text"/> : mins <input type="text"/> <input type="text"/>		
		OR in Minutes only	or minutes <input type="text"/> <input type="text"/> <input type="text"/>		

**Note:** Code **DK** for "Don't know" or "Don't remember".

History of High Blood Pressure				
V 2	How many times did you visit the doctor during the last 12 months? (Include hospitalisation or visits to the outpatient department/health clinics; do not include visits to the dentist).	Number of times		<input type="text"/> <input type="text"/>
H 1	When was your blood pressure last measured by a health professional?	Within past 12 months 1 1-5 years ago 2 Not within past 5 yrs 3		<input type="text"/>
H 2	During the past 12 months have you been told by a doctor or other health worker that you have elevated blood pressure or hypertension?	Yes 1 No 2		<input type="text"/> <i>If No, skip to H6</i>
H 3	Are you currently receiving any of the following treatments for high blood pressure prescribed by a doctor or other health worker?			
H 3a	Drugs (medication) that you have taken in the last 2 weeks	Yes 1 No 2		<input type="text"/>
H 3b	Special prescribed diet	Yes 1 No 2		<input type="text"/>
H 3c	Advice or treatment to lose weight	Yes 1 No 2		<input type="text"/>
H 3d	Advice or treatment to stop smoking	Yes 1 No 2		<input type="text"/>
H 3e	Advice to start or do more exercise	Yes 1 No 2		<input type="text"/>
H 4	During the past 12 months have you seen a traditional healer for elevated blood pressure or hypertension	Yes 1 No 2		<input type="text"/>
H 5	Are you currently taking any herbal or traditional remedy for your high blood pressure?	Yes 1 No 2		<input type="text"/>
History of Diabetes				
H 6	When was your blood sugar last measured by a health professional?	Within past 12 months 1 1-5 years ago 2 Not within past 5 yrs 3		<input type="text"/>
H 7	Have you ever been told by a doctor or other health worker that you have diabetes?	Yes 1 No 2		<input type="text"/> <i>If No, skip to V3</i>
H 8	Are you currently receiving any of the following treatments for diabetes prescribed by a doctor or other health worker?			
H 8a	Insulin	Yes 1 No 2		<input type="text"/>
H 8b	Oral drug (medication that you have taken in the last 2 weeks)	Yes 1 No 2		<input type="text"/>
H 8c	Special prescribed diet	Yes 1 No 2		<input type="text"/>
H 8d	Advice or treatment to lose weight	Yes 1 No 2		<input type="text"/>
H 8e	Advice or treatment to stop smoking	Yes 1 No 2		<input type="text"/>
H 8f	Advice to start or do more exercise	Yes 1 No 2		<input type="text"/>
H 9	During the past 12 months have you seen a traditional healer for diabetes?	Yes 1 No 2		<input type="text"/>
H 10	Are you currently taking any herbal or traditional remedy for your diabetes?	Yes 1 No 2		<input type="text"/>
Comments: Step 1 (to be answered by the Interviewer)				
V 3	Are there any irregularities or problems with the measurements?	Yes 1 No 2		<input type="text"/>

If yes, please describe. \_\_\_\_\_

## Step 2 Physical Measurements

Height and weight				Coding Column	
M 1	Technician ID Code			<input type="text"/>	
M 2a & 2b	Device IDs for height and weight	(2a) height	(2b) weight	<input type="text"/>	
M 3	Height	(in Centimetres)		<input type="text"/>	
M 4	Weight <i>If too large for scale, use two scales</i>	(in Kilograms)		<input type="text"/>	
M 5	(For women) Are you pregnant?	Yes No	1 2	<input type="text"/>	If Yes, Skip Waist

Waist				
M 6	Technician ID			<input type="text"/>
M 7	Device ID for waist			<input type="text"/>
M 8	Waist circumference	(in Centimetres)		<input type="text"/>
M 16	Hip circumference	(in Centimetres)		<input type="text"/>

Blood pressure				Coding Column	
M 9	Technician ID			<input type="text"/>	
M 10	Device ID for blood pressure			<input type="text"/>	
M 11	Cuff size used	Standard Large Extra large	1 2 3	<input type="text"/>	
M 12a	Reading 1	Systolic BP	Systolic mmHg	<input type="text"/>	
M 12b		Diastolic BP	Diastolic mmHg	<input type="text"/>	
M 13a	Reading 2	Systolic BP	Systolic mmHg	<input type="text"/>	
M 13b		Diastolic BP	Diastolic mmHg	<input type="text"/>	
M 14a	Reading 3	Systolic BP	Systolic mmHg	<input type="text"/>	
M 14b		Diastolic BP	Diastolic mmHg	<input type="text"/>	

Heart Rate				
M 17a	Reading 1	Beats per minute:		<input type="text"/>
M 17b	Reading 2	Beats per minute:		<input type="text"/>
M 17c	Reading 3	Beats per minute:		<input type="text"/>

## Step 3 Biochemical Measurements

Blood glucose				Coding Column
B 1	Since 10pm last night, have you had anything to eat, drink chew or suck, other than water?	Yes 1 No 2	<input type="checkbox"/>	
B 2	Technician ID Code		<input type="checkbox"/> <input type="checkbox"/>	
B 3	Device ID code		<input type="checkbox"/> <input type="checkbox"/>	
B 4	Time of day blood specimen taken (24 hour clock)		hrs <input type="checkbox"/> <input type="checkbox"/> : mins <input type="checkbox"/> <input type="checkbox"/>	
B 5	Blood glucose	OR Low 1 High 2 Unable to assess 3	mmol/l <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> OR <input type="checkbox"/>	
Blood Lipids				
B 6	Technician ID Code		<input type="checkbox"/> <input type="checkbox"/>	
B 7	Device ID code		<input type="checkbox"/> <input type="checkbox"/>	
B 8	Total cholesterol	OR Low 1 High 2 Unable to assess 3	mmol/l <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> OR <input type="checkbox"/>	
Haemoglobin				
B 15	<i>(For women age 15-44 years)</i> Are you breastfeeding?	Yes 1 No 2	<input type="checkbox"/>	
B 16	Technician ID Code		<input type="checkbox"/> <input type="checkbox"/>	
B 17	Device ID code		<input type="checkbox"/> <input type="checkbox"/>	
B 18	Haemoglobin		<input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>	

Comments: Step 2 and 3 (to be answered by any Step 2 or 3 technician)			
V 4	Are there any irregularities or problems with the measurements?	Yes 1 No 2	<input type="checkbox"/>

If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_