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**The FSM Department of HESA and the Chuuk State Department of Health Services  
in collaboration with the World Health Organization & the World Health Organization**



**The WHO STEPwise approach to Surveillance of Non-Communicable Diseases (STEPS)**

Check if the following are completed	(to be checked by:)	Yes	No	Signature
Fasting status	(Registration Station)	<input type="checkbox"/>	<input type="checkbox"/>	
Step 1, 2 & 3 data collection	(Checkout Station)	<input type="checkbox"/>	<input type="checkbox"/>	
First EpiData data entry	(Data entry personnel)	<input type="checkbox"/>	<input type="checkbox"/>	
Second EpiData 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:**

I 1	Island code	<input type="checkbox"/>
I 2	Island Name:	
I 3	Village code: (SEE NOTE BELOW)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
I 4	Village Name	
I 5	Interviewer code	<input type="checkbox"/> <input type="checkbox"/>
I 6	Date of completion of the questionnaire	<input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> /200 <input type="checkbox"/> Day                  Month                  Year

Respondent ID Number -

<b>Consent</b>			
I 7	Consent has been read out to respondent	Yes 1 No 2	<input type="checkbox"/> If NO, read consent
I 8	Consent has been obtained (verbal or written)	Yes 1 No 2	<input type="checkbox"/> If NO, END
I 9	Interview Language	Chuukese 1 English 2	<input type="checkbox"/>
I 10	Time of interview (24 hour clock)		<input type="checkbox"/> <input type="checkbox"/> : <input type="checkbox"/> <input type="checkbox"/>
I 11	Family Name		
I 12	First Name		
I 13	Hospital Number		<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>
I 14	Contact phone number where possible		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
I 15	Specify whose phone	Work 1 Home 2 Neighbour 3 Other (specify) 4	<input type="checkbox"/>

*Note: Identification information I7 to I15 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.*

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<b>Step 1</b>		<b>Demographic Information</b>																									
<b>C1</b>	Sex ( <i>Record Male / Female as observed</i> )	<table style="width: 100%; border: none;"> <tr> <td style="text-align: right; padding-right: 10px;">Male</td> <td style="text-align: center; padding: 0 10px;">1</td> <td style="width: 20px;"></td> </tr> <tr> <td style="text-align: right; padding-right: 10px;">Female</td> <td style="text-align: center; padding: 0 10px;">2</td> <td style="width: 20px;"></td> </tr> </table>	Male	1		Female	2		<input type="checkbox"/>																		
Male	1																										
Female	2																										
<b>C2</b>	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"/>																									
<b>C3</b>	How old are you?	Years	<input type="text"/> <input type="text"/>																								
<b>C4</b>	What is your <i>ethnic background</i> ?	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding-right: 10px;">Chuukese</td> <td style="text-align: center; padding: 0 10px;">1</td> <td style="width: 50%; padding-right: 10px;">Pohnpei – O.I</td> <td style="text-align: center; padding: 0 10px;">6</td> </tr> <tr> <td style="padding-right: 10px;">Mortlockese</td> <td style="text-align: center; padding: 0 10px;">2</td> <td style="padding-right: 10px;">Yapese</td> <td style="text-align: center; padding: 0 10px;">7</td> </tr> <tr> <td style="padding-right: 10px;">Hallese</td> <td style="text-align: center; padding: 0 10px;">3</td> <td style="padding-right: 10px;">Yap - O.I</td> <td style="text-align: center; padding: 0 10px;">8</td> </tr> <tr> <td style="padding-right: 10px;">Westlockese</td> <td style="text-align: center; padding: 0 10px;">4</td> <td style="padding-right: 10px;">Kosraean</td> <td style="text-align: center; padding: 0 10px;">9</td> </tr> <tr> <td style="padding-right: 10px;">Pohnpeian</td> <td style="text-align: center; padding: 0 10px;">5</td> <td style="padding-right: 10px;">Filipino</td> <td style="text-align: center; padding: 0 10px;">10</td> </tr> <tr> <td></td> <td></td> <td style="padding-right: 10px;">Others</td> <td style="text-align: center; padding: 0 10px;">11</td> </tr> </table>	Chuukese	1	Pohnpei – O.I	6	Mortlockese	2	Yapese	7	Hallese	3	Yap - O.I	8	Westlockese	4	Kosraean	9	Pohnpeian	5	Filipino	10			Others	11	<input type="checkbox"/>
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Pohnpeian	5	Filipino	10																								
		Others	11																								
<b>C5</b>	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"/>																								
<b>C6</b>	What is the highest level of education you have <u>completed</u> ?	<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 10px;">Never attended school</td> <td style="text-align: center; padding: 0 10px;">1</td> </tr> <tr> <td style="padding-right: 10px;">Elementary school (1-8 Grades)</td> <td style="text-align: center; padding: 0 10px;">2</td> </tr> <tr> <td style="padding-right: 10px;">High school (9-12Grades)</td> <td style="text-align: center; padding: 0 10px;">3</td> </tr> <tr> <td style="padding-right: 10px;">2 Year college</td> <td style="text-align: center; padding: 0 10px;">4</td> </tr> <tr> <td style="padding-right: 10px;">4 Year college</td> <td style="text-align: center; padding: 0 10px;">5</td> </tr> <tr> <td style="padding-right: 10px;">Postgraduate</td> <td style="text-align: center; padding: 0 10px;">6</td> </tr> </table>	Never attended school	1	Elementary school (1-8 Grades)	2	High school (9-12Grades)	3	2 Year college	4	4 Year college	5	Postgraduate	6	<input type="checkbox"/>												
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Postgraduate	6																										
<b>C7</b>	Which of the following best describes your <u>main</u> work status over the last 12 months?  USE SHOWCARD	<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 10px;">Government employee</td> <td style="text-align: center; padding: 0 10px;">1</td> </tr> <tr> <td style="padding-right: 10px;">Non-government employee</td> <td style="text-align: center; padding: 0 10px;">2</td> </tr> <tr> <td style="padding-right: 10px;">Self-employed</td> <td style="text-align: center; padding: 0 10px;">3</td> </tr> <tr> <td style="padding-right: 10px;">Non-paid</td> <td style="text-align: center; padding: 0 10px;">4</td> </tr> <tr> <td style="padding-right: 10px;">Student</td> <td style="text-align: center; padding: 0 10px;">5</td> </tr> <tr> <td style="padding-right: 10px;">Homemaker</td> <td style="text-align: center; padding: 0 10px;">6</td> </tr> <tr> <td style="padding-right: 10px;">Retired</td> <td style="text-align: center; padding: 0 10px;">7</td> </tr> <tr> <td style="padding-right: 10px;">Unemployed (able to work)</td> <td style="text-align: center; padding: 0 10px;">8</td> </tr> <tr> <td style="padding-right: 10px;">Unemployed (unable to work)</td> <td style="text-align: center; padding: 0 10px;">9</td> </tr> </table>	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"/>						
Government employee	1																										
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Student	5																										
Homemaker	6																										
Retired	7																										
Unemployed (able to work)	8																										
Unemployed (unable to work)	9																										
<b>C8</b>	How many people older than 18 years, including yourself, live in your household?	Number of people	<input type="text"/> <input type="text"/>																								
<b>C9</b>	Taking the <u>past year</u> , can you tell me what the average earnings of the household have been?	<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 20px;">Per week</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td style="padding-right: 20px;">OR per month</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td style="padding-right: 20px;">OR per year</td> <td style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> </table> <p style="text-align: right; font-size: small; margin-top: 5px;"><i>Go to Next Section (S1a) if given estimated earnings</i></p>	Per week	<input type="text"/> <input type="text"/> <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"/> <input type="text"/> <input type="text"/>	OR per year	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 10px;">Refused</td> <td style="text-align: center; padding: 0 10px;">8</td> </tr> </table> <input type="checkbox"/>	Refused	8																
Per week	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																										
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<b>C10</b>	If you don't know the amount, can you give an estimate of the annual household income if I read some options to you? Is it	<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 10px;">Less than \$5,000</td> <td style="text-align: center; padding: 0 10px;">1</td> </tr> <tr> <td style="padding-right: 10px;">between \$5,000 and \$10,000</td> <td style="text-align: center; padding: 0 10px;">2</td> </tr> <tr> <td style="padding-right: 10px;">between \$10,000 and \$15,000</td> <td style="text-align: center; padding: 0 10px;">3</td> </tr> <tr> <td style="padding-right: 10px;">between \$15,000 and \$20,000</td> <td style="text-align: center; padding: 0 10px;">4</td> </tr> <tr> <td style="padding-right: 10px;">More than \$20,000</td> <td style="text-align: center; padding: 0 10px;">5</td> </tr> <tr> <td style="padding-right: 10px;">Refused</td> <td style="text-align: center; padding: 0 10px;">8</td> </tr> </table>	Less than \$5,000	1	between \$5,000 and \$10,000	2	between \$10,000 and \$15,000	3	between \$15,000 and \$20,000	4	More than \$20,000	5	Refused	8	<input type="checkbox"/>												
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More than \$20,000	5																										
Refused	8																										
<b>C11</b>	For each of the following, indicate whether any immediate member of your family (siblings, parents, or children) has been affected by this health problem  TICK all that apply	<table style="width: 100%; border: none;"> <tr> <td style="padding-right: 10px;">Heart disease</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Mental health disease</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Diabetes</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Stroke</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Asthma</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Kidney disease</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Liver disease</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Hypertension</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Cancer (specify site if possible)</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Hearing related</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> <tr> <td style="padding-right: 10px;">Visual related</td> <td style="text-align: center; padding: 0 10px;"><input type="checkbox"/></td> </tr> </table>	Heart disease	<input type="checkbox"/>	Mental health disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Cancer (specify site if possible)	<input type="checkbox"/>	Hearing related	<input type="checkbox"/>	Visual related	<input type="checkbox"/>			
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Cancer (specify site if possible)	<input type="checkbox"/>																										
Hearing related	<input type="checkbox"/>																										
Visual related	<input type="checkbox"/>																										

If Refused  
Go to C10

**Note\***: 1) The **Date of Birth** (C2) or the **age** (C3) or **both** (C2 and C3) have to be filled. If both C2 and C3 not available, then STOP.  
CODE "DK" FOR DON'T KNOW or DON'T REMEMBER

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**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>S 1a</b>	Do you currently smoke any tobacco products, such as cigarettes, cigars or pipes?	Yes 1 No 2	<input type="checkbox"/>	<i>If No, go to S5</i>
<b>S 1b</b>	<u>If Yes,</u> Do you currently smoke tobacco products daily?	Yes 1 No 2	<input type="checkbox"/>	<i>If No, go to S5</i>
<b>S 2a</b>	How old were you when you first started smoking daily?	Age (years) Don't remember D K	<input type="text"/> <input type="text"/>	<i>If Known, go to S 3</i>
<b>S 2b</b>	Do you remember how long ago it was?	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, how many of the following do you smoke each day? <i>(RECORD FOR EACH TYPE)</i>  _____	Manufactured cigarettes  Hand-rolled cigarettes  Pipes full of tobacco  Cigars, cheroots, cigarillos  ← 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"/> <input type="text"/>	
<b>S 4</b>	If you smoke, how useful would each of the following be in helping you to quit? <i>(code for each group as below)</i> Not useful 1 Somewhat useful 2 Very useful 3	Friends Substance abuse & mental health program staff Medical Doctor Hang out with friends who don't smoke Pastor/Minister/Priest Youth groups Teacher/Professor Uncles, spouse or other relatives Parents Exercise/Increase participation in sports Stay away from bars/night clubs	<input type="checkbox"/> <input type="checkbox"/>	
<b>S 5</b>	In the past did you ever smoke daily?	Yes 1 No 2	<input type="checkbox"/>	<i>If No, go to S7a</i>
<b>S 6a</b>	How old were you when you stopped smoking daily?		<input type="text"/> <input type="text"/>	
<b>S 6b</b>	If you don't remember how old you were, how long ago?	In Years  OR in Months  OR in Weeks	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<b>S 7a</b>	Do you currently use smokeless tobacco such as chewing tobacco or snuff?	Yes 1 No 2	<input type="text"/> <input type="text"/>	<i>If No, go to S9</i>
<b>S 7b</b>	if Yes, do you currently use smokeless tobacco products daily?	Yes 1 No 2	<input type="text"/> <input type="text"/>	
<b>S 8</b>	On average, how many times do you use smokeless tobacco on the days that you use it?	Number of times per day	<input type="text"/> <input type="text"/>	



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<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 USE SHOWCARD)</i>	Monday	<input type="checkbox"/>	<input type="checkbox"/>
		Tuesday	<input type="checkbox"/>	<input type="checkbox"/>
		Wednesday	<input type="checkbox"/>	<input type="checkbox"/>
		Thursday	<input type="checkbox"/>	<input type="checkbox"/>
		Friday	<input type="checkbox"/>	<input type="checkbox"/>
		Saturday	<input type="checkbox"/>	<input type="checkbox"/>
		Sunday	<input type="checkbox"/>	<input type="checkbox"/>
<b>A 5a</b>	<b>For Men</b> In the past 12 months on how many days did you have 5 or more alcoholic drinks on a single day?	Number of days	<input type="checkbox"/>	<input type="checkbox"/>
<b>A 5b</b>	<b>For Women</b> In the past 12 months on how many days did you have 4 or more alcoholic drinks on a single day?	Number of days	<input type="checkbox"/>	<input type="checkbox"/>
<b>A 6</b>	In the past 12 months, what was the <b>largest number of drinks</b> you had on a single occasion, counting all types of alcoholic beverages combined?	Number of drinks	<input type="checkbox"/>	<input type="checkbox"/>
<b>A 7</b>	If you consume alcohol, how useful would each of the following be in helping you to quit? <i>(code for each group as below)</i> Not useful                    1 Somewhat useful            2 Very useful                    3	Friends Substance abuse & mental health program staff Medical Doctor Hang out with friends who don't smoke Pastor/Minister/Priest Youth groups Teacher/Professor Uncles, spouse or other relatives Parents Exercise/Increase participation in sports Stay away from bars/night clubs	<input type="checkbox"/>	<input type="checkbox"/>

**Diet (Section D)**

The next questions ask about the fruits and vegetables that you usually eat. I have a nutrition card here that describes some examples of local fruits and vegetables. As you answer these questions please think of a typical week in the last year.

<b>D 1a</b>	In a typical week, on how many days do you eat fruit? <i>USE SHOWCARD</i>	Number of days	<input type="checkbox"/>	
<b>D 1b</b>	How many <b>servings</b> of fruit do you eat on one of those days? <i>USE SHOWCARD</i>	Number of servings Don't know            D K	<input type="checkbox"/>	<input type="checkbox"/>
<b>D 2a</b>	In a typical week, on how many days do you eat vegetables? <i>USE SHOWCARD</i>	Number of days	<input type="checkbox"/>	
<b>D 2b</b>	How many <b>servings</b> of vegetables do you eat on one of those days? <i>USE SHOWCARD</i>	Number of servings Don't know            D K	<input type="checkbox"/>	<input type="checkbox"/>

*If Zero days, go to D2a*

*If Zero days, go to D3*

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D 3	On how many days do you eat the following in a typical week?					Meat <input type="checkbox"/> <input type="checkbox"/> Chicken <input type="checkbox"/> <input type="checkbox"/> Eggs <input type="checkbox"/> <input type="checkbox"/> Milk Products <input type="checkbox"/> <input type="checkbox"/> Fish <input type="checkbox"/> <input type="checkbox"/>
	Do you usually prepare meals?	Yes	1			
		No	2			<input type="checkbox"/>
D 4b	What type of oil or fat is most often used for meal preparation in your household? <i>SELECT ONLY ONE</i>	Vegetable oil	1			
		Lard or suet	2			
		Butter	3			
		Margarine	4			
		Coconut oil	5			<input type="checkbox"/>
		← Other	6			
		None in particular	7			
		None used	8			
		Don't know	9			
D 5	In a typical week, on how many days do you eat fresh fish?	Number of days				<input type="checkbox"/>
D 6	In a typical week, on how many days do you eat canned fish?	Number of days				<input type="checkbox"/>

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

**Physical Activity (Section P)**

Next I am going to ask you about the time you spend doing different types of physical activity. Please answer these questions even if you do not consider yourself to be an active person.  
Think first about the time you spend doing work. Think of work as the things that you have to do such as paid or unpaid work, household chores, harvesting food, fishing or hunting for food, seeking employment. *[Insert other examples if needed]*

P 1	Did you work mostly in the household?	Yes	1			<input type="checkbox"/>
		No	2			
P 2	How long is your typical work day?	Number of hours		hrs	<input type="checkbox"/> <input type="checkbox"/>	
P 3	Does your work involve mostly sitting or standing, with walking for no more than 10 minutes at a time?	Yes	1			<input type="checkbox"/>
		No	2			
P 4	Does your work involve vigorous activity, like <i>[heavy lifting, digging or construction work]</i> for at least 10 minutes at a time? <i>INSERT EXAMPLES &amp; USE SHOWCARD</i>	Yes	1			<input type="checkbox"/>
		No	2			
P 4a	In a typical week, on how many days do you do vigorous activities as part of your work?	Days a week				<input type="checkbox"/>
P 4b	On a typical day on which you do vigorous activity, how much time do you spend doing such work?	In hours and minutes	hrs	<input type="checkbox"/> <input type="checkbox"/> : mins	<input type="checkbox"/> <input type="checkbox"/>	
		OR in Minutes only		or minutes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
P 5	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	1			<input type="checkbox"/>
		No	2			
P 6a	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 6b	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="checkbox"/> <input type="checkbox"/> : mins	<input type="checkbox"/> <input type="checkbox"/>	
		OR in Minutes only		or minutes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

*If Yes, go to P7*

*If No, go to P5*

*If No, go to P7*

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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. *[insert other examples if needed]*

<b>P 7</b>	Do you walk or use a bicycle ( <i>pedal cycle</i> ) for at least 10 minutes continuously to get to and from places?	Yes 1 No 2	<input type="checkbox"/>
<b>P 8a</b>	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"/>
<b>P 8b</b>	On a typical day during which you would walk or bicycle for travel for at least 10 minutes, how much time would you spend doing this?	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"/>	

*If No, go to P9*

The next questions ask about activities you do in your leisure time. Think about activities you do for recreation, fitness or sports *[insert relevant terms]*. Do not include the physical activities you do at work or for travel mentioned already.

<b>P 9</b>	Does your [ <i>recreation, sport or leisure time</i> ] involve mostly sitting, reclining, or standing, with no physical activity lasting more than 10 minutes at a time?	Yes 1 No 2	<input type="checkbox"/>
<b>P 10</b>	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 1 No 2	<input type="checkbox"/>
<b>P 11a</b>	<i>If Yes,</i> 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"/>
<b>P 11b</b>	On a typical day on which you do vigorous activity as part of your [ <i>leisure time</i> ], how much time do you spend doing this?	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"/>	

*If Yes, go to P 14*

*If No, go to P 12*

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

<b>P 12</b>	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 1 No 2	<input type="checkbox"/>
<b>P 13a</b>	<i>If Yes</i> 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"/>
<b>P 13b</b>	On a typical day on which you do moderate-intensity activity as part of your [ <i>leisure time</i> ], how much time do you spend doing this?	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"/>	

*If No, go to P 14*

The following question is about sitting or reclining. Think back over the past 7 days, to time spent at work, at home, in [*leisure*], including time spent sitting at a desk, visiting friends, reading, or watching television, but do not include time spent sleeping.

<b>P 14</b>	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"/>	
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**History of High Blood Pressure**

<b>H 1</b>	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="checkbox"/>
<b>H 2</b>	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="checkbox"/>
<b>H 3</b>	Are you currently receiving any of the following treatments for high blood pressure prescribed by a doctor or other health worker?		
<b>H 3a</b>	Drugs (medication) that you have taken in the last 2 weeks	Yes 1 No 2	<input type="checkbox"/>
<b>H 3b</b>	Special prescribed diet	Yes 1 No 2	<input type="checkbox"/>
<b>H 3c</b>	Advice or treatment to lose weight	Yes 1 No 2	<input type="checkbox"/>

*If No, skip to Next Section*

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<b>H 3d</b>	Advice or treatment to stop smoking	Yes 1 No 2			<input type="checkbox"/>
<b>H 3e</b>	Advice to start or do more exercise	Yes 1 No 2			<input type="checkbox"/>
<b>H 4</b>	During the past 12 months have you seen a traditional healer for elevated blood pressure or hypertension	Yes 1 No 2			<input type="checkbox"/>
<b>H 5</b>	Are you currently taking any herbal or traditional remedy for your high blood pressure?	Yes 1 No 2			<input type="checkbox"/>
<b>History of Diabetes</b>					
<b>H 6</b>	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="checkbox"/>
<b>H 7</b>	Have you ever been told by a doctor or other health worker that you have diabetes?	Yes 1 No 2			<input type="checkbox"/>
<b>H 8</b>	Are you currently receiving any of the following treatments for diabetes prescribed by a doctor or other health worker?				
<b>H 8a</b>	Insulin	Yes 1 No 2			<input type="checkbox"/>
<b>H 8b</b>	Oral drug (medication that you have taken in the last 2 weeks)	Yes 1 No 2			<input type="checkbox"/>
<b>H 8c</b>	Special prescribed diet	Yes 1 No 2			<input type="checkbox"/>
<b>H 8d</b>	Advice or treatment to lose weight	Yes 1 No 2			<input type="checkbox"/>
<b>H 8e</b>	Advice or treatment to stop smoking	Yes 1 No 2			<input type="checkbox"/>
<b>H 8f</b>	Advice to start or do more exercise	Yes 1 No 2			<input type="checkbox"/>
<b>H 9</b>	During the past 12 months have you seen a traditional healer for diabetes?	Yes 1 No 2			<input type="checkbox"/>
<b>H 10</b>	Are you currently taking any herbal or traditional remedy for your diabetes?	Yes 1 No 2			<input type="checkbox"/>
<b>H 11</b>	About how many times in the past 12 months has a health worker checked your feet for any sores or irritations?	Number of times			<input type="checkbox"/>
<b>H 12</b>	When was the last time you had an eye examination in which pupils were dilated	Within the past month (anytime less than 1 month ago) Within the past year (1 month but less than 12 months ago) Within the past 2 years (1 year but less than 2 years ago) 2 or more years Never Don't know/Not sure Refused			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>H 13</b>	In the past 12 months have you had a flu shot?	Yes 1 No 2 Don't know/Not sure 3			<input type="checkbox"/>

*If No, skip to Next Section*

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<b>H 14</b>	In the last 12 months, have you had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called pneumococcal vaccine.	Yes No Don't know/Not sure	1 2 3	<input type="checkbox"/>
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**Comments: Step 1 (to be answered by the Interviewer)**

<b>V 2</b>	Are there any irregularities or problems with the questions?	Yes No	1 2	<input type="checkbox"/>
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If yes, please describe. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Step 2</b>		<b>Physical Measurements</b>			
<b>Height and weight</b>				<b>Coding Column</b>	
<b>M 1</b>	Technician ID Code				<input type="checkbox"/> <input type="checkbox"/>
<b>M 2a &amp; 2b</b>	Device IDs for height and weight				(2a) height <input type="checkbox"/> (2b) weight <input type="checkbox"/>
<b>M 3</b>	Height	(in Centimetres)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>
<b>M 4</b>	Weight <i>If too large for scale, code 666.6</i>	(in Kilograms)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>
<b>M 5</b>	(For women) Are you pregnant?	Yes No Uncertain	1 2 3		<input type="checkbox"/>
<b>Waist and Hip</b>					
<b>M 6</b>	Technician ID				<input type="checkbox"/> <input type="checkbox"/>
<b>M 7</b>	Device ID for waist				<input type="checkbox"/>
<b>M 8</b>	Waist circumference	(in Centimetres)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>
<b>M 9</b>	Hip circumference	(in Centimetres)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/>
<b>Blood pressure</b>				<b>Coding Column</b>	
<b>M 10</b>	Technician ID				<input type="checkbox"/> <input type="checkbox"/>
<b>M 11</b>	Device ID for blood pressure				<input type="checkbox"/>
<b>M 12</b>	Cuff size used	Normal Large Manual	1 2 3		<input type="checkbox"/>
<b>M 13a</b>	Reading 1                      Systolic BP	Systolic	mmHg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>M 13b</b>	Diastolic BP	Diastolic	mmHg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>M 14a</b>	Reading 2                      Systolic BP	Systolic	mmHg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>M 14b</b>	Diastolic BP	Diastolic	mmHg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>M 15a</b>	Reading 3                      Systolic BP	Systolic	mmHg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>M 15b</b>	Diastolic BP	Diastolic	mmHg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

*If Yes, Skip  
Waist and Hip*

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**Step 3 Biochemical Measurements**

Blood glucose		Coding Column	
<b>B 1</b>	Since 10pm last night, have you had anything to eat or drink, other than water?	Yes 1 No 2 Uncertain 3	<input type="checkbox"/>
<b>B 2</b>	Technician ID Code		<input type="checkbox"/> <input type="checkbox"/>
<b>B 3</b>	Device ID code		<input type="checkbox"/>
<b>B 4</b>	Time of day blood specimen taken (24 hour clock)		hrs <input type="checkbox"/> <input type="checkbox"/> : mins <input type="checkbox"/> <input type="checkbox"/>
<b>B 5</b>	Blood glucose	Low 1 High 2 Unable to assess 3	mmol/l <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>

**Blood Lipids**

<b>B 6</b>	Technician ID Code (cholesterol)		<input type="checkbox"/> <input type="checkbox"/>
<b>B 7</b>	Device ID code (cholesterol)		<input type="checkbox"/>
<b>B 8</b>	Total cholesterol	Low 1 High 2 Unable to assess 3	mmol/l <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>B 9</b>	Technician ID Code (triglycerides)		<input type="checkbox"/> <input type="checkbox"/>
<b>B 10</b>	Device ID code (triglycerides)		<input type="checkbox"/>
<b>B 11</b>	Triglycerides	Low 1 High 2 Unable to assess 3	mmol/l <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**Comments: Step 2 and 3 (to be answered by any Step 2 or 3 technician)**

<b>V 3</b>	Are there any irregularities or problems with the measurements?	Yes 1 No 2	<input type="checkbox"/>
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If yes, please describe. \_\_\_\_\_  
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