# A Phase 1 Data

1.1 AWI-Gen Participant Study code

_____

Site ID

_____

Gender

○ Female ○ Male

Date of Birth known

○ Yes ○ No

Date of Birth

_____

Unique Site Identify

_____

Year of birth

○ Yes ○ No

Home Language

○ Afrikaans ○ English ○ isiNdebele ○ isiXhosa ○ isiZulu ○ Sesotho ○ Sepedi
○ Setswana ○ siSwati ○ Tshivenda ○ Xitsonga ○ Shona ○ Embu ○ Kalenjin
○ Kamba ○ Kikuyu ○ Kisii ○ Luhya ○ Luo ○ Maasai ○ Meru ○ Mijikenda
○ Somali ○ Swahili ○ Taita ○ Taveta ○ Nankam ○ Kassem ○ Buli ○ Sisali
○ Kusal ○ Gruni ○ Dagbani ○ Dagaare ○ Mamprusi ○ Moore ○ Gourounsi
○ Fulani ○ Gourmatchema ○ Dioula ○ Bissa ○ Dagara ○ Francais ○ Other
○ Unknown

Ethnicity

○ Zulu ○ Xhosa ○ Ndebele ○ Sotho ○ Venda ○ Tsonga ○ Tswana ○ BaPedi
○ Zimbabwean ○ Embu ○ Kalenjin ○ Kamba ○ Kikuyu ○ Kisii ○ Luhya ○ Luo
○ Maasai ○ Meru ○ Mijikenda ○ Somali ○ Swahili ○ Taita ○ Taveta ○ Kassena
○ Nankana ○ Bulsa ○ Dagaati ○ Sisala ○ Dagomba ○ Kusasi ○ Mampruga
○ Frafra ○ Mossi ○ Gourounsi ○ Peulh ○ Gourmatche ○ Dioula ○ Bissa ○ Dagara
○ Swati ○ Unknown ○ Other ○ Missing

Ethnolinguistic data available

○ Yes ○ No

# 1. Participant Identification

## 1.1 General Information

1.1.1 Is Unique Site Identifier [phase_1_arm_1][phase_1_unique_site_id] correct?

○ Yes ○ No

1.1.2 Please enter the correct Unique Site ID.

_____

1.1.3 Site name

○ Agincourt
○ DIMAMO
○ Nairobi
○ Nanoro
○ Navrongo
○ Soweto

1.1.4 Data collection date

_____

1.1.5 Start time of questionnaire

_____

1.1.6 End time of questionnaire

_____

1.1.7 Cash compensation paid to participant?

○ Yes ○ No

## 1.2 Demographic Information

1.2.1 Date of birth unknown and approximate year of birth is [phase_1_arm_1][phase_1_year_of_birth]?

○ Yes ○ No

1.2.2 Date of birth known and the correct date of birth is [phase_1_arm_1][phase_1_dob]?

○ Yes ○ No

1.2.3 Date of birth known?

○ Yes ○ No

1.2.4 What is your date of birth?

_____

1.2.5 What is your approximate year of birth?

_____

(will always be 15 June YYYY)

1.2.6 Age at collection

1.2.7 What is your sex?

○ Female ○ Male

1.2.8.1 Home Language

◯ Afrikaans ◯ English ◯ isiNdebele ◯ isiXhosa ◯ isiZulu ◯ Sesotho ◯ Sepedi
◯ Setswana ◯ siSwati ◯ Tshivenda ◯ Xitsonga ◯ Shona ◯ Embu ◯ Kalenjin
◯ Kamba ◯ Kikuyu ◯ Kisii ◯ Luhya ◯ Luo ◯ Maasai ◯ Meru ◯ Mijikenda
◯ Somali ◯ Swahili ◯ Taita ◯ Taveta ◯ Nankam ◯ Kassem ◯ Buli ◯ Sisali
◯ Kusal ◯ Gruni ◯ Dagbani ◯ Dagaare ◯ Mamprusi ◯ Moore ◯ Gourounsi
◯ Fulani ◯ Gourmatchema ◯ Dioula ◯ Bissa ◯ Dagara ◯ Francais ◯ Other
◯ Unknown

1.2.8.2 Other Home Language

_____

1.2.9.1 Ethnicity

◯ Zulu ◯ Xhosa Ndebele ◯ Sotho ◯ Venda ◯ Tsonga ◯ Tswana ◯ BaPedi
◯ Zimbabwean ◯ Embu ◯ Kalenjin Kamba Kikuyu Kisii ◯ Luhya ◯ Luo
◯ Maasai ◯ Meru ◯ Mijikenda ◯ Somali Swahili ◯ Taita ◯ Taveta ◯ Kassena
◯ Nankana ◯ Bulsa ◯ Dagaati ◯ Sisala Dagomba Kusasi Mampruga
◯ Frafra ◯ Mossi Gourounsi ◯ Peulh ◯ Gourmatche Dioula Bissa Dagara
◯ Swati ◯ Other Unknown

1.2.9.2 Other ethnicity

_____

1.2.10 Identity of participant confirmed?

◯ Yes ◯ No

# 2. Family Composition

**2. Family Composition**

2.1 Do you have siblings with whom you share at least one parent? (half siblings and those that have passed away are included)

○ Yes ○ No ○ Don't know ○ Decline to answer

2.2 How many brothers?

_____

2.3 How many of your brothers are still alive?

_____

2.4 How many sisters?

_____

2.5 How many of your sisters are still alive?

_____

2.6 Do you have any biological children?

○ Yes ○ No ○ Don't know ○ Decline to answer

2.7 How many biological sons?

_____

2.8 How many of your biological sons are still alive?

_____

2.9 How many biological daughters?

_____

2.10 How many of your biological daughters are still alive?

_____

# 3. Pregnancy and Menopause

## 3. Pregnancy And Menopause

3.1 Are you pregnant?

○ Yes ○ No

Pregnancy is an exclusion criterion for this study. Please end this Study Visit, and request that participant returns when not pregnant

3.2 How many pregnancies have you had?

_____

3.3 How many live births have you had?

_____

3.4 Are you currently taking birth control pills, a birth control injection, or using coil?

○ Yes ○ No ○ Don't know ○ Decline to answer

3.5 Have you had a hysterectomy?

○ Yes ○ No ○ Don't know ○ Decline to answer

3.6 Do you have regular periods? (i.e. every 21-35 days)

○ Yes ○ No ○ Don't know ○ Decline to answer

3.7 Do you remember when your last period was?

○ Yes ○ No ○ Don't know ○ Decline to answer

3.8 When was your last period?

3.8.1 Month

_____

(mm)

3.8.2 Year

_____

(yyyy)

3.10 Was your last period more than a year ago?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 4. Civil Status (Marital Status, Education & Employment)

## 4.1 Marital Status

4.1.1 What is your marital status?

- ◯ Married
- ◯ Living together
- ◯ Never married or co-habited
- ◯ Divorced, and partner is alive
- ◯ Separated, and partner is alive
- ◯ Partner deceased
- ◯ Decline to answer

## 4.2 Education

4.2.1 What is the highest level of education you have reached?

◯ No formal education ◯ Primary ◯ Secondary ◯ Tertiary ◯ Decline to answer

4.2.2 What is the total number of successfully completed years at your highest level of education?

_____

4.2.3 What is the total number of years of formal education that you have had?

_____

## 4.3 Employment

4.3.1 What is your current employment status?

- ◯ Self-employed
- ◯ Formal full-time
- ◯ Formal part-time
- ◯ Informal
- ◯ Unemployed
- ◯ Decline to answer

4.3.2 How many days a week do you work?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7

# 5.a. Cognition One

## 5.1 General Cognition Questions

5.1.1 Can you read this sentence for me please? Even if you can only read part of it? Show the participant a card with the following sentence: "This morning I saw the sun rise"

- ○ Cannot read at all
- ○ Able to read part of the sentence
- ○ Able to read whole sentence
- ○ Blind or severely visually impaired

5.1.2 At present how good is your memory?

○ Excellent ○ Very good ○ Fair ○ Poor ○ Decline to answer

5.1.3 Over the past month did you have any difficulty remembering things?

○ No ○ A little ○ Some ○ Quite a lot ○ I couldn't remember anything ○ Decline to answer

5.1.4 Over the past month did you have any difficulty concentrating?

○ No ○ A little ○ Quite a lot ○ I couldn't concentrate ○ Decline to answer

5.1.5 In the last 30 days, how much difficulty did you have in learning a new task (for example, learning how to get to a new place, learning a new game, learning a new recipe)?

- ○ None
- ○ Mild
- ○ Moderate
- ○ I couldn't learn something new
- ○ There was no opportunity to learn something new
- ○ Decline to answer

## 5.2 Word Recall

Next, I will read a set of 10 words and ask you to remember as many as you can. We have purposely made the list long so that it will be difficult for anyone to recall all the words. Most people remember only a few. Please listen carefully as I read the list of words because I won't repeat them. When I finish, I will ask you to repeat aloud as many of the words as you can, in any order. Do you understand?

Butter, Arm, Road, Paper, Chief, House, Stick, Money, Grass,

Engine Read once

5.2.1 Now please tell me the words you can remember.

☐ Butter ☐ Arm ☐ Road ☐ Paper ☐ Chief ☐ House ☐ Stick ☐ Money ☐ Grass
☐ Engine ☐ Decline to answer

5.2.2 Immediate Recall Score

_____

## 5.3 Orientation

5.3.1 What is the year?

○ Correct ○ Incorrect ○ Decline to answer

5.3.2 What is the month?

○ Correct ○ Incorrect ○ Decline to answer

5.3.3 What is the day of the month?

○ Correct ○ Incorrect ○ Decline to answer

5.3.4 What is the country that we are in?

○ Correct ○ Incorrect ○ Decline to answer

5.3.5 What is the Sub-County/County?

○ Correct ○ Incorrect ○ Decline to answer

5.3.6 What is the village/town/city?

○ Correct ○ Incorrect ○ Decline to answer

5.3.7 Now let's list the days of the week forward. Please start from Sunday.

○ Correct ○ Incorrect ○ Decline to answer

5.3.8 Now please list the days of the week backwards, starting again from Sunday.

○ Correct ○ Incorrect ○ Decline to answer

5.3.9 Orientation Score

_____

# 5.b Frailty Measurements

## 5.4 Stand And Sit Assessment

**This section uses SOP 304**

5.4.1 Time from saying "stand" to sitting for the 5th time, with seconds to one decimal place.

_____

5.4.2 Did the participant use their hands during the procedure?

○ Yes ○ No

5.4.3 Five sit-stands completed?

○ Yes ○ No ○ Don't know ○ Decline to answer

5.4.4 If no, please comment why.

_____

## 5.5 Grip Strength Test

**This section uses SOP 304**

5.5.1 Which is the dominant hand?

(Use non-dominant hand)

○ Left ○ Right

5.5.2 With how much force does the participant squeeze the dynometer the first time?

_____

5.5.3 With how much force does the participant squeeze the dynometer the second time?

_____

5.5.4 With how much force does the participant squeeze the dynometer the third time?

_____

5.5.5 Did the participant manage to complete the procedure?

○ Yes ○ No ○ Don't know ○ Decline to answer

5.5.6 If no, please comment why

_____

**5.6 5m Walk**

**This section uses SOP 304**

5.6.1 From the time saying "start", how long does it take to walk from the start line on the 2.5m line, to turn around, and to walk back to the start line (in seconds to one decimal place)?

_____

5.6.2 Did the participant need your physical support to walk during the procedure?

○ Yes ○ No ○ Decline to answer

5.6.3 Did the participant manage to complete the procedure?

○ Yes ○ No ○ Decline to answer

5.6.4 If no, please comment why

# 5.c. Cognition Two

## 5.7 Delayed Recall

The same list of words will be read to you in a different order. Please say out loud the words from this list you can remember. Are you ready?

Arm, Money, Paper, Stick, Road, Chief, Engine, Grass, Butter, House

5.7.1 Now please tell me the words you can remember.

☐ Arm ☐ Money ☐ Paper ☐ Stick ☐ Road ☐ Chief ☐ Engine ☐ Grass ☐ Butter
☐ House ☐ Decline to answer

5.7.2 Delayed Recall Score

_____

## 5.8 Word Recognition

Now I am going to read you a list of words. Some of the words are from the list I read to you earlier and some of the words I haven't read to you before.

5.8.1 I want you to say YES if the word I read you is one you heard earlier and NO if it is not a word you heard earlier.

Do you have any questions? Are you ready?

☐ Church ☐ Coffee ☐ Butter ☐ Dollar ☐ Arm ☐ Road ☐ Five ☐ Paper ☐ Hotel
☐ Mountain ☐ Chief ☐ House ☐ Shoe ☐ Stick ☐ Village ☐ String ☐ Money
☐ Police ☐ Grass ☐ Engine ☐ Decline to answer

5.8.2 Word Recognition Score

_____

## 5.9 Verbal Fluency

5.9.1 Now I want to see how many different animals you can name. You have 60 seconds. When I say, 'Start', say the animal names as fast as you can.

Are you ready? (Pause) Start.

_____

5.10 Cognition Comments

# 6. Household Attributes

**6. Household Attributes**

6.1 How many people besides you live in your household?

_____

6.2 How many rooms are there in the house and outside structures used by household member?

_____

6.3 How many rooms are used for sleeping in?

_____

**6.4 Which of the following items in working order, do you have in your household at the present time?**

| | Yes | No | Don't know | Decline to answer |
|---|---|---|---|---|
| Electricity | ○ | ○ | ○ | ○ |
| Solar energy | ○ | ○ | ○ | ○ |
| Power generator | ○ | ○ | ○ | ○ |
| Alternative power source | ○ | ○ | ○ | ○ |
| Television | ○ | ○ | ○ | ○ |
| Radio | ○ | ○ | ○ | ○ |
| Motor vehicle | ○ | ○ | ○ | ○ |
| Motorcycle | ○ | ○ | ○ | ○ |
| Bicycle | ○ | ○ | ○ | ○ |
| Refrigerator | ○ | ○ | ○ | ○ |
| Washing machine | ○ | ○ | ○ | ○ |
| Sewing machine | ○ | ○ | ○ | ○ |
| Telephone | ○ | ○ | ○ | ○ |
| Mobile phone | ○ | ○ | ○ | ○ |
| Microwave | ○ | ○ | ○ | ○ |
| DVD player | ○ | ○ | ○ | ○ |
| Satellite TV or DSTV | ○ | ○ | ○ | ○ |
| Computer or laptop | ○ | ○ | ○ | ○ |
| Internet by computer | ○ | ○ | ○ | ○ |
| Internet by mobile phone | ○ | ○ | ○ | ○ |
| Electric iron | ○ | ○ | ○ | ○ |
| Fan | ○ | ○ | ○ | ○ |
| Electric or gas stove | ○ | ○ | ○ | ○ |
| Kerosene stove | ○ | ○ | ○ | ○ |
| Plate gas stove | ○ | ○ | ○ | ○ |
| Electric plate | ○ | ○ | ○ | ○ |
| Torch | ○ | ○ | ○ | ○ |
| Gas lamp | ○ | ○ | ○ | ○ |
| Kerosene lamp with glass | ○ | ○ | ○ | ○ |
| Toilet facilities | ○ | ○ | ○ | ○ |
| Portable water | ○ | ○ | ○ | ○ |
| Grinding mill | ○ | ○ | ○ | ○ |
| Table | ○ | ○ | ○ | ○ |
| Sofa set | ○ | ○ | ○ | ○ |
| Wall clock | ○ | ○ | ○ | ○ |
| Bed | ○ | ○ | ○ | ○ |
| Mattress | ○ | ○ | ○ | ○ |

| | | | | |
|---|---|---|---|---|
| Blankets | ○ | ○ | ○ | ○ |
| Cattle | ○ | ○ | ○ | ○ |
| Other livestock | ○ | ○ | ○ | ○ |
| Poultry | ○ | ○ | ○ | ○ |
| Tractor | ○ | ○ | ○ | ○ |
| Plough | ○ | ○ | ○ | ○ |

# 7. Substance Use

## 7.1 Tobacco Use

7.1.1 Have you ever smoked any tobacco products such as cigarettes, cigars or pipes?

○ Yes ○ No ○ Decline to answer

7.1.2 Have you smoked more than 100 times in your whole life?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.1.3 Do you currently smoke any tobacco products, such as cigarettes, cigars or pipes?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.1.4 Did you smoke within the last hour?

○ Yes ○ No ○ Decline to answer

7.1.5 What do you smoke?
(Tick more than one if appropriate)

☐ Cigarettes ☐ Pipe ☐ Hand rolled ☐ Cigars ☐ Others ☐ Decline to answer

If other, please specify what you smoke

_____

7.1.6 How often do you smoke tobacco products?

○ Daily
○ 5-6 days per week
○ 1-4 days per week
○ 1-3 days per month
○ less than once per month
○ Decline to answer

7.1.7 On the days that you smoke, how many times do you smoke tobacco products?

○ Once a day ○ Twice a day ○ Three times a day ○ More than three times a day
○ Decline to answer

7.1.8 How old were you when you started smoking?

_____

7.1.9 In which year did you stop smoking completely?

_____
(yyyy)

7.1.10 Have you ever used any smokeless tobacco such as snuff, snus, betel with tobacco or chewing?

○ Yes ○ No ○ Decline to answer

7.1.11 Do you use snuff?

○ Yes ○ No ○ Decline to answer

7.1.12 How do you take snuff?

○ Through nose ○ Through mouth/on lip ○ Decline to answer

7.1.13 How often do you use snuff?

○ Daily
○ 5-6 days per week
○ 1-4 days per week
○ 1-3 days per month
○ less than once per month
○ Decline to answer

7.1.14 On the days that you use snuff, how many times a day do you use it?

○ Once a day ○ Twice a day ○ Three times a day ○ More than three times a day
○ Decline to answer

7.1.15 Do you use chewing tobacco?

○ Yes ○ No ○ Decline to answer

7.1.16 How often do you use chewing tobacco?

○ Daily
○ 5-6 days per week
○ 1-4 days per week
○ 1-3 days per month
○ less than once per month
○ Decline to answer

7.1.17 On the days that you use chewing tobacco, how many times a day do you use it?

○ Once a day ○ Twice a day ○ Three times a day ○ More than three times a day
○ Decline to answer

## 7.2 Alcohol Use

7.2.1 Have you ever consumed an alcohol drink such as beer, wine, spirits, fermented cider, or traditional beer?

For this question use Alcohol_showcard_1

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.2 Do you currently (in last 30 days) consume any alcohol drink such as beer, wine, spirits, fermented cider, or traditional beer?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.3 How often do you have at least one alcoholic drink?

○ Daily
○ 5-6 days per week
○ 1-4 days per week
○ 1-3 days per month
○ less than once per month
○ Decline to answer

7.2.4 On the days that you drink alcohol drinks, how many alcoholic drinks do you have?
For this question use Alcohol_showcard_2

_____

7.2.5 Have you ever felt that you should cut down on your drinking?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.6 Have people annoyed you by criticizing your drinking?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.7 Have you ever felt bad or guilty about your drinking?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.8 Have you ever had an alcoholic drink first thing in the morning to steady your nerves or get rid of hangover?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.9 In the past year, did you ever take ONE or more alcoholic drinks in a single morning, afternoon, or night? I understand that you may share drinks and that some drinks have different sizes, but please do your best to answer

○ Yes ○ No ○ Don't know ○ Decline to answer

7.2.10 What type of alcohol beverage do you, or did you usually drink?

☐ Beer ☐ Wine ☐ Spirits ☐ Home brew ☐ Other

7.2.8.1 If other, please specify other type of alcohol beverage

_____

## 7.3 Drug Use

7.3.1 Do you, or have you ever taken marijuana (dagga, weed)?

○ Yes ○ No ○ Don't know ○ Decline to answer

7.3.2 Do you, or have you ever taken methamphetamines, cocaine or any other drugs (dagga, glue, heroin, crack, mandrax, acid)?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 8.a General Health - Cancer

**8.1 Please indicate whether you have, or have had, any of the following illnesses**

8.1.1 Breast cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.1.1 Have you received treatment prescribed by a doctor to treat the illness?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.1.2 Are you currently on treatment prescribed by a doctor?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.1.3 What medication has been prescribed? Please list names if possible.

8.1.1.4 Are you currently taking any herbal or traditional remedy for any of the above illnesses?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.2 Cervical cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.2.1 Have you received treatment prescribed by a doctor to treat the illness?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.2.2 Are you currently on treatment prescribed by a doctor?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.2.3 What medication has been prescribed? Please list names if possible.

8.1.2.4 Are you currently taking any herbal or traditional remedy for any of the above illnesses?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.3 Prostate cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.3.1 Have you received treatment prescribed by a doctor to treat the illness?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.3.2 Are you currently on treatment prescribed by a doctor?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.3.3 What medication has been prescribed? Please list names if possible.

8.1.3.4 Are you currently taking any herbal or traditional remedy for any of the above illnesses?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.4 Oesophageal cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.4.1 Have you received treatment prescribed by a doctor to treat the illness?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.4.2 Are you currently on treatment prescribed by a doctor?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.4.3 What medication has been prescribed? Please list names if possible.

8.1.4.4 Are you currently taking any herbal or traditional remedy for any of the above illnesses?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.5 Other cancers

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.5.1Specify other cancers

_____

8.1.5.2 Have you received treatment prescribed by a doctor to treat the illness?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.5.3 Are you currently on treatment prescribed by a doctor?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.1.5.4 What medication has been prescribed? Please list names if possible.

8.1.5.5 Are you currently taking any herbal or traditional remedy for any of the above illnesses?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 8.b General Health - Family History

**8.2 Please indicate if your mother has, or has had, any of the following illnesses**

8.2.1 Weight problem/obesity

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.2 High blood pressure

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.3 High cholesterol

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.4 Breast cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.5 Cervical cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.6 Oesophageal cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.7 Other cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.2.8 Asthma or reactive air disease (lung disease)

○ Yes ○ No ○ Don't know ○ Decline to answer

**8.3 Please indicate if your father has, or has had, any of the following illnesses**

8.3.1 Weight problem/obesity

○ Yes ○ No ○ Don't know ○ Decline to answer

8.3.2 High blood pressure

○ Yes ○ No ○ Don't know ○ Decline to answer

8.3.3 High cholesterol

○ Yes ○ No ○ Don't know ○ Decline to answer

8.3.4 Prostate cancer

○ Yes ○ No ○ Don't know ○ Decline to answer

8.3.5 Other cancers

○ Yes ○ No ○ Don't know ○ Decline to answer

8.3.6 Asthma or reactive air disease

○ Yes ○ No ○ Don't know ○ Decline to answer

# 8.c General Health - Diet

## 8.4 Diet

8.4.1 In a typical week, on how many days do you eat fruit?
This question uses Diet_showcard_1

_____

8.4.2 How many servings of fruit do you eat on a typical day?
This question uses Diet_showcard_2

_____

8.4.3 In a typical week, on how many days do you eat vegetables?
This question uses Diet_showcard_3

_____

8.4.4 How many servings of vegetables do you eat on a typical day?
This question uses Diet_showcard_4

_____

8.4.5 Which are the main starchy staple foods that you eat most of? Please choose one or two of the following

- ☐ Potatoes
- ☐ Brown rice
- ☐ White rice
- ☐ Brown porridge or pap
- ☐ White porridge or pap
- ☐ Brown bread purchased at the shop
- ☐ White bread purchased at the shop
- ☐ Brown bread made at home
- ☐ White bread made at home
- ☐ Samp
- ☐ Brown pasta (including spaghetti & macaroni)
- ☐ White pasta (including spaghetti & macaroni)
- ☐ Decline to answer

8.4.6 In a typical week, on how many days do you eat such starchy staple foods?
This question uses Diet_showcard_5

_____

8.4.7 How many servings of these starchy staple foods do you eat on a typical day?
This question uses Diet_showcard_6

_____

8.4.8 How many meals per week do you buy from a vendor or take-away or restaurant?

_____
(By meal, I mean breakfast, lunch or dinner)

8.4.9 How many cans or bottles, or cups of sugary cold drinks (excluding fruit juice), do you drink in a week?
This question uses Diet_showcard_7 and Diet_showcard_8

_____

8.4.10 How many cans, bottles, or cups of juice do you drink in a week?
This question uses Diet_showcard_7 and Diet_showcard_8

_____

8.4.11 Has a doctor, nurse, or other healthcare worker ever told you to change your diet (e.g to eat less sugar)?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.4.12 Has a doctor, nurse, or other healthcare worker ever advised you to lose weight?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 8.d General Health - Exposure to Pesticides & Pollutants

## 8.5 Exposure to pesticides

8.5.1 Do you work with insecticides or pesticides?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.5.2 How long (in years) have you been working with insecticides or pesticides?

_____

(yyyy)

8.5.3 Do you live close to a farm or region where insecticides or pesticides are used?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.5.4 Do you know what type of pesticides or insecticides are used, either by you, or within your area?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.5.5 Please list them if possible:

## 9.6 Exposure to indoor pollutants

8.6.1 Do you cook inside a kitchen or in an open environment?

○ Kitchen ○ Open environment ○ Other

8.6.1.1 Please specify other place of cooking

8.6.2 If cooking is done inside a kitchen, apart from the door is there a vent to the exterior (chimney, window, or other open connection)?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.6.3 What type of energy source do you use for cooking in your house?

☐ Firewood ☐ Charcoal ☐ Liquid-petroleum gas ☐ Electricity ☐ Paraffin ☐ Other

8.6.3.1 If other, please specify other energy source

_____

8.6.4 Did anyone smoke in your house in the past 12 months (this includes you)?

○ Yes ○ No ○ Don't know ○ Decline to answer

8.6.5 On average, how often did someone smoke in your house in the past 12 months?

○ Less than once per month
○ A few days each month
○ More than half the days of the month
○ Most days
○ Don't know
○ Decline to answer

8.6.6 Do you use insect repellent in your rooms (coils, aerosols, powered spray, any other repellent)?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 9. Infection History

## 9.1 Malaria

9.1.1 Have you ever had malaria?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.1.2 Have you had malaria fever in the last month?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.1.3 Have you traveled to an area with a high incidence of malaria, in the last 2 months?
This question uses the showcard, Malaria_areas

○ Yes ○ No ○ Don't know ○ Decline to answer

## 9.2 Tuberculosis

9.2.1 Have you ever been told by a doctor, nurse or other healthcare worker that you have TB?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.2.2 Have you been newly-diagnosed with TB in the last 12 months?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.2.3 When was it diagnosed?

_____
(mm-yyyy)

9.2.4 Have you ever received treatment for TB prescribed by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.2.5 Are you currently receiving treatment for TB prescribed by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.2.6 Have you ever been counselled by a doctor, nurse or other healthcare worker, on how you can avoid passing TB onto others?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.2.7 Are you currently taking any herbal or traditional remedy for TB?

○ Yes ○ No ○ Don't know ○ Decline to answer

**9.3. Human Immunodeficiency Virus(HIV)**

**participants can choose not to answer this section**

9.3.1 Do you feel comfortable with answering questions about your HIV status?

○ Yes ○ No

9.3.2 Have you ever been tested for HIV?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.3.3 Do you know your HIV status?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.3.4 Have you ever tested positive for HIV?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.3.5 When were you diagnosed?

_____

(mm-yyyy)

9.3.6 Do you or have you used ARV medication prescribed by a doctor, nurse or healthcare worker to treat it?
This and proceeding questions use the ARV_showcard

○ Yes ○ No ○ Don't know ○ Decline to answer

9.3.7 In which year did you first start treatment?

_____

(yyyy)

9.3.8 What ARV medication did you first start taking?

_____

9.3.9 Are you currently taking ARV medication?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.3.10 What ARV medication are you currently taking?

_____

9.3.11 Is your current ARV medication a single pill once a day?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.3.12 What size pill is it? The size of an aspirin (small) or a very large pill (large)?

A photo will be provided

○ Small ○ Large ○ Decline to answer

9.3.13 Are you currently taking any herbal or traditional remedy for HIV?

○ Yes ○ No ○ Don't know ○ Decline to answer

**9.4 Have you experienced any of the following that your doctor has told you is related to HIV or your ARV medication?**

**Please select all that apply**

9.4.1 Painful feet or hands?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.2 Hypersensitivity reaction (or allergy)?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.3 Kidney problems?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.4 Liver problems?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.5 Change in body shape (buffalo hump or growth of breasts)?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.6 Change in mental state (such as forgetfulness, dizziness, hallucinations)?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.6 Change in cholesterol levels?

○ Yes ○ No ○ Don't know ○ Decline to answer

9.4.7 If you do not know your HIV status would you like to be tested for HIV?

○ Yes ○ No

9.4.8 Do you agree to pre-HIV and post-HIV test counselling?

Answer must be yes if participant is to have test.

○ Yes ○ No

# 10.a Cardiometabolic Risk Factors - Diabetes

## 10.1 Diabetes

10.1.1 Has a doctor, nurse, or other healthcare worker ever measured your blood or urine for diabetes (sugar in the blood)?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.2 Have you ever been told by a doctor or healthcare worker, that you have diabetes or high blood sugar (outside of pregnancy)?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.3 Have you been newly-diagnosed with diabetes in the last 12 months?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.4 Have you ever received treatment for diabetes prescribed by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.5 Are you currently receiving treatment for diabetes prescribed by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.6 Are you doing anything to treat your diabetes?

(Please tick all that apply)

☐ Insulin Injection
☐ Pills (that you swallow)
☐ Special diet
☐ Weight loss
☐ Other (specify)

10.1.6.1 If other, please specify

10.1.7 Please list if possible, medicine you taking for diabetes?

10.1.8 Are you currently taking any herbal or traditional remedy for diabetes?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9 Do you have a family history of diabetes?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.1 Mother

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.2 Father

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.3 Brother 1

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.4 Brother 2

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.5 Brother 3

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.6 Brother 4

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.7 Sister 1

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.8 Sister 2

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.9 Sister 3

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.10 Sister 4

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.11 Son 1

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.12 Son 2

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.13 Son 3

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.14 Son 4

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.15 Daughter 1

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.16 Daughter 2

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.17 Daughter 3

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.18 Daughter 4

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.19 Other family member

○ Yes ○ No ○ Don't know ○ Decline to answer

10.1.9.20 Please specify other family member(s)

# 10.b Cardiometabolic Risk Factors - Heart Conditions

## 10.2 Stroke

10.2.1 Have you ever been told by a doctor, nurse, or other healthcare worker that you have had a stroke?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.2 When was it first diagnosed? (year)

_____

(yyyy)

10.2.3 Have you ever been told by a doctor, nurse, or other healthcare worker that you have had a ministroke, or transient ischemic attack (TIA)?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.4 Have you ever had sudden painless weakness on one side of your body?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.5 Have you ever had sudden numbness or a dead feeling on one side of your body?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.6 Have you ever had sudden painless loss of vision in one or both eyes?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.7 Have you ever suddenly lost one half of your vision?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.8 Have you ever suddenly lost the ability to understand what people are saying?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.2.9 Have you ever suddenly lost the ability to express yourself verbally, or in writing?

○ Yes ○ No ○ Don't know ○ Decline to answer

## 10.3 Angina

10.3.1 Have you ever been told by a doctor, nurse, or other healthcare worker that you have angina (chest pain due to heart disease)?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.2 Have you ever received treatment for chest pain due to heart disease prescribed by a doctor, nurse or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.3 Are you currently taking any medication for angina prescribed by a doctor or other healthcare worker for this?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.4 What medicine are you taking for this?

Please list if possible

10.3.5 Are you currently taking any herbal or traditional remedy for angina?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.6 During the last months, have you experienced any pain or discomfort in your chest, or pain going to the left arm or neck, when you walk uphill or hurry?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.7 During the last months, have you experienced any pain or discomfort in your chest, or pain going to the left arm or neck, when you walk at an ordinary pace on level ground?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.8 What do you do if you get the pain or discomfort when you are walking?

○ Stop or slow down
○ Rest for a while and then carry on
○ Carry on after taking a pain relief medicine that dissolves in your mouth (a nitro spray or tablet)
○ Carry on walking
○ Decline to answer

10.3.9 Is the pain or discomfort relieved if you stand still?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.3.10 Will you show me where you usually experience the pain or discomfort?

Show participant a diagram of an upper torso with regions labelled 1-18

(Choose pain location 1-18 from diagram. Tick more than one if appropriate.)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13
☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18

## 10.4 Heart Attack

10.4.1 Have you ever been told by a doctor, nurse, or other healthcare worker that you have had a heart attack?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.4.2 Did you ever receive medical treatment for your heart attack?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.4.3 What medicine are you taking for your heart attack?

Please list if possible

10.4.4 Are you currently taking any herbal or traditional remedy for your heart attack?

○ Yes ○ No ○ Don't know ○ Decline to answer

## 10.5 Congestive Heart Failure

10.5.1 Have you ever been told by a doctor, nurse, or other healthcare worker that you have had heart failure?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.5.2 Have you ever received medical treatment for heart failure prescribed by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.5.3 Are you currently on treatment for heart failure prescribed by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.5.4 Are you taking medicine for this?

Please list if possible

10.5.5 Are you currently taking any herbal or traditional remedy for heart failure?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 10.c Cardiometabolic Risk Factors - Hypertension, Cholesterol



## 10.6 Hypertension

11.6.1 Has a doctor, nurse, or other healthcare worker ever measured your blood pressure?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.6.2 Have you ever been told by a doctor, nurse, or other healthcare worker that you have hypertension (high blood pressure)?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.6.3 Have you been newly-diagnosed with hypertension in the last 12 months?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.6.4 Have you ever received treatment for hypertension prescribed by a doctor, nurse or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.6.5 Are you currently on treatment for hypertension prescribed by a doctor, nurse or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.6.6 Are you taking medicine for this?

Please list if possible

10.6.7 Are you currently taking any herbal or traditional remedy for hypertension?

○ Yes ○ No ○ Don't know ○ Decline to answer

## 10.7 High Cholesterol

10.7.1 Has a doctor, nurse or other healthcare worker ever measured your cholesterol?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.7.2 Have you ever been told by your doctor or other healthcare worker told you that you have high cholesterol?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.7.3 Have you ever been treated for high cholesterol by a doctor, nurse, or other healthcare worker?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.7.4 Are you currently using any of the following to treat your high cholesterol, as prescribed by a doctor, nurse, or other healthcare worker?

☐ Special Diet ☐ Weight loss ☐ Medicine ☐ Other (please specify)

10.7.4.1 Specify other treatment

10.7.5 Are you taking medicine for this?

Please list if possible

10.7.6 Are you currently taking any herbal or traditional remedy for high cholesterol?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 10.d Cardiometabolic Risk Factors - Kidney, Thyroid & RA

## 10.8 Thyroid Disease

11.8.1 Has a doctor ever told you that you have thyroid disease?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.8.2 Do you know what type of thyroid disease you were diagnosed with?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.8.3 If yes, please specify

_____

10.8.4 Have you ever been treated for it?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.8.5 What treatment did you use?

○ Thyroid hormone ○ Surgery ○ Radioactive iodine ○ Antithyroid drugs ○ Don't Know

10.8.6 Do either of your parents have, or have they had, thyroid disease?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.8.7 Please specify which

○ Mother ○ Father ○ Both

## 10.9 Kidney Disease

10.9.1 Has a doctor ever told you that you have kidney disease?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.9.2 Do you know what type of kidney disease?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.9.3 Please specify the type of kidney disease

_____

10.9.4 Has a doctor ever told you that your kidneys have low function?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.9.5 Has anyone in your family either had kidney disease, or died from it?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.9.6 If yes, mother?

○ Yes ○ No

10.9.7 If yes, father?

○ Yes ○ No

10.9.8 If yes, other?

○ Yes ○ No

10.9.9 If other, who?

_____

10.9.10 Do you know what kind of kidney disease he or she had?

○ Yes ○ No

10.9.11 If yes, please specify

_____

## 10.10 Rheumatoid Arthritis

10.10.1 Are your joints ever swollen or painful?

○ Yes ○ No ○ Don't know ○ Decline to answer

10.10.2 How many joints are swollen or painful?

○ None ○ One joint ○ Two or more joints ○ Don't know ○ Decline to answer

10.10.3 Which joints are involved? Small joints (hands, feet) or Large joints (wrists, elbows, shoulders, hips, knees, ankles)

○ Small ○ Large ○ Don't know ○ Decline to answer

10.10.4 Do they hurt mostly in the morning, afternoon or all the time

○ Morning ○ Afternoon ○ All the time ○ Decline to answer

10.10.5 In retrospect, how long do you think that you've had these symptoms?

○ Less than 6 weeks ○ More than 6 weeks ○ Don't know ○ Decline t answer

10.10.6 Have you had the following laboratory tests performed to assess the arthritis and been told the result?

○ Yes ○ No ○ Don't know ○ Declined to answer

10.10.6 Rheumatoid Factor (RF)

○ Positive ○ Negative ○ Not tested ○ Decline to answer

10.10.7 Anti-citrullinated protein antibody (ACPA)

○ Positive ○ Negative ○ Not tested ○ Decline to answer

10.10.8 ESR and/or CRP

○ Positive ○ Negative ○ Not tested ○ Decline to answer

# 11. Physical Activity and Sleep

## 11.1 Global Physical Activity Questionnaire (GPAQ)

The following questions are about the time you spend doing different types of physical activities. This includes activities you do at home, at work, travelling from place to place and during your spare time. Work can be paid or unpaid. You are requested to answer the questions even if you don't consider yourself an active person.

11.1.1 In question 4.3.2, you indicated that you work [empl_days_work] days per week? If not, may you please make the correction.

11.1.2 Do you work over the weekend?

○ Yes ○ No ○ Decline to answer

## 11.2 Occupation-Related Physical Activity (Paid Or Unpaid Work)

The following questions have been aligned with the validated GPAQ for Physical Activity. Respondents should consider their activity during a usual week. 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, study/training, household chores, harvesting food/crops, fishing or hunting for food, seeking employment. In the following questions 'vigorous-intensity activities' are activities that require hard physical effort and cause large increases in breathing or heart rate, 'moderate-intensity activities' are activities that require moderate physical effort and cause small increases in breathing or heart rate. PLEASE USE THE SHOWCARDS FOR PHYSICAL ACTIVITY TO ANSWER THESE QUESTIONS

11.2.1 Does your work involve mostly sitting or standing still, or walking for very short periods (less than 10 minutes)?

○ Yes ○ No ○ Decline to answer

11.2.2 Does your work involve vigorous activities (heavy lifting, digging, manual labour or construction) for at least 10 minutes at a time?

○ Yes ○ No ○ Decline to answer

11.2.3 In a usual week, how many days are spent doing vigorous activities as part of your work?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

11.2.4 On a usual day of vigorous work, how much time do you spend doing these activities?

_____
(ENTER HOURS AND MINUTES BELOW.)

11.2.4.1 On a usual day of vigorous work, how many hours are spent doing these activities? (hours)

_____
(HOURS ONLY)

11.2.4.2 On a usual day of vigorous work, how many hours are spent doing these activities? (minutes)

_____
(MINUTES ONLY)

11.2.5 Does your work involve moderate-intensity activities (brisk walking or carrying light loads) for at least 10 minutes at a time?

○ Yes ○ No ○ Decline to answer

11.2.6 In a usual week, how many days are spent doing moderate-intensity activities at work?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

11.2.7 On a usual work day, how much time do you spend doing moderate-intensity activities?

_____

(ENTER HOURS AND MINUTES BELOW.)

11.2.7.1 On a usual work day, how many hours are spent doing moderate-intensity activities (hours)?

_____

(HOURS ONLY)

11.2.7.2 On a usual work day, how many hours are spent doing moderate-intensity activities (minutes)?

_____

(MINUTES ONLY)

11.2.8 How long is your usual work day?

_____

(ENTER HOURS AND MINUTES BELOW.)

11.2.8.1 How long is your usual work day (hours)?

_____

(HOURS ONLY)

11.2.8.2 How long is your usual work day (minutes)?

_____

(MINUTES ONLY)

## 11.3 Travel Related Physical Activity

The following questions have been aligned with the validated GPAQ for Physical Activity. Respondents should consider their activity during a usual week. These questions exclude the physical activities at work that you have already mentioned. These questions are about the usual way you travel to and from places. For example to work, for shopping, to market, to place of worship. PLEASE USE THE SHOWCARDS FOR PHYSICAL ACTIVITY TO ANSWER THESE QUESTIONS

11.3.1 Do you walk or use a bicycle (for at least minutes at a time) to get to and from places?

○ Yes ○ No ○ Don't know ○ Decline to answer

11.3.2 In a usual week, how many days do you walk or cycle, for at least 10 minutes, to get to and from places?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

11.3.3 On a usual day, how much time do you spend walking or cycling for travel?

_____

(ENTER HOURS AND MINUTES BELOW.)

11.3.3.1 On a usual day, how many hours do you spend walking or cycling for travel? (hours)

_____

(HOURS ONLY)

11.3.3.2 On a usual day, how many minutes do you spend walking or cycling for travel? (minutes)

_____

(MINUTES ONLY)

## 11.4 Non-Work Related and Leisure Time Physical Activity

11.4.1 In your spare time, do you engage in any vigorous or moderate-intensity physical activities lasting more than 10 minutes at a time?

○ Yes ○ No ○ Decline to answer

11.4.2 In your spare time do you do any vigorous activities like running, strenuous sport or exercise, for at least 10 minutes at a time?

○ Yes ○ No ○ Decline to answer

11.4.3 In a usual week, how many days do you engage in vigorous activities as part of your leisure time?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

11.4.4 In a normal day, how much leisure time is spent doing vigorous activities?

_____

(ENTER HOURS AND MINUTES BELOW.)

11.4.4.1 In a normal day, how many leisure hours are spent doing vigorous activities? (hours)

_____

(HOURS ONLY)

11.4.4.2 In a normal day, how many leisure minutes are spent doing vigorous activities? minutes)

_____

(MINUTES ONLY)

11.4.5 In your spare time, do you engage in any moderately intense physical activities like walking or swimming, for at least 10 minutes at a time?

○ Yes ○ No ○ Decline to answer

11.4.6 In a normal week, how many days are spent engaging in moderately intense physical activities as part of your leisure time?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

11.4.7 How much leisure time is spent doing moderate-intensity activities in a normal day?

_____

(ENTER HOURS AND MINUTES BELOW.)

11.4.7.1 How many leisure hours are spent doing moderate-intensity activities in a normal day? (hours)

_____

(HOURS ONLY)

11.4.7.2 How many leisure minutes are spent doing moderate-intensity activities in a normal day? (minutes)

_____

(MINUTES ONLY)

## 11.5 Sitting/Resting Activity

11.5.1 On a working day, how much time do you usually spend sitting or reclining (excluding sleep)? This may include time sitting at a desk, visiting friends, reading, or sitting down to watch television during working hours and leisure or spare time

_____

(ENTER HOURS AND MINUTES BELOW.)

11.5.1.1 On a working day, how much time do you usually spend sitting or reclining (excluding sleep)? This may include time sitting at a desk, visiting friends, reading, or sitting down to watch television during working hours and leisure or spare time (hours).

_____

(HOURS ONLY)

11.5.1.2 On a working day, how much time do you usually spend sitting or reclining (excluding sleep)? This may include time sitting at a desk, visiting friends, reading, or sitting down to watch television during working hours and leisure or spare time (minutes).

_____

(MINUTES ONLY)

11.5.2 On a non-working day, how much time do you usually spend sitting or reclining (excluding sleep)? This may include time sitting at a desk, visiting friends, reading, or sitting down to watch television during working hours and leisure or spare time

_____

(ENTER HOURS AND MINUTES BELOW.)

11.5.2.1 On a non-working day, how much time do you usually spend sitting or reclining (excluding sleep)? This may include time sitting at a desk, visiting friends, reading, or sitting down to watch television during working hours and leisure or spare time (hours).

_____

(HOURS ONLY)

11.5.2.2 On a non-working day, how much time do you usually spend sitting or reclining (excluding sleep)? This may include time sitting at a desk, visiting friends, reading, or sitting down to watch television during working hours and leisure or spare time (minutes)

_____

(MINUTES ONLY)

## 11.6 SLEEP

11.6.1 What time do you go to sleep during the week?

_____

(PLEASE USE 24 HOUR NOTATION)

11.6.2 What time do you wake up during the week?

_____

(PLEASE USE 24 HOUR NOTATION)

11.6.3 What time do you go to sleep during the weekend?

_____

(PLEASE USE 24 HOUR NOTATION)

11.6.4 What time do you wake up during the weekend?

_____

(PLEASE USE 24 HOUR NOTATION)

11.6.5 How many people sleep in the same room as you, including you?

_____

11.6.6 Do the livestock sleep in the same room as you?

◯ Yes ◯ No ◯ Decline to answer

11.6.7 What do you sleep on?

◯ On a mat ◯ On a floor / On a mattress only ◯ On a bed ◯ Decline to answer

11.6.8 Do you sleep under a mosquito net?

◯ Yes ◯ No ◯ Decline to answer

11.6.9 When do you feel the most alert, awake, and energetic?

◯ Definitely more in the morning ◯ A bit more in the morning ◯ More in the middle of the day
◯ A bit more in the evening ◯ Definitely more in the evening ◯ Decline to answer

11.6.10 Do you have any difficulty falling asleep?

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe ◯ Decline to answer

11.6.11 Do you have any difficulty staying asleep?

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe ◯ Decline to answer

11.6.12 Do you have any problems waking up too early?

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe ◯ Decline to answer

12.6.13 Do you have problems with waking up still feeling tired?

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe ◯ Decline to answer

11.6.14 How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

◯ Very Satisfied ◯ Satisfied ◯ Moderately Satisfied ◯ Dissatisfied ◯ Very Dissatisfied
◯ Decline to answer

11.6.16 To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

◯ Not at all ◯ Interfering A Little ◯ ◯ Somewhat ◯ Much ◯ Very Much Interfering
Decline to answer

# 12. Anthropometric Measurements

## 12.1 Standing Height

13.1.1 Standing height (cm)

_____

## 12.2 Weight

13.2.1 Weight (kg)

_____

## 12.3 Waist Circumference

13.3.1 Waist circumference (cm)

_____

12.3.2 Waist circumference (cm)

_____

12.3.3 Average waist circumference (cm)

_____

## 12.4 Hip Circumference

12.4.1 Hip circumference (cm)

_____

12.4.2 Hip circumference (cm)

_____

12.4.3 Average hip circumference (cm)

_____

12.5 Person performing measurements

○ Nomses ○ Siphumelele ○ Thonniah

# 13. Blood Pressure and Pulse Measurements

## 13.1 First Measurements

13.1.1 Systolic measurement 1

_____

13.1.2 Diastolic measurement 1

_____

13.1.3 Pulse measurement 1

_____

13.1.4 Time that first set of measurements were taken

_____

## 13.2 Second Measurements

13.2.1 Systolic measurement 2

_____

13.2.2 Diastolic measurement 2

_____

13.2.3 Pulse measurement 2

_____

13.2.4 Time that second set of measurements were taken

_____

## 13.3 Third Measurements

13.3.1 Systolic measurement 3

_____

13.3.2 Diastolic measurement 3

_____

13.3.3 Pulse measurement 3

_____

13.3.4 Time that third set of measurements were taken

_____

13.4 Person performing measurements

○ Researcher 1 ○ Researcher 2

## 13.5 Average Calculations

13.5.1 BP Systolic Average

_____

13.5.2 BP Diastolic Average

_____

13.5.3 BP Pulse average

_____

# 14. Ultrasound and DXA Measurements

## 14.1 Visceral(VAT) and Subcutaneous(SCAT) Fat Measurements

14.1.1 Was VAT and SCAT measured?

○ Yes ○ No

14.1.1.1 Comment if No

14.1.2 Name of ultrasound technician

_____

14.1.3 Visceral (medial) fat (cm), to two decimal points.

_____

14.1.4 Subcutaneous (transverse) fat (cm), to two decimal points

_____

## 14.2 Carotid Intima-Media Thickness(cIMT)

14.2.1 Was cIMT measured?

○ Yes ○ No

14.2.1.1 Comment if No

_____

14.2.2 Name of ultrasound technician

_____

14.2.3 Minimum cIMT on the right

_____

14.2.4 Maximum cIMT on the right

_____

14.2.5 Average cIMT on the right

_____

14.2.6 Minimum cIMT on the left

_____

14.2.7 Maximum cIMT on the left

_____

14.2.8 Mean cIMT on the left

_____

## 14.3 PLAQUE

14.3.1 Was plaque measured?

○ Yes ○ No

14.3.1.1 Comment if No

_____

14.3.2 Name of ultrasound technician

_____

14.3.3 Was plaque present?

○ Yes ○ No

14.3.4 Minimum plaque thickness on the right

_____

14.3.5 Maximum plaque thickness on the right

_____

14.3.6 Average plaque thickness on the right

_____

14.3.7 Minimum plaque thickness on the left

_____

14.3.8 Maximum plaque thickness on the left

_____

14.3.9 Mean plaque thickness on the left

_____

**14.4 DXA Scan**

14.4.1 Was the DXA Scan Completed?

◯ Yes ◯ No

14.4.1.1 Comment if No

_____

14.4.2 Measurement 1

_____

14.4.3 Measurement 2

_____

14.4.4 Measurement 3

_____

14.4.5 Measurement 4

_____

14.4.6 Measurement 5

_____

# 15.a Respiratory Health

**15.1 Respiratory Health questions**

**The following set of questions will help us understand more about your lung function.**

15.1.1 Do you have any of the following symptoms?

15.1.1.1 Do you CURRENTLY suffer from shortness of breath and a productive cough that has not gone away over the last year?

○ Yes ○ No ○ Don't know

15.1.1.2 Have you EVER experienced shortness of breath and a productive cough that persisted for a year or more?

○ Yes ○ No ○ Don't know

15.1.1.3 Do you bring up phlegm/sputum/mucus on most days?

○ Yes ○ No ○ Don't know

15.1.1.4 Are you often too short of breath to leave the house, or short of breath on dressing or undressing?

○ Yes ○ No ○ Don't know

15.1.1.5 Do you usually cough when you don’t have a cold?

○ Yes ○ No ○ Don't know

15.1.1.6 Have you had wheezing or whistling in the chest in the past 12 months?

○ Yes ○ No ○ Don't know

15.1.2 Has a doctor, nurse or healthcare professional ever told you that you have asthma?
(If no, skip to 15.1.3)

○ Yes ○ No ○ Don't know

15.1.2.1 At what age were you first diagnosed with asthma?

_____

15.1.2.2 Have you received treatment prescribed by a health professional for your asthma?

○ Yes ○ No ○ Don't know

15.1.2.3 Are you currently on treatment prescribed by a health professional for asthma?

○ Yes ○ No ○ Don't know

15.1.3 Has a doctor, nurse or healthcare professional ever told you that you suffer from any of the following conditions?

○ Chronic bronchitis ○ Emphysema ○ COPD ○ Don't know

15.1.3.2 Are you currently on treatment prescribed by a health professional for any of the above?

○ Yes ○ No ○ Don't know

15.1.4 Do you use any inhaled medication using a puffer? Please note that you will have been asked to bring your inhaled medication with you today.

○ Yes ○ No ○ Don't know

15.1.4.1 If yes, please list the medication and dosage.

15.1.4.2 If yes, how many puffs at a time.

_____

15.1.4.3 If yes, how many times a day.

_____

15.1.5 Have you ever suffered from any of the following?

○ Measles ○ Whooping cough ○ Don't know

# 15.b Spirometry Eligibility

**15.2 Screening questions to determine eligibility for Respiratory Health spirometry test.**

**Ensure that the participant is familiar with the procedure before proceeding. In this section there is no "declined to answer" check box as these are safety questions.**

15.2.1 Have you had chest trauma or any major surgery in the last 6 weeks involving the eye, ear, chest, abdomen, brain, nose or throat?
(If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.2 In the last 4 weeks have you had any chest pain due to heart disease that is not well controlled, or been told that you have an aneurysm, or suffered from a heart attack or stroke? (If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.3 Have you recently or are you currently coughing up any blood?
(If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.4 Has a health professional told you that you had or currently have an acute retinal detachment? (explain that this is a serious eye condition where a thin layer at the back of the eye has lifted - other eye conditions like cataracts and glaucoma should not be excluded)?
(If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.5 Are you in any pain now that could limit you from blowing with effort?
(If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.6 Are you currently suffering from acute diarrhea, vomiting or nausea that may limit you from blowing with effort?
(If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.7 Does the participant have high blood pressure above 180mmHg systolic or 110mmHg diastolic (tested in section xxxx)? (use average of the last two blood pressure measurements) (If yes, do not test at this time and skip to 16.2.12)

○ Yes ○ No ○ Don't know

15.2.8 Have you been recently diagnosed with TB?
(If no, skip to 2.9)

○ Yes ○ No ○ Don't know

15.2.8.1 Did you start your treatment within the past 4 weeks?

○ Yes ○ No ○ Don't know

15.2.9 Have you had a respiratory infection in the last 3 weeks? If yes, show options: flu, pneumonia, bronchitis, chest cold

○ Flu ○ Pneumonia ○ Bronchitis ○ Chest cold

15.2.9 If yes, do you feel well enough to participate in this test?

○ Yes ○ No ○ Don't know

15.2.10 Are you wearing any tight clothing that interferes with your ability to breathe deeply?

○ Yes ○ No ○ Don't know

15.2.11 Are you wearing dentures?

○ Yes ○ No ○ Don't know

The participant cannot do spirometry because of

_____

1 - Major Surgery in the last 6 weeks
2 - Chest pain in the last 4 weeks
3 - Coughing up blood
4 - Acute Retinal Detachment
5 - In pain
6 - Acute diarrhea, vomiting or nausea
7 - High Blood Pressure (above 180/110)
8 - Respiratory Infection
9 - Not feeling well enough

15.2.12 Is participant able to take the spirometry test?
(If Yes, proceed to the spirometry test. If no, please explain to the participant that for the reason above it would not be safe for them to have the spirometry test today.)

○ Yes ○ No

# 15.c Spirometry Test

**15.3 Spirometry test**

**Confirm that the participant understands what the test is for.**

15.3.1 Confirm that the participant is eligible to perform the test

○ Yes ○ No

15.3.2 Person performing spirometry

○ Researcher 1 ○ Researcher 2

15.3.3.1 Total number of blows

_____

15.3.3.2 Number of valid blows

_____

15.3.4 Was the FEV1/FVC ratio for one of the three valid blows less than 0.7?
(If yes, proceed to reversibility screen. Go to 16.4)

○ Yes ○ No

15.3.5 Comments

# 15.d Reversibility Test

**15.4 Reversibility spirometry test**

**Explain to participant that their lung function is low and the reversibility test will help us understand what the cause may be. They will be asked to use the puffer and wait for 15 minutes. Then they will need to do the spirometry test again.**

15.4.1 Was the salbutamol administered?

○ Yes ○ No

15.4.1.1What time was the salbutamol administered?

_____

15.4.1.2 What time was the spiromentry started?

_____

15.4.2 Person performing spirometry

○ Researcher 1 ○ Researcher 2

15.4.3 Total number of blows

_____

15.4.4 Number of valid blows

_____

15.4.5 Comments

# 16.a. Microbiome

## 16.1 Microbiome

16.1.1 When did you last take an antibiotic?

Give the most accurate answer you can

- ◯ Within the last week
- ◯ Within the last month
- ◯ Within the last six months
- ◯ Within the last year
- ◯ Within the last last two years
- ◯ Within the last last three years
- ◯ Longer
- ◯ Never
- ◯ Don't Know
- ◯ Decline to answer

16.1.2 When did you last have diarrhea?

Give the most accurate answer you can

- ◯ Within the last week
- ◯ Within the last month
- ◯ Within the last six months
- ◯ Within the last year
- ◯ Within the last two years
- ◯ Within the last three years
- ◯ Longer
- ◯ Can't remember
- ◯ Never
- ◯ Don't know
- ◯ Decline to answer

16.1.3 Have you ever been treated for worms in your intestine?

◯ Yes ◯ No ◯ Don't know ◯ Decline to answer

16.1.4 How long ago did you take probiotics?

Probiotics are live bacteria and yeasts that are good for you, especially your digestive system.

- ◯ Within the last week
- ◯ Within the last month
- ◯ Within the last six months
- ◯ Within the last three years
- ◯ Longer
- ◯ Can't remember
- ◯ Don't know
- ◯ Decline to answer

16.1.5 How long ago did you take medication for worms in your intestine

- ◯ Within the last week
- ◯ Within the last month
- ◯ Within the last six months
- ◯ Within the last three years
- ◯ Longer
- ◯ Can't remember
- ◯ Don't know
- ◯ Decline to answer

16.1.6 Have you ever taken probiotics?

◯ Yes ◯ No ◯ Don't know ◯ Decline to answer

# 16.b. Blood Collection

## 16.2 Blood Collection

16.2.1 At what time did you last eat?

_____

16.2.1.1 Hours last ate

_____

16.2.2 At what time did you last drink a sugar sweetened or alcohol containing beverage

_____

16.2.2.1 Hours last drunk

_____

16.2.3 Fasting confirmed?

○ Yes ○ No

16.2.4 Have TWO RED tubes been drawn?

○ Yes ○ No

16.2.4.1 If no, how many RED tubes are there?

_____

16.2.5 Has ONE PURPLE tube been drawn?

○ Yes ○ No

16.2.5.1 If no, how many PURPLE tubes are there?

_____

16.2.6 Has ONE GREY tube been drawn?

○ Yes ○ No

16.2.6.1 If no, how many GREY tubes are there?

_____

16.2.7 Phlebotomist name

○ Researcher 1 ○ Researcher 2

16.2.8 Date blood taken

_____

16.2.9 Time of blood collection

_____

# 16.c Urine Collection

## 16.3 Urine Collection

16.3.1 Has urine been collected?

○ Yes ○ No

16.3.2 If No, please specify reason(s)

16.3.3 What is the batch number of the urine container?

○ X0039A

16.3.4 What is the expiry date of the urine container?

○ 01-01-2020

16.3.5 Name of specimen collector

○ Researcher 1 ○ Researcher 2

16.3.6 Date urine taken

_____

16.3.7 Time of urine collection

_____

# 17. Point of Care Testing

## 17.1 Glucose And Cholesterol Test (single test strip)

17.1.1 Does participant want to have glucose or cholesterol tested?

○ Yes ○ No

17.1.1.1 Comment, if No

17.1.2 What is the serial number of instrument?

○ 00381931765016 ○ Serial Number 2

17.1.3 What is the batch number of the test strip?

○ A816 ○ Batch Number 2

***17.1.4 What is the expiry date of the test strip?

(mm-yyyy)

○ 28-10-2019

17.1.5 Date test administered

_____

17.1.6 Time test administered

_____
(PLEASE USE 24 HOUR NOTATION)

17.1.7 Name of researcher providing test

○ Researcher 1 ○ Researcher 2

17.1.8 What is the Glucose test result?

_____

17.1.9 What is the Cholesterol test result?

_____

17.1.10 Were the glucose test results provided to participant?

○ Yes ○ No

17.1.10.1 If no, please specify reason(s)

17.1.11 Were the cholesterol test results provided to participant?

○ Yes ○ No

17.1.11.1 If no, please specify reason(s)

17.1.12 Were the glucose test results discussed with the participant?

○ Yes ○ No

17.1.13 Were the cholesterol test results discussed with the participant?

○ Yes ○ No

17.1.14 Was participant recommended to seek further advice from a health care worker?

○ Yes ○ No

## 17.2 HIV Test

17.2.1 Was the test conducted?

○ Yes ○ No

17.2.1.1 Comment if No

17.2.2 Was HIV pre-test counselling provided?

Answer MUST be Yes

○ Yes ○ No

17.2.3 Name of health care worker providing pre-test counselling

17.2.4 Serial number of test kit

○ Serial Number 1 ○ Serial Number 2

17.2.5 What is the batch number of the test strip?

○ 20180516 ○ Batch Number 2

***17.2.6 What is the expiry date of the test strip?

(mm-yyyy)

○ 15-05-2020

17.2.7 Date test administered

_____

17.2.8 Name of researcher completing the test

○ Researcher 1 ○ Researcher 2 ○ Researcher 3

17.2.9 What is the HIV test result

○ Positive ○ Negative ○ Inconclusive

17.2.10 Was test result provided to participant?

○ Yes ○ No

17.2.11 Was post test counselling provided? Answer MUST be Yes if test was conducted

○ Yes ○ No

17.2.12 Name of health care worker providing post-test counselling

○ Thonniah ○ Siphumemelele

17.2.13 If this was a first-time positive test, was participant referred for secondary testing?

○ Yes ○ No

17.2.14 Was the participant recommended to seek further advice from a health care worker?

○ Yes ○ No

# 18. Trauma

Have you experienced any of the following events in the past 6 months? Check time from original

## 18.1 Trauma

18.1.1 A serious illness, injury or an assault?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.1.2 A serious illness, injury or assault that happened to a close relative?

○ Yes ○ No ○ Don't know ○ Decline to answer

## 18.2 Life Threatening Events With Long Term Consequences(LTE-Q)

18.2.1 Your parent, child or spouse died?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.2 A close family friend or another relative (aunt, cousin, grandparent) died?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.3 You had a separation due to marital difficulties?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.4 You broke off a steady relationship?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.5 You had a serious problem with a close friend, neighbour or relative?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.6 You became unemployed or you were seeking work unsuccessfully for more than one month?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.7 You were sacked, fired or laid off from your job?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.8 You had a major financial crisis?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.9 You had problems with the police and/or a court appearance?

○ Yes ○ No ○ Don't know ○ Decline to answer

18.2.10 Something you valued was lost or stolen?

○ Yes ○ No ○ Don't know ○ Decline to answer

# 19. Completion of Questionnaire

**19. Checklist**

19.1 Sections 1-12: General Questionnaire

○ Yes ○ No

Comment if No

19.2 Section 13: Anthropometric Measurements

○ Yes ○ No

Comment if No

19.3 Section 14: Blood Pressure and Pulse Measurements

○ Yes ○ No

Comment if No

19.4 Section 15: Ultrasound and DXA Measurements

○ Yes ○ No

Comment if No

19.5 Section 16: Respiratory Health, Spirometry & Reversibility Spirometry

○ Yes ○ No

Comment if No

19.6 Section 17: Blood Collection, Urine Collection & Microbiome

○ Yes ○ No

Comment if No

19.7 Section 18: Point of Care Testing

○ Yes ○ No

Comment if No

19.8 Section 19: Trauma

○ Yes ○ No

Comment if No