

**SOUTH AFRICA DEMOGRAPHIC AND HEALTH SURVEY 2003
ADULT HEALTH QUESTIONNAIRE**

IDENTIFICATION								
PROVINCE* _____	<input style="width: 20px; height: 20px;" type="checkbox"/>							
DISTRICT _____	<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> </table>							
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SADHS CLUSTER NUMBER.....	<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> </table>							
HOUSEHOLD NUMBER.....	<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> </table>							
NAME OF HOUSEHOLD HEAD _____								
NAME AND LINE NUMBER OF ADULT _____	<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td><td style="width: 25%;"></td></tr> </table>							
INTERVIEWER VISITS								
	1	2	3	FINAL VISIT				
DATE	_____	_____	_____	DAY <table border="1" style="width: 20px; height: 20px;"> <tr><td style="width: 10px;"></td><td style="width: 10px;"></td></tr> </table>				
INTERVIEWER'S NAME	_____	_____	_____	MONTH <table border="1" style="width: 20px; height: 20px;"> <tr><td style="width: 10px;"></td><td style="width: 10px;"></td></tr> </table>				
RESULT**	_____	_____	_____	YEAR <table border="1" style="width: 20px; height: 20px;"> <tr><td style="width: 10px;">2</td><td style="width: 10px;">0</td><td style="width: 10px;"></td><td style="width: 10px;"></td></tr> </table>	2	0		
2	0							
NEXT VISIT: DATE	_____	_____		INT.CODE <table border="1" style="width: 20px; height: 20px;"> <tr><td style="width: 10px;"></td><td style="width: 10px;"></td></tr> </table>				
TIME	_____	_____		RESULT <table border="1" style="width: 20px; height: 20px;"> <tr><td style="width: 10px;"></td><td style="width: 10px;"></td></tr> </table>				
				TOTAL NO. OF VISITS <input style="width: 20px; height: 20px;" type="checkbox"/>				
** RESULT CODES:								
1 COMPLETED	4 REFUSED	7 OTHER _____ (SPECIFY)						
2 NOT AT HOME	5 PARTLY COMPLETED							
3 POSTPONED	6 INCAPACITATED							
LANGUAGE								
LANGUAGE OF QUESTIONNAIRE: ENGLISH				<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 50%;">0</td><td style="width: 50%;">1</td></tr> </table>	0	1		
0	1							
LANGUAGE OF INTERVIEW *** _____				<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 50%;"></td><td style="width: 50%;"></td></tr> </table>				
HOME LANGUAGE OF RESPONDENT*** _____				<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 50%;"></td><td style="width: 50%;"></td></tr> </table>				
WAS A TRANSLATOR USED? (YES=1, NO=2).....				<table border="1" style="width: 100%; height: 20px;"> <tr><td style="width: 50%;"></td><td style="width: 50%;"></td></tr> </table>				
*** LANGUAGE CODES:								
01 ENGLISH	04 isiZULU	07 SePEDI	10 XITSONGA					
02 AFRIKAANS	05 SeSOTHO	08 SiSWATI	11 isiNDEBELA					
03 isiXHOSA	06 SeTSWANA	09 TshiVENDA	12 OTHER _____					
(SPECIFY)								
SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY					
NAME _____	NAME _____							
DATE _____	DATE _____							

*PROVINCE: EASTERN CAPE=1; FREE STATE=2; GAUTENG=3; KWAZULU-NATAL=4; MPUMALANGA=5; NORTHERN CAPE=6; LIMPOPO=7; NORTHWEST=8; WESTERN CAPE=9

SECTION 1: HEALTH SERVICE UTILIZATION

NO.	QUESTIONS AND FILTERS				
1	During the last month have you been to any of the following health services for medical care for yourself: PROBE.		2. Were you satisfied with the care you received at (PLACE)?		3. Why were you not satisfied with the care you received at (PLACE)? DO NOT READ ANSWERS TO THE RESPONDENT
1A	Community Health Centre?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE DOCTOR 04 NO PRESCRIBED DRUGS AVAILABLE 05 OTHER 96 (SPECIFY)
1B	Government Hospital/Government Clinic?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE DOCTOR 04 NO PRESCRIBED DRUGS AVAILABLE 05 OTHER 96 (SPECIFY)
1C	Private Hospital/Private Clinic?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE DOCTOR 04 TOO EXPENSIVE 05 OTHER 96 (SPECIFY)
1D	Private Doctor?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 TOO EXPENSIVE 04 OTHER 96 (SPECIFY)
1E	Chemist/Pharmacist?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE PHARMACIST 04 DRUGS TOO EXPENSIVE 05 OTHER 96 (SPECIFY)
1F	Faith Healer?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 OTHER 96 (SPECIFY)
1G	Traditional Healer or Herbalist?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 TOO EXPENSIVE 04 OTHER 96 (SPECIFY)
1H	Health Services at the Workplace?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 DIDN'T SEE DOCTOR 04 OTHER 96 (SPECIFY)
1I	Have you had visits by Home-Based Care Services/House visits/Community-Based Care?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2 LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 OTHER 96 (SPECIFY)

NO.	QUESTIONS AND FILTERS					
1J	Dentist/Oral Hygienist/Oral Therapist?	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2	LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 TOO EXPENSIVE 04 OTHER 96 (SPECIFY)
1K	Rehabilitation Therapists? (E.g. physiotherapists; occupational therapists; speech, hearing and language therapists; orthotists/prosthetists; or optometrist).	YES 1	NO 2 ↘ ↓	YES 1 ↘ ↓	NO 2	LONG WAIT 01 SHORT CONSULTATION 02 STAFF RUDE/UNKIND 03 TOO EXPENSIVE 04 OTHER 96 (SPECIFY)
1L	Other? (SPECIFY)	YES 1	NO 2 ↘ ↓			
4	Sometimes, one misses appointments with a health-service provider. What were the most common reasons that you missed an appointment with a health-service provider the last time this happened? RECORD ALL MENTIONED DO NOT READ ANSWERS TO THE RESPONDENT				LACK OF MONEY A LACK OF TIME B I FORGOT C I FELT BETTER D CANNOT TAKE TIME FROM WORK E NO TRANSPORT AVAILABLE F TOO ILL TO TRAVEL G OTHER RESPONSIBILITIES H DO NOT WANT TO GO BACK TO THE HEALTH-CARE PROVIDER I HAVE NOT MISSED APPOINTMENTS J OTHER X (SPECIFY)	
5	Are you covered by a Medical Aid or Medical Benefit Scheme or any scheme that helps you pay for health-care/drug services?				YES 1 NO 2	
6	Have you had your blood pressure measured in the past 12 months?				YES 1 NO 2	
7	Do you know what your blood pressure is?				YES 1 NO 2 → 9A	
8	Is it high, normal or low?				HIGH 1 NORMAL 2 LOW 3 DON'T KNOW 8	

SECTION 2: FAMILY MEDICAL HISTORY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
9	Now I would like to ask you about your family. Do you have a close blood relative (father, mother, brother, sister or child) who has ever had any of the following conditions:		
9A	High Blood Pressure?	YES.....1 NO.....2 DON'T KNOW.....8	
9B	Heart attack or angina or chest pain when exerting himself/herself?	YES.....1 NO.....2 DON'T KNOW.....8] → 9D
9C	Was this relative younger or older than 50 years old when they first had a heart attack, angina or chest pain?	YOUNGER THAN 50 YEARS.....1 OLDER THAN 50 YEARS.....2 DON'T KNOW.....8	
9D	Stroke?	YES.....1 NO.....2 DON'T KNOW.....8	

SECTION 3: QUALITY OF LIFE AND CLINICAL CONDITIONS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
10A	Did you grow up in a household where people smoked cigarettes, pipe or other tobacco products every day?	YES1 NO2 DON'T KNOW8			
10B	Would you say your health is poor, average, good, or very good/excellent?	POOR1 AVERAGE2 GOOD3 VERY GOOD/EXCELLENT4			
10C	Do you personally think that you are underweight, normal weight or overweight?	UNDERWEIGHT1 NORMAL WEIGHT2 OVERWEIGHT3 DON'T KNOW8			
11	Has a doctor or nurse or health worker at a clinic or hospital told you that you have or have had any of the following conditions:				
11A	High Blood Pressure?	YES1 NO2 DON'T KNOW8			
11B	Heart attack or angina (chest pains)?	YES1 NO2 DON'T KNOW8			
11C	Stroke?	YES1 NO2 DON'T KNOW8			
11D	High blood cholesterol or fats in the blood?	YES1 NO2 DON'T KNOW8			
11E	Diabetes or Blood Sugar?	YES1 NO2 DON'T KNOW8			
11F	Emphysema/Bronchitis?	YES1 NO2 DON'T KNOW8			
11G	Asthma?	YES1 NO2 DON'T KNOW8			
11H	Sore joints, e.g. Arthritis, Gout?	YES1 NO2 DON'T KNOW8			
11I	Osteoporosis?	YES1 NO2 DON'T KNOW8			
11J	Epilepsy / Fits?	YES1 NO2 DON'T KNOW8			
11K	TB?	YES1 NO2 DON'T KNOW8			
11L	How many episodes of TB have you ever been treated for?	NUMBER OF TB EPISODES <table border="1" data-bbox="1101 1768 1227 1831" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			11M
11M	Cancer?	YES1 NO2 DON'T KNOW8			

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
12	Now I would like to ask you about chest conditions :		
12A	Do you feel you have less breath when exerting (exercising or moving a lot) yourself when compared to other people your age?	YES.....1 NO.....2 DON'T KNOW.....8	
12B	During the last 12 months have you had wheezing (difficult breathing) or tightness of your chest?	YES.....1 NO.....2 DON'T KNOW.....8] → 12D
12C	Were you also short of breath?	YES.....1 NO.....2 DON'T KNOW.....8	
12D	Do you usually get wheezing (difficult breathing) when you have a cold?	YES.....1 NO.....2 DON'T KNOW.....8	
12E	Is your sleep ever interrupted by wheezing or a tight chest?	YES.....1 NO.....2 DON'T KNOW.....8	
12F	Is your sleep ever interrupted by your coughing?	YES.....1 NO.....2 DON'T KNOW.....8	
12G	Do you usually cough (on most days)?	YES.....1 NO.....2 DON'T KNOW.....8] → 13A
12H	When you cough, do you usually bring up phlegm from your chest?	YES.....1 NO.....2 DON'T KNOW.....8] → 13A
12I	Have you brought up phlegm every day for at least three months during the last year?	YES.....1 NO.....2 DON'T KNOW.....8] → 13A
12J	For how many years have you brought up phlegm in this way?	NUMBER OF YEARS..... <input type="text"/> <input type="text"/>	

SECTION 4: DENTAL HEALTH

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
13A	Have you lost all of your own teeth?	YES1 NO.....2	
13B	Have you had pain or problems with your mouth and/or teeth in the last 6 months ?	YES1 NO.....2	→13E
13C	Please indicate which part of your mouth was affected: RECORD ALL MENTIONED	TEETH A GUMS B ULCERS /SORES IN THE MOUTH..... C DENTURES D OTHER _____ X (SPECIFY)	
13D	What did you do when you had problems in your mouth? RECORD ALL MENTIONED	TOOK A TABLET A WENT TO THE DENTIST/ORAL HYGIENIST/DENTAL THERAPIST..... B WENT TO THE DOCTOR..... C WENT TO THE TRADITIONAL HEALER D NOTHING E OTHER _____ X (SPECIFY)	
13E	What do you usually do to look after your teeth/mouth? RECORD ALL MENTIONED DO NOT READ ANSWERS TO THE RESPONDENT	RINSE MOUTH..... A CLEAN/BRUSH/FLOSS..... B EAT LESS SWEET FOOD/DRINK LESS SWEET DRINKS... C VISIT DENTIST/DENTAL THERAPIST/ORAL HYGIENIST/ ORAL THERAPIST AT LEAST ONCE A YEAR D NOTHING E OTHER _____ X (SPECIFY)	

SECTION 5: OCCUPATIONAL HEALTH

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
14	In the past 12 months , have you worked for payment?	YES1 NO.....2	→15A
14A	In the past 12 months , have you had any injury or health problem caused by your work?	YES1 NO.....2	→15A
14B	Did you stay away from work because of this injury or problem?	YES1 NO.....2	→15A
14C	For how many days did you stay away?	NUMBER OF DAYS..... <input type="text"/> <input type="text"/>	
14D	What was the injury or health problem? WRITE THE ANSWER	_____ _____ _____ <input type="text"/> <input type="text"/> <input type="text"/> _____	

SECTION 6: VIOLENCE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																											
15	<p>CHECK FOR PRESENCE OF OTHERS: DO NOT CONTINUE UNTIL THE RESPONDENT IS ALONE.</p> <p>RESPONDENT ALONE AND ELIGIBLE FOR Qs. 15A-15I <input type="checkbox"/></p> <p>RESPONDENT NOT ALONE OR NOT ELIGIBLE FOR Qs. 15A-15I <input type="checkbox"/></p>		-> 16A																											
15A	<p>Now I would like to ask you some questions about violence:</p> <p>In the last 12 months, has anyone, someone you know or a stranger, physically attacked you in any of the following ways:</p> <p>a) By pushing, shaking or throwing something at you?</p> <p>b) By slapping you or twisting your arm?</p> <p>c) By punching you with their fist or something that could hurt you?</p> <p>d) By kicking or dragging you?</p> <p>e) By trying to strangle or burn you?</p> <p>f) By threatening you with a knife, gun, or other type of weapon?</p> <p>g) By shooting or stabbing you?</p> <p>h) In any other way?</p>	<table border="0"> <thead> <tr> <th></th> <th align="center"><u>YES</u></th> <th align="center"><u>NO</u></th> </tr> </thead> <tbody> <tr> <td>a)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>b)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>c)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>d)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>e)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>f)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>g)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>h)</td> <td align="center">1</td> <td align="center">2</td> </tr> </tbody> </table>		<u>YES</u>	<u>NO</u>	a)	1	2	b)	1	2	c)	1	2	d)	1	2	e)	1	2	f)	1	2	g)	1	2	h)	1	2	
	<u>YES</u>	<u>NO</u>																												
a)	1	2																												
b)	1	2																												
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d)	1	2																												
e)	1	2																												
f)	1	2																												
g)	1	2																												
h)	1	2																												
15B	<p>CHECK 15A:</p> <p>AT LEAST ONE "YES" CIRCLED <input type="checkbox"/></p> <p>NOT ONE SINGLE "YES" CIRCLED <input type="checkbox"/></p>		-> 16A																											
15C	<p>In the last 12 months, how many times did this (TYPE OF ATTACK FROM 15A) happen to you?</p> <p>RECORD THE NUMBER OF ALL KINDS OF ATTACK EVENTS IN THE LAST 12 MONTHS</p>	<p>NUMBER OF TIMES..... <input type="text"/> <input type="text"/></p>																												
15D	<p>Where were you attacked the last time it happened?</p> <p>DO NOT READ ANSWERS TO THE RESPONDENT</p>	<p>PUBLIC ROAD01</p> <p>PLACE OF WORK.....02</p> <p>PLACE OF EDUCATION.....03</p> <p>CLUB/SHEBEEN/DISCO/BAR.....04</p> <p>CROWDED VENUE (E.G. SOCCER GAME, CONCERT, ETC.)05</p> <p>HOME06</p> <p>OTHER _____ 96</p> <p align="center">(SPECIFY)</p>																												
15E	<p>As a result of this attack did you have any of the following:</p> <p>a) Aches and pains?</p> <p>b) Bruises or cuts that bled?</p> <p>c) Broken bones or other types of injuries?</p> <p>d) Collapsed or went into a coma?</p>	<table border="0"> <thead> <tr> <th></th> <th align="center"><u>YES</u></th> <th align="center"><u>NO</u></th> </tr> </thead> <tbody> <tr> <td>a)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>b)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>c)</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>d)</td> <td align="center">1</td> <td align="center">2</td> </tr> </tbody> </table>		<u>YES</u>	<u>NO</u>	a)	1	2	b)	1	2	c)	1	2	d)	1	2													
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a)	1	2																												
b)	1	2																												
c)	1	2																												
d)	1	2																												
15F	<p>CHECK 15A:</p> <p>AT LEAST ONE "YES" CIRCLED <input type="checkbox"/></p> <p>NOT ONE SINGLE "YES" CIRCLED <input type="checkbox"/></p>		-> 16A																											
15G	<p>On the last occasion you had (INJURY FROM 15E), did you seek medical attention?</p>	<p>YES1</p> <p>NO2</p>	-> 16A																											
15H	<p>Were you admitted to hospital for more than one day due to injuries from this attack?</p>	<p>YES1</p> <p>NO2</p>																												

15I	In your view, did alcohol or drugs contribute to this attack?	YES1 NO 2 DON'T KNOW/NOT SURE..... 8	
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SECTION 7: MEDICATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
16	Now I want to ask you about any medication you take:		
16A	Do you use any medicine regularly or daily that a doctor or nurse has prescribed?	YES1 NO.....2 DON'T KNOW8	<input type="checkbox"/> → 17
16B	How many different medicines do you use regularly (more than once a month)?	NUMBER OF MEDICINES <input type="text"/> <input type="text"/>	
16C	Who pays for most of the medication, prescribed by a doctor or nurse, that you use? READ THE ANSWER CATEGORIES TO THE RESPONDENT	RESPONDENT01 FAMILY02 MEDICAL AID03 PROVIDED AT CLINIC OR PUBLIC HOSPITAL04 EMPLOYER05 OTHER _____ 96 (SPECIFY)	

Name of drug	WHAT IS IT FOR? (UNPROMPTED)													OFFICE USE		
	High Blood Pressure	Heart attack or angina	Stroke	High cholesterol or other Blood fats	Diabetes, Blood sugar	Emphysema, Bronchitis	Asthma	Sore joints (arthritis)	Osteoporosis	TB	Epilepsy	Cancer	Don't know	Other	ATC Code	Correct = 1 Incorrect = 2 N/A = 3
	01	02	03	04	05	06	07	08	09	10	11	12	13			
	01	02	03	04	05	06	07	08	09	10	11	12	13			
	01	02	03	04	05	06	07	08	09	10	11	12	13			
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	01	02	03	04	05	06	07	08	09	10	11	12	13			
	01	02	03	04	05	06	07	08	09	10	11	12	13			

SECTION 8: HABITS AND LIFESTYLE

8A: PHYSICAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
17	The next 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 . You are requested to answer the questions even if you don't consider yourself to be an active person.		
	Occupation-Related Physical Activity (paid or unpaid work): When answering the following questions, think back over the past 12 months and consider (think of) a usual week .		
18	Does your work involve <u>mostly</u> sitting or standing still, OR walking for very short periods (less than 10 minutes)?	MOSTLY SITTING1 MOSTLY STANDING STILL2 MOSTLY WALKING FOR VERY SHORT PERIODS.....3 MOSTLY DOING MODERATE/VIGOROUS ACTIVITY.....4 NONE OF THE ABOVE5	→ 21 → 22A
19A	Does your work involve <u>vigorous</u> activities, (<u>like</u> heavy lifting, digging, or heavy construction) for at least 10 minutes at a time?	YES1 NO.....2	→ 20A
19B	In a usual week , how many days do you do <u>vigorous</u> activities as part of your work?	DAYS <input type="text"/> <input type="text"/>	
19C	On a usual day on which you do <u>vigorous</u> activities, how much time do you spend doing such work?	HOURS 1 <input type="text"/> <input type="text"/> MINUTES 2 <input type="text"/> <input type="text"/> <input type="text"/>	
20A	Does your work involve <u>moderate-intensity</u> activities (<u>like</u> brisk walking or carrying light loads) for at least 10 minutes at a time?	YES1 NO.....2	→ 21
20B	In a usual week , how many days do you do <u>moderate-intensity</u> activities as part of your work?	DAYS <input type="text"/> <input type="text"/>	
20C	On a usual day on which you do <u>moderate-intensity</u> activities, how much time do you spend doing such work?	HOURS 1 <input type="text"/> <input type="text"/> MINUTES 2 <input type="text"/> <input type="text"/> <input type="text"/>	
21	How long is your usual workday?	HOURS 1 <input type="text"/> <input type="text"/> MINUTES 2 <input type="text"/> <input type="text"/> <input type="text"/>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Travel-Related Physical Activity: Other than activities that you've already mentioned, I would like to ask you about the way you travel to and from places (to work, to shopping, to market, to church, etc.).		
22A	Do you walk or use a bicycle (pedal cycle) for at least 10 minutes at a time to get to and from places?	YES1 NO.....2	→23
22B	In a usual week , how many days do you walk or cycle for at least 10 minutes to get to and from places?	DAYS <input type="text"/> <input type="text"/>	
22C	On a usual day , how much time do you spend walking or cycling for travel?	HOURS 1 <input type="text"/> <input type="text"/> MINUTES 2 <input type="text"/> <input type="text"/> <input type="text"/>	
	Non-Work Related and Leisure Time Physical Activity: The next questions ask about activities you do in your leisure or spare time, for recreation or fitness. Do not include the physical activities you do at work or for travel already mentioned.		
23	In your leisure or spare time do you do any vigorous or moderate-intensity physical activity lasting more than 10 minutes at a time?	YES1 NO.....2	→26
24A	In your leisure or spare time, do you do any <u>vigorous</u> activities (<u>like</u> running or strenuous sports, weightlifting) for at least 10 minutes at a time?	YES1 NO.....2	→25A
24B	In a usual week , how many days do you do <u>vigorous</u> activities as part of your leisure or spare time?	DAYS <input type="text"/> <input type="text"/>	
24C	How much time do you spend doing this on a usual day ?	HOURS 1 <input type="text"/> <input type="text"/> MINUTES 2 <input type="text"/> <input type="text"/> <input type="text"/>	
25A	In your leisure or spare time, do you do any <u>moderate-intensity</u> activities (<u>like</u> brisk walking, cycling or swimming) for at least 10 minutes at a time?	YES1 NO.....2	→26
25B	In a usual week , how many days do you do <u>moderate-intensity</u> activities as part of your leisure or spare time?	DAYS <input type="text"/> <input type="text"/>	
25C	How much time do you spend doing this on a usual day ?	HOURS 1 <input type="text"/> <input type="text"/> MINUTES 2 <input type="text"/> <input type="text"/> <input type="text"/>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<p>Sitting / Resting Activity: Now I would like to ask you about the time spent sitting or resting, not including sleeping, in the past 7 days. 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.</p>		
26	<p>Over the past 7 days, how much time did you spend sitting or reclining (lying) on a usual day (excluding sleeping)?</p>	<p>HOURS..... 1 <input type="text"/> <input type="text"/></p> <p>MINUTES..... 2 <input type="text"/> <input type="text"/> <input type="text"/></p>	

8B: DIETARY INTAKE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	Now, I would like to ask you some questions about the foods that you eat. There are no right or wrong answers so please feel free to give us your information as it is.		
27	<u>Which</u> of the following do you USUALLY eat? MARK ONE PER COLUMN		
27A	Chicken/Poultry	WITH SKIN 1 WITHOUT SKIN..... 2 NONE 3	
27B	Red Meat	FATTY MEAT 1 LEAN MEAT 2 NONE 3	
27C	Spread: (Butter/ Margarine)	BUTTER..... 1 HARD MARGARINE (BRICK)..... 2 SOFT MARGARINE (TUB) 3 NONE 4	
27D	Milk/Milk Products	FULL CREAM 1 2% OR LOW FAT 2 SKIM/FAT FREE 3 BLENDS 4 NONE 5	
28	<u>How often</u> do you USUALLY eat the following?		
28A	Fried foods, e.g. chips, fish, potatoes, doughnuts, eggs	OCCASIONALLY/NEVER 1 WEEKLY (AT LEAST ONCE A WEEK) 2 DAILY 3	
28B	Chips, e.g. packet of 'Simba' chips or other salty snacks	OCCASIONALLY/NEVER 1 WEEKLY (AT LEAST ONCE A WEEK) 2 DAILY 3	
28C	Processed meat, e.g. polony, viennas, meat pies, sausage rolls	OCCASIONALLY/NEVER 1 WEEKLY (AT LEAST ONCE A WEEK) 2 DAILY 3	
29	Do you usually eat your food <u>very salty</u> , <u>lightly salted</u> or <u>not salted</u> ?	VERY SALTY 1 LIGHTLY SALTED 2 NOT SALTED 3 DON'T KNOW 8	
30	Do you usually add salt or Aromat/Fondor to your serving of food? IF YES, ASK: Before or after tasting the food?	NO, I NEVER ADD SALT/AROMAT 1 YES, BUT I TASTE FIRST AND THEN ADD 2 YES, EVEN BEFORE HAVING TASTED FOOD 3 DON'T KNOW 8	
31	Do you eat <u>salty snacks</u> more often than three times per week (Such as chips, nknaks, salted peanuts, salty biscuits, biltong, dried sausage, dried fish)?	YES 1 NO 2	

We are interested in how often people eat certain kinds of foods. Now think about your food intake...								
32	During the PAST 7 days (1 week) , did you eat any of the following? IF YES, ASK HOW OFTEN IF NO, CIRCLE 'NEVER' DO NOT READ ANSWER CATEGORIES TO THE RESPONDENT							
	Food item	NEVER	NOT DAILY		EVERY DAY			CODE
			1-3 TIMES PER WEEK	4-6 TIMES PER WEEK	1 TIME A DAY	2 TIMES A DAY	3+ TIMES A DAY	
A1	Red meat (any type)	0	1	2	3	4	5	
B1	Chicken (any type)	0	1	2	3	4	5	
C1	Tinned fish	0	1	2	3	4	5	
D1	Organ meat, e.g. liver, tripe	0	1	2	3	4	5	
E1	Eggs (any type)	0	1	2	3	4	5	
F1	Milk / yoghurt / maas to drink on cereals	0	1	2	3	4	5	
G1	Milk in tea / coffee	0	1	2	3	4	5	
H1	Cheese (except cottage cheese)	0	1	2	3	4	5	
I1	Legumes, e.g. baked beans, lentils	0	1	2	3	4	5	
J1	Peanuts and nuts	0	1	2	3	4	5	
K1	Brown / whole wheat bread or rolls	0	1	2	3	4	5	
L1	Breakfast cereal (instant, not cooked)	0	1	2	3	4	5	
M1	Oat-porridge	0	1	2	3	4	5	
N1	Soft margarine (tub)	0	1	2	3	4	5	
O1	Broccoli, cauliflower, Brussels sprouts	0	1	2	3	4	5	
P1	Spinach and/or morogo	0	1	2	3	4	5	
Q1	Carrots	0	1	2	3	4	5	
R1	Tomato (raw / cooked)	0	1	2	3	4	5	
S1	Green peas	0	1	2	3	4	5	
T1	Green beans	0	1	2	3	4	5	
U1	Mixed vegetables	0	1	2	3	4	5	
V1	Pumpkin / butternut	0	1	2	3	4	5	
W1	Sweet potato	0	1	2	3	4	5	
X1	Potato (any preparation)	0	1	2	3	4	5	
Y1	Citrus fruit, e.g. orange, grape fruit	0	1	2	3	4	5	
Z1	Pure orange / guava juice (not others)	0	1	2	3	4	5	
A2	Bananas	0	1	2	3	4	5	
B2	Mangoes	0	1	2	3	4	5	
C2	Apples / pears	0	1	2	3	4	5	
D2	Avocado	0	1	2	3	4	5	

8C: TOBACCO USE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
33A	Do you currently smoke any tobacco products, such as cigarettes, cigars, or pipes?	YES1 NO.....2	→36
33B	Do you currently smoke tobacco products daily ?	YES1 NO.....2	→36
34A	How old were you when you first started smoking daily?	YEARS OLD..... <input type="text"/> <input type="text"/> DON'T REMEMBER/NOT SURE.....98	→35
34B	Do you remember how long ago it was when you first started to smoke daily?	WEEKS AGO.....1 <input type="text"/> <input type="text"/> MONTHS AGO..... 2 <input type="text"/> <input type="text"/> YEARS AGO..... 3 <input type="text"/> <input type="text"/>	
35	On average, how many of the following items do you smoke each day? Manufactured cigarettes? Hand-rolled cigarettes? Pipes full of tobacco? Cigars/Cheroots/Cigarillos? IF NONE, RECORD '00'	MANUFACTURED CIGARETTES..... <input type="text"/> <input type="text"/> HAND-ROLLED CIGARETTES..... <input type="text"/> <input type="text"/> PIPES FULL OF TOBACCO..... <input type="text"/> <input type="text"/> CIGARS/CHEROOTS/CIGARILLOS..... <input type="text"/> <input type="text"/>	→38A
36	In the past , did you ever smoke daily?	YES1 NO.....2	→38A
37A	How old were you when you stopped smoking daily?	YEARS OLD..... <input type="text"/> <input type="text"/> DON'T REMEMBER/NOT SURE.....98	→38A
37B	Do you remember how long ago it was when you stopped smoking daily?	WEEKS AGO.....1 <input type="text"/> <input type="text"/> MONTHS AGO..... 2 <input type="text"/> <input type="text"/> YEARS AGO..... 3 <input type="text"/> <input type="text"/>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
ASSESSING USE OF SMOKELESS TOBACCO			
38A	Do you currently use any smokeless tobacco, such as snuff or chewing tobacco?	YES1 NO.....2	→40
38B	Do you currently use smokeless tobacco daily ?	YES1 NO.....2	→40
39	On average, how many times do you use each of the following items per day? Snuff (by mouth)? Snuff (by nose)? Chewing tobacco? IF NONE, RECORD '00'	SNUFF (BY MOUTH)..... <input type="text"/> <input type="text"/> SNUFF (BY NOSE)..... <input type="text"/> <input type="text"/> CHEWING TOBACCO..... <input type="text"/> <input type="text"/>	} →41
40	In the past , did you ever use smokeless tobacco, such as snuff or chewing tobacco daily?	YES1 NO.....2	
41A	Do you live in a house where other people smoke cigarettes regularly?	YES1 NO.....2	
41B	Do you currently work in a job where other people smoke cigarettes around you?	YES1 NO.....2	
41C	Have you ever worked in a job where you were regularly exposed to smoke, dust, fumes or strong smells?	YES1 NO.....2	→42A
41D	How long did you work in that job? IF LESS THAN 1 YEAR, WRITE '00'	YEARS..... <input type="text"/> <input type="text"/>	

8D: ALCOHOL USE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42A	Have you ever consumed a drink that contains alcohol such as beer, wine, spirits or sorghum beer?	YES1 NO.....2	→46
42B	Was this within the past 12 months ?	YES1 NO.....2	→45A
43	In the past 12 months, how frequently have you had at least one drink? READ ANSWER CATEGORIES TO THE RESPONDENT USE SHOWCARD	5 OR MORE DAYS A WEEK1 1-4 DAYS PER WEEK2 1-3 DAYS A MONTH.....3 LESS THAN ONCE A MONTH4	
44A	When you drink alcohol, on average , how many drinks do you have during one day?	DRINKS..... <input type="text"/> <input type="text"/> DON'T KNOW98	
44B	During the past 7 days , how many standard drinks of any alcoholic drink did you have each day? RECORD FOR EACH DAY USE SHOWCARD IF NONE, RECORD '00'	MONDAY..... <input type="text"/> <input type="text"/> TUESDAY..... <input type="text"/> <input type="text"/> WEDNESDAY..... <input type="text"/> <input type="text"/> THURSDAY..... <input type="text"/> <input type="text"/> FRIDAY..... <input type="text"/> <input type="text"/> SATURDAY..... <input type="text"/> <input type="text"/> SUNDAY..... <input type="text"/> <input type="text"/>	
45A	Have you ever felt that you should cut down on your drinking?	YES1 NO.....2	
45B	Have people annoyed you by criticizing your drinking?	YES1 NO.....2	
45C	Have you ever felt bad or guilty about your drinking?	YES1 NO.....2	
45D	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	YES1 NO.....2	
46	How old were you at your last birthday?	AGE IN COMPLETED YEARS..... <input type="text"/> <input type="text"/> DON'T KNOW98	
47	RECORD THE POPULATION GROUP THAT THE RESPONDENT BELONGS TO DO NOT READ ANSWER CATEGORIES TO THE RESPONDENT IF UNSURE, ASK THE RESPONDENT	BLACK/AFRICAN1 COLOURED.....2 WHITE3 ASIAN/INDIAN4 NO REPLY/NOT SURE8	

ADULT DEMOGRAPHIC AND HEALTH SURVEY
ANTHROPOMETRIC DATA SHEET

48	DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2	0	0	<input type="text"/>
		d	d	m	m	y	y	y	y
49	FIELDWORKER NUMBER	<input type="text"/>	<input type="text"/>	<input type="text"/>					
50	WEIGHT (KG)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
51	HEIGHT (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
52	WAIST CIRCUMFERENCE (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
53	HIP CIRCUMFERENCE (CM)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
54	SYSTOLIC BLOOD PRESSURE 1	<input type="text"/>	<input type="text"/>	<input type="text"/>					
55	DIASTOLIC BLOOD PRESSURE 1	<input type="text"/>	<input type="text"/>	<input type="text"/>					
56	PULSE 1	<input type="text"/>	<input type="text"/>	<input type="text"/>					
57	SYSTOLIC BLOOD PRESSURE 2	<input type="text"/>	<input type="text"/>	<input type="text"/>					
58	DIASTOLIC BLOOD PRESSURE 2	<input type="text"/>	<input type="text"/>	<input type="text"/>					
59	PULSE 2	<input type="text"/>	<input type="text"/>	<input type="text"/>					
60	SYSTOLIC BLOOD PRESSURE 3	<input type="text"/>	<input type="text"/>	<input type="text"/>					
61	DIASTOLIC BLOOD PRESSURE 3	<input type="text"/>	<input type="text"/>	<input type="text"/>					
62	PULSE 3	<input type="text"/>	<input type="text"/>	<input type="text"/>					
63	PEAK EXPIRATORY FLOW RATE (1)	<input type="text"/>	<input type="text"/>	<input type="text"/>					
64	(2)	<input type="text"/>	<input type="text"/>	<input type="text"/>					