

**AFRICAN POPULATION AND HEALTH RESEARCH CENTRE - SCALE UP PROJECT
BASELINE SURVEY ON CARE SEEKING, MEDICAL HISTORY AND TREATMENT ADHERENCE
AMONG CLINIC ATTENDEES**

1.0 IDENTIFICATION INFORMATION and CONSENT

1.1 INTERVIEWER'S CODE

1.2 DATE OF INTERVIEW (DD/MM/YYYY)

1.3 RESPONDENT'S ID (DSS)

(FW: IF RESPONDENT IS NOT IN DSS FILL IN 99999999999999)

1.4 RESPONDENT'S DATE OF BIRTH (DD/MM/YYYY)

1.5 RESPONDENT'S SEX (F=Female; M=Male)

1.6 RESPONDENT'S FULL NAME

1.7 VILLAGE WHERE RESPONDENT LIVES

1.8 MOBILE NUMBER

1.9 DATA COLLECTION ROUND B=Baseline; O=1-Year Follow-up

INTRODUCTION AND CONSENT

Researcher	Title	Role	Affiliation
Dr. Catherine Kyobutungi	Senior Research Scientist	Principal Investigator	African Population and Health Research Center
Prof. dr. Joep Lange	Executive Scientific Director	Co-Principal Investigator	Amsterdam Institute for Global Health and Development
Dr. Steven van de Vijver	Senior Research Officer	Study Coordinator	African Population and Health Research Center
Dr. Samuel Oti	Senior Research Officer	Study Coordinator	African Population and Health Research Center

Hello, my name is _____ and I work with the African Population and Health Research Centre. We are conducting a survey with people who attend our cardiovascular disease clinics in this community. Your participation in this research is totally voluntary. The information we get from this research will help us in understanding how people who attend our clinics have been faring since they started receiving healthcare for management and control of hypertension and other related conditions. The results of this study will be given to those involved in decision making with the intension that this information will help improve care for cardiovascular diseases in the community and the country. If you agree to participate then we will proceed to interview you as regards your experiences at this clinic. Specifically we would like to know when you were diagnosed and how often you visited the clinic. In addition to that, we would also like to know about lifestyle changes if any that you may have experienced as a result of services you have been getting from this clinic especially knowledge acquired in control of your condition either through diet, increased physical activity or avoidance of risky health related behaviours. We would also like to know how you experienced the project regarding the involvement of CHW, SMS and support groups. After this, we will then measure your height, weight and the width of your waist, and blood pressure. We might also take a few drops of blood and measure your blood sugar levels on the spot if necessary. This interview will take about one hour of your time. You will not receive any direct benefits from participating in this study. However, the information you provide us will help us in improving the quality of care you receive from the clinic. This interview is not expected to cause you any harm or discomfort, but you may feel a little pain if we take the blood drops. If you feel uncomfortable with certain questions you can choose not to answer them and also note that failure to participate in this study will not in any way disqualify you from receiving treatment from this clinic. We, however, hope you will participate in this survey since your views are very important to us. All your information will be treated with confidentiality. We have a secure system that will ensure that no one apart from the main researchers of this study will have access to your personal information.

If you have any questions about the study do not hesitate to contact Dr. Catherine Kyobutungi on this number: 020 400 1000.

If you have any questions about your rights of participation in this study you may contact the Secretary, KEMRI/NERC on any of these numbers: 020 272 2541, 0722 205 901, 0733 400003

You will not be paid for participating in the study.

1.10 Do you accept to participate in the study? (Y=YES; N=NO; IF "NO" SKIP TO 1.12)

1.11 IF THE RESPONDENT ACCEPTS TO BE INTERVIEWED: Thank you for agreeing to participate in our study. Could you please sign here to show that you have accepted to participate in the study.
Respondent's Signature.....

0= REFUSES TO SIGN

1= SIGNS

2= WILLING BUT UNABLE TO SIGN

IF RESPONDENT IS ILLITERATE, ASK HIM/HER FOR A THUMBPRINT.

Witness Signature (for those giving a thumbprint only).....

1.12	FINAL RESULT OF INTERVIEW (CODE SHEET A ⁷)	<input style="width: 30px; height: 20px;" type="text"/>																																									
1.13	DATA ENTRY CLERK'S CODE	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>																																									
2.0 CLINIC HISTORY																																											
2.10	When did you first visited the clinic? <div style="display: flex; justify-content: space-between;"> <div> CROSS CHECK THE DATE WITH THE ORIGINAL DATABASE OTHERWISE CHECK IF THIS DATE IS CORRECT </div> <div style="text-align: right;"> <table style="border-collapse: collapse;"> <tr> <td style="padding: 0 5px;">D</td><td style="padding: 0 5px;">D</td><td style="padding: 0 5px;">M</td><td style="padding: 0 5px;">M</td><td style="padding: 0 5px;">Y</td><td style="padding: 0 5px;">Y</td><td style="padding: 0 5px;">Y</td><td style="padding: 0 5px;">Y</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> </div> </div>			D	D	M	M	Y	Y	Y	Y																																
D	D	M	M	Y	Y	Y	Y																																				
2.11	When did you last visit the clinic? <div style="display: flex; justify-content: space-between;"> <div> CROSS CHECK THE DATE WITH THE ORIGINAL DATABASE OTHERWISE CHECK IF THIS DATE IS CORRECT </div> <div style="text-align: right;"> <table style="border-collapse: collapse;"> <tr> <td style="padding: 0 5px;">D</td><td style="padding: 0 5px;">D</td><td style="padding: 0 5px;">M</td><td style="padding: 0 5px;">M</td><td style="padding: 0 5px;">Y</td><td style="padding: 0 5px;">Y</td><td style="padding: 0 5px;">Y</td><td style="padding: 0 5px;">Y</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> </div> </div>			D	D	M	M	Y	Y	Y	Y																																
D	D	M	M	Y	Y	Y	Y																																				
2.12	How many times did you visit the clinic <input style="width: 30px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between;"> <div>How often did you visit the clinic</div> <div> Once in 2 weeks 1 Once a month 2 Once in 3 months 3 Once in 6 months 4 </div> </div>																																										
2.13	With which conditions were you diagnosed CIRCLE ALL THAT APPLY <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">HYPERTENSION</td> <td style="width: 5%; text-align: center;">1</td> </tr> <tr> <td>DIABETES</td> <td style="text-align: center;">2</td> </tr> <tr> <td>HYPERTENSION AND DIABETES</td> <td style="text-align: center;">3</td> </tr> <tr> <td>NONE OF BOTH</td> <td style="text-align: center;">4</td> </tr> </table>			HYPERTENSION	1	DIABETES	2	HYPERTENSION AND DIABETES	3	NONE OF BOTH	4																																
HYPERTENSION	1																																										
DIABETES	2																																										
HYPERTENSION AND DIABETES	3																																										
NONE OF BOTH	4																																										
2.14	Did you use any drugs for your hypertension/diabetes <div style="display: flex; justify-content: space-between;"> <div> YES.....1 NO.....2 </div> <div style="text-align: right;"> → </div> </div>		2.25																																								
2.15	How often were you taking the medication for high BP? CIRCLE ONLY ONE RESPONSE <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">I WAS TAKING MEDICATION DAILY</td> <td style="width: 5%; text-align: center;">1</td> </tr> <tr> <td>I WAS TAKING MEDICATION ON MOST BUT NOT ALL DAYS</td> <td style="text-align: center;">2</td> </tr> <tr> <td>I WAS TAKING MEDICATION ON SOME DAYS</td> <td style="text-align: center;">3</td> </tr> <tr> <td>I ONLY TOOK MEDICINE WHEN I FELT BAD</td> <td style="text-align: center;">4</td> </tr> <tr> <td>I DID NOT NEED MEDICATION - WAS USING DIET & EXERCISE</td> <td style="text-align: center;">5</td> </tr> </table>			I WAS TAKING MEDICATION DAILY	1	I WAS TAKING MEDICATION ON MOST BUT NOT ALL DAYS	2	I WAS TAKING MEDICATION ON SOME DAYS	3	I ONLY TOOK MEDICINE WHEN I FELT BAD	4	I DID NOT NEED MEDICATION - WAS USING DIET & EXERCISE	5																														
I WAS TAKING MEDICATION DAILY	1																																										
I WAS TAKING MEDICATION ON MOST BUT NOT ALL DAYS	2																																										
I WAS TAKING MEDICATION ON SOME DAYS	3																																										
I ONLY TOOK MEDICINE WHEN I FELT BAD	4																																										
I DID NOT NEED MEDICATION - WAS USING DIET & EXERCISE	5																																										
2.16	Have you had any of the following problems since you started taking the medication? <div style="display: flex; justify-content: space-between;"> <div> CIRCLE ALL THAT APPLY <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 55%;">NAUSEA, VOMITTING OR DIARRHEA</td> <td style="width: 10%; text-align: center;">YES</td> <td style="width: 10%; text-align: center;">NO</td> <td style="width: 10%; text-align: center;">DK</td> <td style="width: 15%;"></td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> <tr> <td>DIZZINESS OR FAINTNESS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> <tr> <td>SKIN RASHES, ITCHING, DISCOLORATION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> <tr> <td>SWELLINGS (FACE, LIPS, TONGUE)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> <tr> <td>DIFFICULTY IN BREATHING, CHEST PAIN</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> <tr> <td>SEXUAL DYSFUNCTION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> <tr> <td>OTHER(SPECIFY)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">9</td> <td></td> </tr> </table> </div> <div></div> </div>			NAUSEA, VOMITTING OR DIARRHEA	YES	NO	DK			1	2	9		DIZZINESS OR FAINTNESS	1	2	9		SKIN RASHES, ITCHING, DISCOLORATION	1	2	9		SWELLINGS (FACE, LIPS, TONGUE)	1	2	9		DIFFICULTY IN BREATHING, CHEST PAIN	1	2	9		SEXUAL DYSFUNCTION	1	2	9		OTHER(SPECIFY)	1	2	9	
NAUSEA, VOMITTING OR DIARRHEA	YES	NO	DK																																								
	1	2	9																																								
DIZZINESS OR FAINTNESS	1	2	9																																								
SKIN RASHES, ITCHING, DISCOLORATION	1	2	9																																								
SWELLINGS (FACE, LIPS, TONGUE)	1	2	9																																								
DIFFICULTY IN BREATHING, CHEST PAIN	1	2	9																																								
SEXUAL DYSFUNCTION	1	2	9																																								
OTHER(SPECIFY)	1	2	9																																								
2.17	Are you currently taking the above medication for high BP? <div style="display: flex; justify-content: space-between;"> <div> YES.....1 NO.....2 </div> <div style="text-align: right;"> → </div> </div>		2.20																																								
2.18	How long ago did you stop taking treatment? UNITS <input style="width: 30px; height: 20px;" type="text"/> (UNITS: D=Days, W=Weeks, M=Months, Y=Years) <div style="display: flex; justify-content: space-between;"> <div>NO. OF UNITS</div> <div> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> </div> </div>																																										
2.19	Why did you stop taking the treatment? <div style="display: flex; justify-content: space-between;"> <div> Could no longer afford the medication I felt better so did not need further treatment My illness was not improving The distance to the source of treatment was far The medication was having a bad effect on my body Other (specify) </div> <div style="text-align: right;"> 1 2 3 4 5 6 </div> </div>																																										
2.20	Did you change any lifestyle regarding health since your involvement in the project <div style="display: flex; justify-content: space-between;"> <div> YES.....1 NO.....2 </div> <div style="text-align: right;"> → </div> </div>		2.30																																								
2.21	What kind of lifestyle did you change CIRCLE ALL THAT APPLY <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">More physical exercise</td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> <tr> <td>Reduction salt in diet</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> <tr> <td>Reduction fat in diet</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> <tr> <td>Reduction sugar in diet</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> <tr> <td>Reduction alcohol</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> <tr> <td>Reduction smoking</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> <tr> <td>Other (Specify)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td></td> </tr> </table>			More physical exercise	Yes	No			1	2		Reduction salt in diet	1	2		Reduction fat in diet	1	2		Reduction sugar in diet	1	2		Reduction alcohol	1	2		Reduction smoking	1	2		Other (Specify)	1	2									
More physical exercise	Yes	No																																									
	1	2																																									
Reduction salt in diet	1	2																																									
Reduction fat in diet	1	2																																									
Reduction sugar in diet	1	2																																									
Reduction alcohol	1	2																																									
Reduction smoking	1	2																																									
Other (Specify)	1	2																																									

2.30	Have you been diagnosed with any of the following since your first visit at this clinic			
		Yes	No	
	DIABETES	1	2	
	HEART DISEASE - HEART ATTACK	1	2	
	HEART DISEASE - ANGINA	1	2	
	HEART DISEASE - ANY OTHER	1	2	
	KIDNEY DISEASE	1	2	
	STROKE	1	2	
	LIVER DISEASE	1	2	
	CANCER OF ANY TYPE	1	2	

2.31	FW: DOES THE PATIENT CURRENTLY HAVE ANY OF THE FOLLOWING COMPLICATIONS?	YES	NO	DK	
	PERIPHERAL NEUROPATHY	1	2	9	
	POOR VISION	1	2	9	
	AMPUTATION	1	2	9	
	KIDNEY PROBLEMS	1	2	9	
	CHEST PAIN	1	2	9	
	BODY SWELLING (ABDOMINAL OR PEDAL OEDEMA)	1	2	9	
	OTHER COMPLICATION (SPECIFY)	1	2	9	

3.0 EVALUATION CHW, SMS AND SUPPORT GROUP				
3.10	After you visited the clinic, did the CHW contact you again for follow up visits			
	YES.....1			
	NO.....2			3.20

3.11	How did the CHW contact you?	Yes	No	
	CIRCLE ALL THAT APPLY			
	Sent me a text message	1	2	
	Called me on the phone	1	2	
	Home visit	1	2	
	Sent a message through my friend/neighbour	1	2	
	Other (Specify)	1	2	

3.12	How many times did the CHW contact you in the last year	<input type="text"/>	<input type="text"/>	
	How often did the CHW visit you in the last year	Once a week or more	1	
		Every 2 weeks	2	
		Once a month	3	
		Once in 6 months	4	
		Only once	5	

3.13	Did the CHW's effort to contact you influence your decision to come to this clinic?	
	CIRCLE ONLY	
	ONE RESPONSE	
	Yes but to a small extent	1
	Yes to a moderate extent	2
	Yes, I wouldnt have come if the CHW did not contact me	3
	No, not at all	4

3.20	Have you received SMS to attend the clinic in the last year	
	YES.....1	
	NO.....2	3.30

3.21	How many times did you receive an SMS in the last year	<input type="text"/>	<input type="text"/>
	How often did you receive SMS in the last year?	Once a week or more	1
		Every 2 weeks	2
		Once a month	3
		Once in 6 months	4
		Only once	5

3.22	Did the SMS influence your decision to come to this clinic?	
	CIRCLE ONLY	
	ONE RESPONSE	
	Yes but to a small extent	1
	Yes to a moderate extent	2
	Yes, I wouldnt have come if I had not received the SMS	3
	No, not at all	4

3.30	Have you visited a support group in the last year	YES.....1 NO.....2 →	3.32										
3.31	How many times did you visit the support group <input type="text"/> <input type="text"/> How often did you attend the support group <table style="width: 100%; margin-top: 5px;"> <tr><td>Once a month</td><td style="text-align: right;">1</td></tr> <tr><td>Once in 3 months</td><td style="text-align: right;">2</td></tr> <tr><td>Once in 6 months</td><td style="text-align: right;">3</td></tr> <tr><td>Only once</td><td style="text-align: right;">4</td></tr> </table>	Once a month	1	Once in 3 months	2	Once in 6 months	3	Only once	4				
Once a month	1												
Once in 3 months	2												
Once in 6 months	3												
Only once	4												
3.32	Did the support group influence your decision to come to this clinic? CIRCLE ONLY ONE RESPONSE <table style="width: 100%; margin-top: 5px;"> <tr><td>Yes but to a small extent</td><td style="text-align: right;">1</td></tr> <tr><td>Yes to a moderate extent</td><td style="text-align: right;">2</td></tr> <tr><td>Yes, I wouldnt have come if I had not received the SMS</td><td style="text-align: right;">3</td></tr> <tr><td>No, not at all</td><td style="text-align: right;">4</td></tr> </table>	Yes but to a small extent	1	Yes to a moderate extent	2	Yes, I wouldnt have come if I had not received the SMS	3	No, not at all	4				
Yes but to a small extent	1												
Yes to a moderate extent	2												
Yes, I wouldnt have come if I had not received the SMS	3												
No, not at all	4												
3.33.	Why didn't you attend the support group <table style="width: 100%; margin-top: 5px;"> <tr><td>No time</td><td style="text-align: right;">1</td></tr> <tr><td>Didn't know about it</td><td style="text-align: right;">2</td></tr> <tr><td>Didn't feel it was important</td><td style="text-align: right;">3</td></tr> <tr><td>Distance to meeting location</td><td style="text-align: right;">4</td></tr> <tr><td>Other specify _____</td><td style="text-align: right;">5</td></tr> </table>	No time	1	Didn't know about it	2	Didn't feel it was important	3	Distance to meeting location	4	Other specify _____	5		
No time	1												
Didn't know about it	2												
Didn't feel it was important	3												
Distance to meeting location	4												
Other specify _____	5												
4.0 ANTHROPOMETRICS AND BIOMARKERS													
Now, we would like to measure a few things, like your general health, blood pressure, your weight and height.													
General examination													
4.10	FW: Is the patient anaemic? (CHECK PALMS, EYES, TONGUE) <table style="width: 100%; margin-top: 5px;"> <tr><td>Yes.....</td><td style="text-align: right;">1</td></tr> <tr><td>No.....</td><td style="text-align: right;">2</td></tr> </table>	Yes.....	1	No.....	2								
Yes.....	1												
No.....	2												
4.11	FW: Is the patient dehydrated? (CHECK EYES, SKIN, LIPS, TONGUE) <table style="width: 100%; margin-top: 5px;"> <tr><td>Yes.....</td><td style="text-align: right;">1</td></tr> <tr><td>No.....</td><td style="text-align: right;">2</td></tr> </table>	Yes.....	1	No.....	2								
Yes.....	1												
No.....	2												
4.12	FW: Does the patient have pedal oedema? <table style="width: 100%; margin-top: 5px;"> <tr><td>Yes.....</td><td style="text-align: right;">1</td></tr> <tr><td>No.....</td><td style="text-align: right;">2</td></tr> </table>	Yes.....	1	No.....	2	→	4.20						
Yes.....	1												
No.....	2												
4.13	FW: What is the level of oedema? 1= Mild, 2=Moderate, 3=Severe <input type="text"/>												
Blood Pressure													
4.20	1st Blood Pressure reading <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 5%;">a</td> <td style="width: 60%;">Systolic</td> <td style="width: 35%;"><input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td>b</td> <td>Diastolic</td> <td><input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td>c</td> <td>Pulse rate</td> <td><input type="text"/> <input type="text"/> <input type="text"/></td> </tr> </table>	a	Systolic	<input type="text"/> <input type="text"/> <input type="text"/>	b	Diastolic	<input type="text"/> <input type="text"/> <input type="text"/>	c	Pulse rate	<input type="text"/> <input type="text"/> <input type="text"/>			
a	Systolic	<input type="text"/> <input type="text"/> <input type="text"/>											
b	Diastolic	<input type="text"/> <input type="text"/> <input type="text"/>											
c	Pulse rate	<input type="text"/> <input type="text"/> <input type="text"/>											
4.21	2nd Blood Pressure reading <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 5%;">a</td> <td style="width: 60%;">Systolic</td> <td style="width: 35%;"><input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td>b</td> <td>Diastolic</td> <td><input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td>c</td> <td>Pulse rate</td> <td><input type="text"/> <input type="text"/> <input type="text"/></td> </tr> </table>	a	Systolic	<input type="text"/> <input type="text"/> <input type="text"/>	b	Diastolic	<input type="text"/> <input type="text"/> <input type="text"/>	c	Pulse rate	<input type="text"/> <input type="text"/> <input type="text"/>			
a	Systolic	<input type="text"/> <input type="text"/> <input type="text"/>											
b	Diastolic	<input type="text"/> <input type="text"/> <input type="text"/>											
c	Pulse rate	<input type="text"/> <input type="text"/> <input type="text"/>											

Anthropometric measurements																						
4.3	FW: Can respondent stand up? IF NO, SKIP TO 4.40	YES.....1 NO.....2 → 4.40																				
4.31	Measured height in cm a 1st Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> b 2nd Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>																					
4.32	Weight in Kg a 1st Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> b 2nd Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>																					
4.33	Waist circumference a 1st Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> b 2nd Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>																					
4.34	Hip Circumference a 1st Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> b 2nd Reading <table border="1"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table> . <table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>																					
Blood measurements																						
4.40	Blood glucose <table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> mg/100ml or mmol/L																					
END THE INTERVIEW BY THANKING THE RESPONDENT																						