



## PAHO/WHO Sodium Detection in 24-hr Urine Samples Questionnaire

< Insert country/site name >

### Questionnaire Information

Location and Date		Response
1	Center/City name	
2	Interviewer ID	
3	Date of completion of the instrument (dd/mm/yyyy)	

Consent, Interview Language and Name		Response	
4	Consent has been read and obtained	Yes <input type="checkbox"/>	
		No <input type="checkbox"/>	<b>If NO,END</b>
5	Interview Language <i>[insert language]</i>	English <input type="checkbox"/>	
		<i>[add others]</i> <input type="checkbox"/>	
		<i>[add others]</i> <input type="checkbox"/>	
		<i>[add others]</i> <input type="checkbox"/>	
6	Time of Interview (24 hour clock)	Hrs: mins	
7	Family Surname		
8	First Name		
<b>Additional Information that may be helpful</b>			
9	Contact phone number where possible		

*Continued on the next page*

## 1 - Demographic Information

CORE: Demographic Information	
Question	Response
10 Sex ( <i>Record Male/Female as observed</i> )	<div style="display: flex; justify-content: space-between;"> <span>Male</span> <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-between;"> <span>Female</span> <input type="checkbox"/> </div>
11 What is your date of birth? <i>Don't know (leave blank)</i>	/   / dd/mm/yyyy
12 How old are you?	years

EXPANDED: Demographic Information	
Question	Response
13 What is the highest level of education you have completed	<div style="display: flex; flex-direction: column; gap: 5px;"> <span>Not formal schooling <input type="checkbox"/></span> <span>Less than primary school <input type="checkbox"/></span> <span>Primary school completed <input type="checkbox"/></span> <span>Secondary school completed <input type="checkbox"/></span> <span>High school completed <input type="checkbox"/></span> <span>College/university completed <input type="checkbox"/></span> <span>Post graduate degree <input type="checkbox"/></span> <span>Refused <input type="checkbox"/></span> </div>
14 What is your <i>[insert relevant ethnic group /racial group/cultural subgroup /others]</i> background?	<div style="display: flex; flex-direction: column; gap: 5px;"> <span><i>[locally defined]</i> <input type="checkbox"/></span> <span><i>[locally defined]</i> <input type="checkbox"/></span> <span><i>[locally defined]</i> <input type="checkbox"/></span> <span><i>[locally defined]</i> <input type="checkbox"/></span> <span><i>[locally defined]</i> <input type="checkbox"/></span> <span>Refused <input type="checkbox"/></span> </div>
15 What is your marital status?	<div style="display: flex; flex-direction: column; gap: 5px;"> <span>Never married <input type="checkbox"/></span> <span>Currently married <input type="checkbox"/></span> <span>Separated <input type="checkbox"/></span> <span>Divorced <input type="checkbox"/></span> <span>Widowed <input type="checkbox"/></span> <span>Cohabiting <input type="checkbox"/></span> <span>Refused <input type="checkbox"/></span> </div>
16 Which of the following best describes your main work status over the past 12 months?  <i>[insert country-specific categories]</i>	<div style="display: flex; flex-direction: column; gap: 5px;"> <span>Government employee <input type="checkbox"/></span> <span>Non-government employee <input type="checkbox"/></span> <span>Self-employed <input type="checkbox"/></span> <span>Non-paid <input type="checkbox"/></span> <span>Student <input type="checkbox"/></span> <span>Homemaker <input type="checkbox"/></span> <span>Retired <input type="checkbox"/></span> <span>Unemployed (able to work) <input type="checkbox"/></span> <span>Unemployed (unable to work) <input type="checkbox"/></span> <span>Refused <input type="checkbox"/></span> </div>
17 Taking the past year, can you tell me what the average earnings of the household have been? <i>[record only one, not all three]</i>	<div style="display: flex; flex-direction: column; gap: 10px;"> <div>             Per week <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span> </div> <div>             OR per month <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span> </div> <div>             OR per year <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span> </div> <div>             Refused <input type="checkbox"/> </div> </div>

Continued on the next page

## 1 – Behavioral Measurements

### CORE: Tobacco Use

Now I'm going to ask you some questions about various health behaviors. This includes things like smoking, drinking alcohol, eating fruits, and vegetables and physical activity. Let's start with tobacco.

Question	Response
18	Do you currently smoke any tobacco product, such as cigarettes, cigars or pipes? Yes <input type="checkbox"/> No <input type="checkbox"/>
19	Do you currently smoke tobacco products daily? Yes <input type="checkbox"/> No <input type="checkbox"/>
20	How old were you when you first started smoking daily? Age (years) Don't know <input type="checkbox"/>
21	<div>On average, how many of the following do you smoke each day? <i>[record for each type; if don't know leave blank]</i></div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     Manufactured cigarettes Hand-rolled cigarettes Pipes full of tobacco Cigars, cheroots, cigarillos                 </div> <div style="width: 45%;"> <input style="width: 30px; border: 1px solid black;" type="text"/>  <input style="width: 30px; border: 1px solid black;" type="text"/>  <input style="width: 30px; border: 1px solid black;" type="text"/>  <input style="width: 30px; border: 1px solid black;" type="text"/> </div> </div> <div style="text-align: right; margin-top: 5px;">Other</div>

### EXPANDED: Tobacco Use

Question	Response
22	In the past, did you ever smoke daily? Yes <input type="checkbox"/> No <input type="checkbox"/>
23	How old were you when you stopped smoking daily? Age (years) Don't know <input type="checkbox"/>
24	Do you currently use any smokeless tobacco such as <i>[snuff, chewing tobacco, betel]</i> ? Yes <input type="checkbox"/> No <input type="checkbox"/>
25	<div>On average, how many times a day do you use .... <i>[record for each type; if don't know leave blank]</i></div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     Snuff, by mouth Snuff, by nose Chewing of tobacco Betel, quid                 </div> <div style="width: 45%;"> <input style="width: 30px; border: 1px solid black;" type="text"/>  <input style="width: 30px; border: 1px solid black;" type="text"/>  <input style="width: 30px; border: 1px solid black;" type="text"/>  <input style="width: 30px; border: 1px solid black;" type="text"/> </div> </div> <div style="text-align: right; margin-top: 5px;">Other</div>
26	In the past, did you ever use smokeless tobacco such as <i>[snuff, chewing tobacco, or betel]</i> daily? Yes <input type="checkbox"/> No <input type="checkbox"/>

*Continued on the next page*

CORE: Alcohol consumption		
The next questions, ask you about the consumption of alcohol		
Question		Response
27	Have you ever consumed any alcoholic drinks such as beer, wine, spirits, fermented cider, or <i>[add other local examples]</i> ?	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If NO, go to Diet Core Questions page 5</i>
28	Have you consumed an alcoholic drink within the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
29	During the past 12 months, how frequently have you had at least one alcoholic drink?	Daily <input type="checkbox"/> 5-6 days per week <input type="checkbox"/> 1-4 days per week <input type="checkbox"/> 1-3 days per month <input type="checkbox"/> Less than once a month <input type="checkbox"/>
30	Have you consumed an alcoholic drink within the past 30 days?	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If NO, go to Diet Core Questions page 5</i>
31	During the past 30 days, on how many occasions did you have at least one alcoholic drink?	Number Don't know <input type="checkbox"/>
32	During the past 30 days, when you drank alcohol, on average, how many standard alcoholic drinks did you have during one drinking occasion?	Number Don't know <input type="checkbox"/>
33	During the past 30 days, what was the largest number of standard alcoholic drinks you had on a single occasion, counting all types of alcoholic drinks together?	Largest number Don't know <input type="checkbox"/>
34	During the past 30 days, how many times did you have for <b>men: five or more</b> For <b>women: four or more</b> Standard alcoholic drinks in a single drinking occasion?	Number of times Don't know <input type="checkbox"/>

EXPANDED: Alcohol Consumption		
Question		Response
35	During the past 30 days, when you consumed an alcoholic drink, how often was it with meals? Please do not count snacks	Usually with meals <input type="checkbox"/> Sometimes with meals <input type="checkbox"/> Rarely with meals <input type="checkbox"/> Never with meals <input type="checkbox"/>
36	During each of the past 7 days, how many standard alcoholic drinks did you have each day?	<div>Monday <input type="text"/></div> <div>Tuesday <input type="text"/></div> <div>Wednesday <input type="text"/></div> <div>Thursday <input type="text"/></div> <div>Friday <input type="text"/></div> <div>Saturday <input type="text"/></div> <div>Sunday <input type="text"/></div> <div>Don't know <input type="checkbox"/></div>

Continued on the next page

CORE: Diet		
The next questions ask about the fruits and vegetables that you usually eat.		
Question		Response
37	In a typical week, on how many days do you eat fruit?	Number of days <input type="text"/> <input type="text"/> Don't know <input type="checkbox"/>
38	How many servings of fruit do you eat on one of those days?	Number of servings <input type="text"/> <input type="text"/> Don't know <input type="checkbox"/>
39	On a typical week, on how many days do you eat vegetables?	Number of days <input type="text"/> <input type="text"/> Don't know <input type="checkbox"/>
40	How many servings of vegetables do you eat on one of those days?	Number of servings <input type="text"/> <input type="text"/> Don't know <input type="checkbox"/>

EXPANDED: Diet		
Question		Response
41	What type of oil or fat is most often used for meal preparation in your household? [select only one]	Vegetable oil <input type="checkbox"/> Lard or suet <input type="checkbox"/> Butter or ghee <input type="checkbox"/> Margarine <input type="checkbox"/> Other <input type="checkbox"/> None in particular <input type="checkbox"/> None used <input type="checkbox"/> Don't know <input type="checkbox"/> Other _____
42	On average, how many meals per week do you eat that were not prepared at a home? By meal, I mean breakfast, lunch and dinner.	Number <input type="text"/> <input type="text"/> Don't know <input type="checkbox"/>

Continued on the next page

Diet: Knowledge, attitudes, and behavior towards dietary salt		
The next set of questions is about the knowledge, attitudes and behavior towards dietary salt. Please answer the following even you consider yourself to eat a low sodium diet.		
Question	Response	
43	Do you add salt to food at the table? <i>[select only one]</i>	Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/>
44	In the food you eat at home salt is added in cooking...	Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always <input type="checkbox"/>
45	How much salt do you think you consume? <i>[select only one]</i>	Far too much <input type="checkbox"/> Too much <input type="checkbox"/> Just the right amount <input type="checkbox"/> Too little <input type="checkbox"/> Far too little <input type="checkbox"/> Don't know <input type="checkbox"/> Refuse <input type="checkbox"/>
46	Do you think that a high salt diet could cause a serious health problem?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused <input type="checkbox"/> <i>If NO, DON'T KNOW or REFUSED, go to Q 48</i>
47	What sort of serious health problems do you think a high salt diet could cause? <i>[mark as many as it applies]</i>	High blood pressure <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Stomach cancer <input type="checkbox"/> Kidney stones <input type="checkbox"/> None of the above <input type="checkbox"/> All of the above <input type="checkbox"/> Don't know <input type="checkbox"/> Refused <input type="checkbox"/>
48	How important to you is lowering the salt/sodium in your diet?	Not at all important <input type="checkbox"/> Somewhat important <input type="checkbox"/> Very Important <input type="checkbox"/>
49	Do you anything on a regular basis to control your salt or sodium intake?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Refused <input type="checkbox"/> <i>If NO, DON'T KNOW or REFUSED, go to Q 51</i>
50	What do you do on a regular basis to control your salt or sodium intake? <i>[mark as many as it applies]</i>	Avoid/minimize consumption of processed foods <input type="checkbox"/> Look at the salt or sodium labels on food <input type="checkbox"/> Do not add salt at the table <input type="checkbox"/> Buy low salt alternatives <input type="checkbox"/> Buy low sodium alternatives <input type="checkbox"/> Do not add salt when cooking <input type="checkbox"/> Use spices other than salt when cooking <input type="checkbox"/> Avoid eating out <input type="checkbox"/> Other (specify) _____

**CORE: Physical Activity**

The next questions ask about the time you spend doing different types of physical activity in a typical week. Please answer these questions even if you don't consider yourself to be a physically active person. Think about the time you spend doing work. This includes paid and unpaid work, like study/training, household chores, harvesting food/crops, fishing or hunting for food, seeking employment, etc.

Remember that when answering the following questions:

- Vigorous-intensity activities require hard physical effort and cause large increases in breathing or heart rate
- Moderate-intensity activities require moderate physical effort and cause small increases in breathing or heart rate.

Question		Response
<b>Work</b>		
51	Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate like <i>[carrying or lifting heavy loads, digging or construction work]</i> for at least 10 minutes continuously?	Yes <input type="checkbox"/> No <input type="checkbox"/>
52	In a typical week, on how many days do you do vigorous-intensity activities as part of your work?	Number of days <input type="text"/> <input type="text"/>
53	How much time do you spend doing vigorous-intensity activities at work on a typical day?	Hours :minutes <input type="text"/>
54	Does your work involve moderate-intensity activity that causes small increases in breathing or heart rate such as brisk walking <i>[or carrying light loads]</i> for at least 10 minutes continuously? <i>[insert examples]</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
55	In a typical week, on how many days do you do moderate-intensity activities as part of your work?	Number of days <input type="text"/> <input type="text"/>
56	How much time do you spend doing moderate-intensity activities at work on a typical day?	Hours :minutes <input type="text"/>

**Travel to and from places**

The next 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 the market, to place of worship, etc.

57	Do you walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places?	Yes <input type="checkbox"/> No <input type="checkbox"/>
58	In a typical week, on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places?	Number of days <input type="text"/> <input type="text"/>
59	How much time do you spend walking or bicycling for travel on a typical day?	Hours :minutes <input type="text"/>

*Continued on the next page*

CORE: Physical Activity, continued		
Question		Response
<b>Work</b>		
The next questions exclude the work and transport activities that you have already mentioned. Now I would like to ask you about sports, fitness, and recreational activities (leisure), etc.		
60	Do you do any vigorous-intensity sport, fitness or recreational (leisure) activities that cause large increases in breathing or heart rate like <i>[running or football]</i> for at least 10 minutes continuously?	Yes <input type="checkbox"/> No <input type="checkbox"/>
61	In a typical week, on how many days do you do vigorous-intensity sports, fitness or recreational (leisure) activities?	Number of days <input type="text"/> <input type="text"/>
62	How much time do you spend doing vigorous-intensity sports, fitness or recreational (leisure) activities on a typical day?	Hours :minutes <input type="text"/>
63	Do you do any moderate-intensity sports, fitness or recreational (leisure) activity that causes small increases in breathing or heart rate such as brisk walking <i>[cycling, swimming, or volleyball]</i> for at least 10 minutes continuously? <i>[insert examples]</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
64	In a typical week, on how many days do you do moderate-intensity activities as part of your work?	Number of days <input type="text"/> <input type="text"/>
65	How much time do you spend doing moderate-intensity sports, fitness or recreational (leisure) activities on a typical day?	Hours :minutes <input type="text"/>
<b>Travel to and from places</b>		
The next 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 the market, to place of worship, etc.		
66	Do you walk or use a bicycle (pedal cycle) for at least 10 minutes continuously to get to and from places?	Yes <input type="checkbox"/> No <input type="checkbox"/>
67	In a typical week, on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places?	Number of days <input type="text"/> <input type="text"/>
68	How much time do you spend walking or bicycling for travel on a typical day?	Hours :minutes <input type="text"/>

EXPANDED: Physical Activity		
Sedentary Behavior		
These questions are about the amount of time you spend sitting or reclining at work, at home, getting to and from places, or with friends including time spent sitting at the desk, sitting with friends, traveling in car, bus, train, reading, playing cards or watching television, but do not include time spent sleeping.		
Question		Response
69	How much time do you usually spend sitting or reclining on a typical day	Hours :minutes <input type="text"/>



## 2 – Personal Medical History

CORE: Personal Medical History	
Question	Response
70 Have you ever been told by a medical doctor that you have, or have had, <b>heart failure</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
71 Have you ever been told by a medical doctor that you have, or have had, <b>heart attack</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
72 Have you ever been told by a medical doctor that you have, or have had, <b>other heart trouble</b> ?	Yes <input type="checkbox"/> If yes, please specify _____ No <input type="checkbox"/>
73 Have you ever been told by a medical doctor that you have had a <b>stroke</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
74 Have you ever been told by a medical doctor that you have, or have had, <b>kidney trouble</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
75 Have you ever been told by a medical doctor that you have, or have had, <b>peptic ulcer</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
76 Have you ever been told by a medical doctor that you have, or have had, <b>liver disease</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
77 Have you ever been told by a medical doctor that you have a <b>cancer or malignant tumor</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>

*Continued on the next page*

CORE: History of Raised Blood Pressure		
Question		Response
78	Have you ever had your blood pressure measured by a doctor or other health workers?	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If NO, go to Q 67</i>
79	Have you ever been told by a doctor or other health worker that you have raised blood pressure or hypertension?	Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If NO, go to Q 67</i>
80	Have you been told in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
81	Are you currently receiving any of the following treatments/advice for high blood pressure prescribed by a doctor or other health worker?	
	Drugs (medication) that you have taken in the past 2 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice to reduce salt intake?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice or treatment to lose weight?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice or treatment to stop smoking?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice to start or do more exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>
82	Have you ever seen a traditional healer for raised blood pressure or hypertension?	Yes <input type="checkbox"/> No <input type="checkbox"/>
83	Are you currently taking any herbal or traditional remedy for your raised blood pressure?	Yes <input type="checkbox"/> No <input type="checkbox"/>

*Continued on the next page*

CORE: History of Diabetes		
84	Have you ever had your blood sugar measured by a doctor or other health workers?	Yes <input type="checkbox"/> No <input type="checkbox"/>
85	Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
86	Have you been told in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
87	Are you currently receiving any of the following treatments/advice for diabetes prescribed by a doctor or other health worker?	
	Insulin	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Drugs (medication) that you have taken in the past 2 weeks?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Special prescribed diet?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice or treatment to lose weight?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice or treatment to stop smoking?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Advice to start or do more exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>
88	Have you ever seen a traditional healer for raised blood pressure or hypertension?	Yes <input type="checkbox"/> No <input type="checkbox"/>
89	Are you currently taking any herbal or traditional remedy for your raised blood pressure?	Yes <input type="checkbox"/> No <input type="checkbox"/>

### 3 – Physical Measurements

CORE: Height and Weight		
Question		Response
90	Device ID for height and weight	Height device    — — Weight device    — —
91	Height	In Centimeters (cm)    — — — — . —
92	Weight <i>If too large for scale, write 666.6</i>	In Kilograms (kg)    — — — — . —
93	<b>For women:</b> Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
CORE: Waist		
94	Device ID for waist	Device    — —
95	Waist circumference	In Centimeters (cm)    — — — — . —
CORE: Blood Pressure		
96	Device ID for blood pressure	Device    — —
97	Cuff size used	— —
98	Reading 1	Systolic (mmHg)    — — — — Diastolic (mmHg)    — — — —
99	Reading 2	Systolic (mmHg)    — — — — Diastolic (mmHg)    — — — —
100	Reading 3	Systolic (mmHg)    — — — — Diastolic (mmHg)    — — — —

EXPANDED: Physical Measurements		
Question		Response
101	Hip circumference	In Centimeters (cm)    — — — — . —
102	Heart rate	
	Reading 1	Beats per minute    — — — —
	Reading 2	Beats per minute    — — — —
	Reading 3	Beats per minute    — — — —

## 4 – 24 Hour Urine Sample

### 24 Hour Urine Samples Collection

*[At this point, the participant will be given the “Participant’s Guide for the 24-Hour Urine Samples Collection. The participant will be guided through the guide and choose a day to begin the collection. The Interviewer will then make an appointment to pick up the samples within 24 hours of then end of collection. These questions will be questions obtained from the log sheet given to the participant, after the 24-hour urine sample collection. It’s recommended that it be filled in with the participant present.]*

Now I will like to review a few your log sheet and go over any comments or concerns you might have.

Question		Response
103	Device ID for 24 – hour urine sample collection <i>[each equipment set must be labeled with participant’s ID; therefore, the Participant ID and Device ID are the same]</i>	
104	Date collection began	dd/mm/yyyy    __ __/__ __/____
105	Time collection started	hh:mm    __ __ :__ __
106	Date collection finished	dd/mm/yyyy    __ __/__ __/____
107	Time collection finished	hh:mm    __ __ :__ __
108	Total volume of urine collected	In milliliters (ml)    ____