

TALC

Master Assessment Questionnaire Version Date:

RA Initials: ____

Screening ID: _____

Subject ID: _____

Subject Initials: ____

Interview date: __/__/__ (dd/mm/yy)

Time interview started: __ __: __ __

Time interview ended: __ __: __ __

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Conclusion

Administered Assessment	Baseline	3-mo	6-mo	9-mo	12-mo	15-mo	18-mo
Demographics ⁴¹	X		X		X		X
Prior TB	X						
TB re-infection				X	X	X	X
TB symptoms	X			X	X	X	X
St. George's Respiratory Questionnaire ⁴²	X	X	X	X	X	X	X
TB Medication Use and Adherence	X	X	X	X	X	X	X
TB stigma	X		X		X		
TB disclosure		X					
6-min walk	X	X	X	X	X	X	X
Alcohol use (AUDIT) ⁴⁴	X		X				X
AUDIT-C	X	X	X	X	X	X	X
Alcohol TLFB ⁴³	X	X	X	X	X	X	X
Readiness to quit alcohol ⁴⁷	X		X				
Social desirability		X					
Lifetime drinking ⁴⁸ (option to RA at 3- or 6-mo)		(X)					
Alcohol stigma	X		X		X		
Tobacco use (GATS) ⁵⁰	X		X		X		X
Readiness to quit tobacco ⁵³	X		X				
Smoking quit attempts	X		X				
HIV Testing	X						
ART Use and Adherence ⁵⁶	X		X		X		X
HIV stigma	X		X		X		
Middle upper arm circumference	X		X		X		
Grip strength	X		X		X		
Co-Morbidities (ever) ⁵⁸	X						
COVID	X	X	X	X	X	X	X
Medications	X		X		X		X
Drug use ^{60,61}	X		X		X		X
Depressive symptoms (CES-D) ⁵⁴	X		X		X		X
Food insecurity ⁶²	X		X		X		
Malnutrition ^{66,67}	X		X		X		
Social support ⁶³	X		X		X		
VR-12 ⁶⁴	X				X		
MOS-HIV ⁶⁵	X				X		
CT scan tracking	X						X
Spirometry & DLCO tracking & contraindications	X		X		X		X
CD4	X		X		X		X
DBS	X	X	X	X	X	X	X
Urine for pregnancy	X						X

Clinical Values

Weight:_____kg

Height:_____m_____cm

Blood Pressure_____mmHG

ASSESSOR – Read to participant:

The following interview will ask questions about many aspects of your life, including alcohol and drug use, sexual behavior, emotions, general health, TB, and HIV. I will ask you all of the questions. All of your answers will be kept strictly confidential. Your name will not be attached to any of your answers. We greatly appreciate your honesty.

SECTION 1: DEMOGRAPHICS

Assessed at baseline, 6, 12, 18-mo

Before we get started, I would like to explain to you how the interview works. As we discussed earlier, your participation in the interview and every aspect of the study are completely voluntary. You may skip any questions that you prefer not to answer, but we would appreciate your cooperation. You may also ask me to clarify any questions if you don't understand them or decide to stop the interview at any time. Finally, all of the information that you provide for the study will be kept completely confidential. Your responses to our questions are identified only by number, never by name.

We are now going to measure your height and weight.

Participant's gender?	<input type="checkbox"/> Male (2) <input type="checkbox"/> Female (1)
Participant's weight?	___ ___ . ___ ___ kg
Participant's height?	___ ___ ___ . ___ cm

Now I will begin asking you questions. The questions are about a lot of different things in your life. Please answer the questions as well as you can, and ask me if you are not sure what I am asking or if you need help answering a question. We will keep your answers anonymous and you may decline to answer any question. Please let me know if you need a break from answering the questions.

What is your age?	___ ___ years (-8 Don't know; -9 Declined)
What is your date of birth? (NOTE TO RA: Choose 1 if day is unknown; choose June (6) if month is unknown; choose 1900 if year is unknown)	___ ___ day ___ ___ month ___ ___ ___ year
What is your religion? (Mark one selection)	<input type="checkbox"/> Protestant/Anglican (1) <input type="checkbox"/> Catholic (2) <input type="checkbox"/> Moslem (3) <input type="checkbox"/> Seventh Day Adventist (4) <input type="checkbox"/> Saved/Pentecostal (5) <input type="checkbox"/> None (6) <input type="checkbox"/> Other (8) (specify) ___ ___ ___ ___ ___ ___ <input type="checkbox"/> Declined (-9)
What is the highest level of school you completed?	<input type="checkbox"/> None (1) <input type="checkbox"/> P1-P6 (2) <input type="checkbox"/> P7 (3) <input type="checkbox"/> S1-S3 (4) <input type="checkbox"/> S4 (5) <input type="checkbox"/> S5 (6) <input type="checkbox"/> S6 (7) <input type="checkbox"/> Tertiary/Vocational (8) <input type="checkbox"/> University (9) <input type="checkbox"/> Postgraduate (10) <input type="checkbox"/> Other (11) (specify) ___ ___ ___ ___ ___ ___ ___ ___

	<input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
<p>Some people find it difficult to read documents. How often do you need to have someone help you when you read instructions, pamphlets, or other written materials?</p>	<input type="checkbox"/> Never (1) <input type="checkbox"/> Rarely (2) <input type="checkbox"/> Sometimes (3) <input type="checkbox"/> Often (4) <input type="checkbox"/> Always (5) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
<p>Now I would like you to read this sentence to me. In what language do you read?</p> <p><i>(NOTE TO RA: Show the appropriate literacy card to subject, which contains these sentences: "The children study hard at school. Parents love their children. The man is reading a book.")</i></p>	<input type="checkbox"/> Cannot read at all (1) <input type="checkbox"/> Able to read only parts of a sentence (2) <input type="checkbox"/> Able to read whole sentence (3) <input type="checkbox"/> No card with required language (4) <input type="checkbox"/> Other (5) (specify language): _ _ _ _ _ <input type="checkbox"/> Declined (-9)
<p><i>NOTE TO RA (do not read aloud): What is your assessment of the participant's literacy level in either English or Runyankole?</i></p>	<input type="checkbox"/> Literate <input type="checkbox"/> Somewhat literate <input type="checkbox"/> Not literate
<p>What is the main activity or job you do to provide for your family/household- either jobs you are paid for or for which you are given other goods or services? (Mark one selection)</p>	<input type="checkbox"/> Teacher (1) <input type="checkbox"/> Student (2) <input type="checkbox"/> Technician/artisan (plumber, electrician, welder) (3) <input type="checkbox"/> Military/police/security (4) <input type="checkbox"/> Selling goods – on the street (5) <input type="checkbox"/> Trucker/driver/conductor (6) <input type="checkbox"/> Construction worker (7) <input type="checkbox"/> Housekeeper (8) <input type="checkbox"/> Farmer (agro, animal husbandry, etc) (9) <input type="checkbox"/> Sex worker (10) <input type="checkbox"/> Local brew seller (11) <input type="checkbox"/> Bar attendant (12) <input type="checkbox"/> Restaurant attendant (13) <input type="checkbox"/> Selling goods – from an established shop (14) <input type="checkbox"/> Business person (15) <input type="checkbox"/> Government/clerical/secretarial (16) <input type="checkbox"/> Health care worker (17) <input type="checkbox"/> Mechanic (18) <input type="checkbox"/> Trader (19) <input type="checkbox"/> None/Unemployed (20) → <i>(skip to household)</i> <input type="checkbox"/> Decline (-9) <input type="checkbox"/> Other (21) (specify other: indicate if he/she receives support from family or a 'friend'): _ _ _ _ _ _ _ _ _ _
<p>How much money do you <u>normally</u> make in one day of doing work and other income generating activities?</p>	<p>If you are not able to estimate this, please let us know.</p> <p>_, _ _ _ , _ _ _ Shillings MONEY EARNED PER DAY</p>

<p>(NOTE TO RA: If the participant responds with a salary, divide by the number of working days to obtain a daily income)</p>	<input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
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Now I will ask you some questions about your **household**. For this study, consider your household to include **people with whom you usually live and share meals**. *household*

First I want to ask you some questions about your spouse (men: or spouses), if you have one.

<p>What is your current marital status?</p>	<input type="checkbox"/> Married, living together (1) <input type="checkbox"/> Married, not living together (2) <input type="checkbox"/> Divorced/Separated (3) → <i>(skip to members of household)</i> <input type="checkbox"/> Widowed (4) → <i>(skip to members of household)</i> <input type="checkbox"/> Never married and not living together (5) → <i>(skip to members of household)</i> <input type="checkbox"/> Declined (-9) → <i>(skip to members of household)</i>
<p>Is your husband HIV positive (women)? Are any of your wives HIV positive (men)?</p>	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)

*(Research assistant: remember this section is about people in the household, in addition to the participant).
Members of household*

<p>Now I want to ask you some questions about the other members of your household. Not including yourself, how many other people are currently in your household? Again, for this study consider your household to include people with whom you usually live and share meals.</p>	<p>___ ___ members of household (-8 don't know; -9 declined)</p>
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<p>Do members of the household own any of the following items? (Mark all that apply, including only those in working condition).</p>	<input type="checkbox"/> Electric Iron <input type="checkbox"/> Motorbike <input type="checkbox"/> Bicycle <input type="checkbox"/> Shoes other than slippers <input type="checkbox"/> Stove with gas or electric burners <input type="checkbox"/> Clock <input type="checkbox"/> Television <input type="checkbox"/> Car <input type="checkbox"/> Refrigerator or freezer <input type="checkbox"/> Bed <input type="checkbox"/> Lantern <input type="checkbox"/> Radio <input type="checkbox"/> Mobile telephone
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	<input type="checkbox"/> Sofa <input type="checkbox"/> Cupboard <input type="checkbox"/> Mattress <input type="checkbox"/> None of these items <input type="checkbox"/> Declined
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Now I am going to ask you some questions about your **house**. For this study, we define your house as **the place where your household spends the most time and where you usually share meals**.

How many separate rooms are in your house, including all living areas, bathrooms and any other rooms?	___ ___ rooms (-8 don't know; -9 declined)
How many of these rooms are used for sleeping?	___ ___ rooms (-8 don't know; -9 declined)
Does your house have electricity?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
What kind of toilet facility does your house use?	<input type="checkbox"/> Covered pit latrine (1) <input type="checkbox"/> Pan/bucket (2) <input type="checkbox"/> VIP pit latrine (pit latrine with a vent) (3) <input type="checkbox"/> Uncovered pit latrine (4) <input type="checkbox"/> Flush toilet (5) <input type="checkbox"/> None (6) <input type="checkbox"/> Other (7) (specify) ___ _ _ _ _ _ _ _ _ _ <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
What are the walls of your house made of?	<input type="checkbox"/> Mud/dirt (1) <input type="checkbox"/> Mud/clay bricks (2) <input type="checkbox"/> Cement (3) <input type="checkbox"/> Other (4) (specify) ___ _ _ _ _ _ _ _ _ _ <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
What is the floor of your housing made of?	<input type="checkbox"/> Mud/dirt/dung (1) <input type="checkbox"/> Mud/dirt with covering (2) <input type="checkbox"/> Cement (3) <input type="checkbox"/> Vinyl/asphalt strips (4) <input type="checkbox"/> Tiles (5) <input type="checkbox"/> Other (6) (specify) ___ _ _ _ _ _ _ _ _ _ <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
What is the main fuel used for cooking?	<input type="checkbox"/> Charcoal (1) <input type="checkbox"/> Wood (2)

	<input type="checkbox"/> Straw/shrubs/grass (3) <input type="checkbox"/> LPG/natural gas (4) <input type="checkbox"/> Electricity (5) <input type="checkbox"/> Kerosene (6) <input type="checkbox"/> Biogas (7) <input type="checkbox"/> No food cooked in household (8) (<i>skip to water</i>) <input type="checkbox"/> Other (9) (specify) _ _ _ _ _ <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
Is the cooking usually done in the house, in a separate building, or outdoors?	<input type="checkbox"/> In the house (1) <input type="checkbox"/> In a separate building (2) (<i>skip to cooking</i>) <input type="checkbox"/> Outdoors (3) (<i>skip to cooking</i>) <input type="checkbox"/> Other (4) (specify) _ _ _ _ _ <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
Do you have a separate room which is used as the kitchen?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
Who does most of the cooking in the household? <i>cooking</i>	<input type="checkbox"/> Self (1) <input type="checkbox"/> Someone else (2) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
Where do you get water? <i>water</i>	<input type="checkbox"/> Piped into dwelling/compound (1) <input type="checkbox"/> Communal tap (2) <input type="checkbox"/> Open well (3) <input type="checkbox"/> Protected well (4) <input type="checkbox"/> Protected stream – a constant flow of water out of an open pipe, in which the source is underground or protected (5) <input type="checkbox"/> Unprotected spring – a constant flow of water from an open natural spring without fencing to protect it from animals or children (6) <input type="checkbox"/> Stream- flowing water without a point source (7) <input type="checkbox"/> Public borehole (8) <input type="checkbox"/> Other (9) (specify) _ _ _ _ _ <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)

We will now ask you some questions about past incarceration.

Have you ever been arrested?	<input type="checkbox"/> No (0) (<i>skip to next section</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
In the last year, have you spent time in a jail, prison, or other correctional institution?	<input type="checkbox"/> No (0) (<i>skip to priorlast</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

How many months have you spent in a jail/prison in the last year? Round response to the nearest month (for example, 0-14 days → 00 months, 15-30 days → 01 month).	Response: ___ ___ months (-8 don't know; -9 declined)
Prior to the last year, have you spent time in a jail, prison, or other correctional institution? <i>priorlast</i>	<input type="checkbox"/> No (0) (<i>skip to next section</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
How many months have you spent in a jail/prison prior to the last year? Round response to the nearest month (for example, 0-14 days → 00 months, 15-30 days → 01 month).	Response: ___ ___ months (-8 don't know; -9 declined)

SECTION 2: PRIOR TB

Asked at baseline visit

Now I am going to ask you some questions about your previous experiences with TB.

Is this the first time you have been diagnosed with TB?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) (<i>skip to next section</i>) <input type="checkbox"/> Declined (-9)
When was the last time you were diagnosed with TB?	Response: Month ___ ___ Year ___ ___ ___ ___ (-8 don't know; -9 declined)
Were you hospitalized for TB the last time you had TB?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
Did you complete TB treatment the last time you had TB?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
Did your doctor tell you that you had any lung damage from the last time you had TB?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
Apart from this current TB episode and the last time you had TB, how many other times have you been diagnosed with TB?	Response: ___ ___ (-8 don't know; -9 declined)

SECTION 3: TB Re-Infection

Asked at 9-, 12-, 15-, and 18-mo visits

Now I am going to ask you some questions about reinfection of TB.

Since your last visit, have you had a new positive TB test?	<input type="checkbox"/> No (0) <i>skip to next section</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9) <i>skip to next section</i>
Were you hospitalized for TB the last time you had TB?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

What type of TB were you diagnosed with for this new episode?	<input type="checkbox"/> Pulmonary TB (in your lungs) (1) <input type="checkbox"/> Extrapulmonary TB (outside of your lungs) (2) <input type="checkbox"/> TB meningitis (in the tissue around your brain/spinal cord) (3) <input type="checkbox"/> Disseminated TB (in multiple parts of the body) (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
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SECTION 4: TB SYMPTOMS

Asked at baseline, 9-, 12-, 15-, and 18-mo visits

Now I am going to ask some questions about potential TB symptoms.

In the past 2 weeks, have you:

Had a cough?	<input type="checkbox"/> No (0) (<i>skip next question</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
How long have you had this cough?	___ ___ (##) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Declined (-9)
Had a fever?	<input type="checkbox"/> No (0) (<i>skip next question</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
How long have you had this fever?	___ ___ (##) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Declined (-9)
Had excessive night sweats?	<input type="checkbox"/> No (0) (<i>skip next question</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
How long have you had excessive night sweats?	___ ___ (##) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Declined (-9)
Had unexplained weight loss?	<input type="checkbox"/> No (0) (<i>skip next question</i>)

	<input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
How long have you had unexplained weight loss?	___ ___ (##) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Declined (-9)
Been coughing up blood?	<input type="checkbox"/> No (0) (<i>skip next question</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
How long have you been coughing up blood?	___ ___ (##) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years <input type="checkbox"/> Declined (-9)

SECTION 5: ST. GEORGE'S RESPIRATORY QUESTIONNAIRE (SGRQ)

Asked at all study visits

This questionnaire is designed to help us learn more about how your breathing is troubling you and how it affects your life. We are using it to find out which aspects of your illness cause you the most problems.

Please listen to the questions carefully and ask if you do not understand anything. Do not spend too much time deciding about your answers.

Please select how you describe your current health	<input type="checkbox"/> Very good (1) <input type="checkbox"/> Good (2) <input type="checkbox"/> Fair (3) <input type="checkbox"/> Poor (4) <input type="checkbox"/> Very poor (5) <input type="checkbox"/> Declined (-9)
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Part 1

I am now going to ask you some questions about how much chest trouble you have had over the past 4 weeks.

Over the past 4 weeks, I have coughed:	<input type="checkbox"/> Most days a week (1) <input type="checkbox"/> Several days a week (2) <input type="checkbox"/> A few days a month (3) <input type="checkbox"/> Only with chest infections (4) <input type="checkbox"/> Not at all (5) <input type="checkbox"/> Declined (-9)
Over the past 4 weeks, I have brought up sputum:	<input type="checkbox"/> Most days a week (1) <input type="checkbox"/> Several days a week (2)

	<input type="checkbox"/> A few days a month (3) <input type="checkbox"/> Only with chest infections (4) <input type="checkbox"/> Not at all (5) <input type="checkbox"/> Declined (-9)
Over the past 4 weeks, I have had shortness of breath:	<input type="checkbox"/> Most days a week (1) <input type="checkbox"/> Several days a week (2) <input type="checkbox"/> A few days a month (3) <input type="checkbox"/> Only with chest infections (4) <input type="checkbox"/> Not at all (5) <input type="checkbox"/> Declined (-9)
Over the past 4 weeks, I have had episodes of wheezing:	<input type="checkbox"/> Most days a week (1) <input type="checkbox"/> Several days a week (2) <input type="checkbox"/> A few days a month (3) <input type="checkbox"/> Only with chest infections (4) <input type="checkbox"/> Not at all (5) <input type="checkbox"/> Declined (-9)
During the past 4 weeks, how many severe or very unpleasant attacks of chest trouble have you had?	<input type="checkbox"/> More than 3 attacks (1) <input type="checkbox"/> 3 attacks (2) <input type="checkbox"/> 2 attacks (3) <input type="checkbox"/> 1 attack (4) <input type="checkbox"/> No attacks (0) (<i>skip next question</i>) <input type="checkbox"/> Declined (-9)
How long did the worst attack of chest trouble last?	<input type="checkbox"/> A week or more (1) <input type="checkbox"/> 3 to 6 days (2) <input type="checkbox"/> 1 or 2 days (3) <input type="checkbox"/> Less than a day (4) <input type="checkbox"/> Declined (-9)
Over the past 4 weeks, in an average week, how many good days (with little chest trouble) have you had?	<input type="checkbox"/> No good days (1) <input type="checkbox"/> 1 or 2 good days (2) <input type="checkbox"/> 3 or 4 good days (3) <input type="checkbox"/> 5 or 6 good days (4) <input type="checkbox"/> Every day is good (5) <input type="checkbox"/> Declined (-9)
Do you have a wheeze?	<input type="checkbox"/> No (0) (<i>skip next question</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
If you have a wheeze, is it worse in the morning?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

Part 2

Section 1:

How would you describe your chest condition?	<input type="checkbox"/> The most important problem I have (1) <input type="checkbox"/> Causes me quite a lot of problems (2) <input type="checkbox"/> Causes me a few problems (3) <input type="checkbox"/> Causes no problem (4) <input type="checkbox"/> Declined (-9)
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If you have ever worked, please choose one of these answers:	<input type="checkbox"/> My chest trouble made me stop work altogether. (1) <input type="checkbox"/> My chest trouble interferes with my work or made me change my work. (2) <input type="checkbox"/> My chest trouble does not affect my work. (3) <input type="checkbox"/> Declined (-9)
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Section 2: These questions are about what activities usually make you feel breathless *these days*. Please say either True or False as it applies to you **these days**.

Sitting or lying still	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Getting washed or dressed	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Walking around the home	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Walking outside on the level	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Walking up a flight of stairs	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Walking up hills	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Playing sports or games	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)

Section 3: These questions are some questions about your cough and breathlessness *these days*. Please say either True or False as it applies to you *these days*.

My cough hurts.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My cough makes me tired.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I am breathless when I talk.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I am breathless when I bend over.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My cough or breathing disturbs my sleep.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I get exhausted easily.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)

Section 4: These questions are about other effects that your chest trouble may have on you *these days*. Please say either True or False as it applies to you **these days**.

My cough or breathing is embarrassing in public.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My chest trouble is a nuisance to my family, friends or neighbors.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I get afraid or panic when I cannot get my breath.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I feel that I am not in control of my chest problem.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I do not expect my chest to get any better.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I have become frail or an invalid because of my chest.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Exercise is not safe for me.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Everything seems too much of an effort.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)

Section 5: These questions are about your medication. Please say either True or False as it applies to you **these days**.

Are you receiving medication for chest trouble?	<input type="checkbox"/> No (0) (<i>skip to next section</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
My medication does not help me very much.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I get embarrassed using my medication in public.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I have unpleasant side effects from my medication.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My medication interferes with my life a lot.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)

Section 6: These are questions about how your activities might be affected by your breathing. Please say True if one or more parts applies to you because of your breathing. Otherwise answer False.

I take a long time to get washed or dressed.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1)
--	---

	<input type="checkbox"/> Declined (-9)
I cannot take a bath or shower, or I take a long time.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
I walk slower than other people, or I stop for rests.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
Jobs such as housework take a long time, or I have to stop for rests.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
If I walk up one flight of stairs, I have to go slowly or stop.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
If I hurry or walk fast, I have to stop or slow down.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My breathing makes it difficult to do things such as walk up hills, carrying things, light work, or dance	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My breathing makes it difficult to do things such as carry heavy loads, shovel dirt, or run	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)
My breathing makes it difficult to do things such as very heavy manual work, run fast, or play sports	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) <input type="checkbox"/> Declined (-9)

Section 7: We would like to know how your chest **usually** affects your daily life. Choose True or False as it applies to you because of your **chest trouble**.

I cannot play sports or games.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) Declined (-9)
I cannot go out for entertainment or fun	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) Declined (-9)
I cannot go out of the house to do shopping.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) Declined (-9)
I cannot do housework.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) Declined (-9)
I cannot move far from my bed or chair.	<input type="checkbox"/> False (0) <input type="checkbox"/> True (1) Declined (-9)

Here is a list of other activities that your chest trouble may prevent you from doing. (You do not have to fill these in, they are just to remind you of ways in which your breathlessness may affect you):

- Walking around the compound or garden
- Sweeping
- Doing things at home or in the garden
- Sexual intercourse
- Going out to church, mosque, pub, club, or place of entertainment
- Going out in bad weather or into smoky rooms

- Visiting family or friends or playing with children

Please tell me any other important activities that your chest trouble may stop you from doing:	<hr/> <input type="checkbox"/> Declined (-9)
Which statement do you think best describes how your chest affects you?	<input type="checkbox"/> It does not stop me doing anything I would like to do. (1) <input type="checkbox"/> It stops me doing one or two things I would like to do. (2) <input type="checkbox"/> It stops me doing most of the things I would like to do. (3) <input type="checkbox"/> It stops me doing everything I would like to do. (4) <input type="checkbox"/> Declined (-9)

SECTION 6: TB MEDICATION HISTORY AND ADHERENCE

Asked at all study visits

I'm going to ask you a few questions about TB medications.

<p>1. Are you currently taking TB Medication?</p>	<p><input type="checkbox"/> No (0) (<i>skip to next section</i>)</p> <p><input type="checkbox"/> Yes (1)</p> <p><input type="checkbox"/> Declined (-9)</p>
<p>2. <i>RA only question (look at chart):</i> Which medications is the participant currently taking for TB?</p>	<p><input type="checkbox"/> Rifampicin</p> <p><input type="checkbox"/> Isoniazid</p> <p><input type="checkbox"/> Ethambutol</p> <p><input type="checkbox"/> Pyrazinamide</p> <p><input type="checkbox"/> Other: ___ ___ ___</p> <p><input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Declined (-9)</p>
<p>3. We understand that many people on TB medication find it very difficult to take it regularly and often miss doses. We won't be surprised if you have missed lots of doses as well. We need to know how many doses you have missed. Please say the number that is your best guess about the percentage of medication you have taken in the last month. We would be surprised if this was 100% for most people, for example, 0% means you have taken no medication; 50% means you have taken half your medication; 100% means you have taken every single dose of medication.</p>	<p>Percentage of Medicine Taken in the Last 30 Days</p> <p>_____ %</p> <p><input type="checkbox"/> Declined</p>

SECTION 7: TB STIGMA

Asked at baseline, 6-, and 12-month visits

I am now going to read a list of statements describing thoughts or feelings that you may have from time to time or may be familiar to you. Most of these statements describe thoughts and feelings that are generally painful or negative in some way. Try to be as honest as you can in responding.

To what extent do you agree with the following statements?

<p>People may not want to eat or drink with friends who have TB.</p>	<p><input type="checkbox"/> Strongly disagree (1)</p> <p><input type="checkbox"/> Somewhat disagree (2)</p> <p><input type="checkbox"/> Neutral (3)</p> <p><input type="checkbox"/> Somewhat agree (4)</p> <p><input type="checkbox"/> Strongly agree (5)</p> <p><input type="checkbox"/> Declined (-9)</p>
<p>People may feel uncomfortable about being near those with TB.</p>	<p><input type="checkbox"/> Strongly disagree (1)</p> <p><input type="checkbox"/> Somewhat disagree (2)</p> <p><input type="checkbox"/> Neutral (3)</p> <p><input type="checkbox"/> Somewhat agree (4)</p>

	<input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
If a person has TB, some community members will behave differently towards that person for the rest of his/her life	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People do not want those with TB playing near their children.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People keep their distance from people with TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People think that those with TB are disgusting.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People do not want to talk to others with TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People are afraid of those with TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People try not to touch others with TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4)

	<input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People may not want to eat or drink with relatives who have TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People prefer not to have those with TB living in their community.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB feel hurt of how others react to knowing they have TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB lose friends when they share with them they have TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB feel alone.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB keep their distance from others to avoid spreading TB germs.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB are afraid to tell those outside their family that they have TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4)

	<input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB are afraid of going to TB clinics because other people may see them there.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB are afraid to tell others that they have TB because others may think that they also have HIV.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB feel guilty because their family has the burden of caring for them.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB will choose carefully who they tell about having TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB feel guilty for getting TB because of their smoking, drinking, or other behaviors.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB are worried about also having HIV.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People who have TB are afraid to tell their family that they have TB.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4)

- Strongly agree (5)
- Declined (-9)

SECTION 7a: TB DISCLOSURE

Asked at 3-month visit

1. Have you disclosed your current TB status to your household members?	<input type="checkbox"/> No (0) (<i>skip to question 5</i>) <input type="checkbox"/> Yes, all (1) <input type="checkbox"/> Yes, some (2) <input type="checkbox"/> Declined (-9)
2. What is your relationship with the household members you disclosed to?	<input type="checkbox"/> Father (1) <input type="checkbox"/> Mother (2) <input type="checkbox"/> Spouse (3) <input type="checkbox"/> Child (4) <input type="checkbox"/> Brother/sister (5) <input type="checkbox"/> Close relative (6) <input type="checkbox"/> Other (7) → _____ (specify) <input type="checkbox"/> Declined (-9)
3. Do you have a particular reason why you disclosed to the above people?	<input type="checkbox"/> No (0) (<i>skip to next section</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
4. Indicate the reason why you chose to disclose (check all that apply):	<input type="checkbox"/> Need for support with activities of daily living (i.e., childcare, household tasks) (1) <input type="checkbox"/> Need for support with TB care (i.e., taking medication, medical appointments) (2) <input type="checkbox"/> Need for emotional support/coping (3) <input type="checkbox"/> Need to avoid transmitting TB (4) <input type="checkbox"/> Other (5) → _____ (specify) <input type="checkbox"/> Declined (-9)
5. Would you want to disclose to any of your household members?	<input type="checkbox"/> No (0) (<i>skip to next section</i>) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
6. When would you want to disclose?	<input type="checkbox"/> Immediately/as soon as possible, 1-2 days (1) <input type="checkbox"/> Later, 3 or more days (2) <input type="checkbox"/> Declined (-9)

SECTION 8: AUDIT

Asked at baseline, 6-, and 18-month visits

Now I have some questions about alcohol. It is important for us to know how much you take. Please try to be as honest and accurate as possible. As we told you when you agreed to participate in this study, all your answers to the questions will be kept completely confidential.

Alcohol includes **wine, beer, hard liquor, tonto, mukumbot, omuramba, kwete, malwa**, or **any beverage that contains alcohol**. The only exception to this is small amounts of communion wine or wine that you received at church or a religious ceremony. **Redbull, Rock boom, Sting, and Horsepower are not alcohol**.

Please show participant the conversion scale and other materials to help them understand drink sizes.




Conversion Scale

<u>Wine</u>	<u>milliliters</u>	<u>ounces</u>	<u>drinks</u>
Glass	140	~4.5	1
Half bottle	375	~12	~3
Bottle	750	~24	~6

<u>Beer</u>			
12 oz can/bottle	300-360	~12	1
500 ml can/bottle	500	~17	~1.5

<u>Hard Liquor</u>			
Shot	40	~1.3	1
Half pint	240	~8	~6
Pint	480	~16	~12
Fifth	750	~25	~19
Quart	1000	~32	~24

1 Standard Drink is Equal to

 <p>One 360 ml can/bottle of beer</p>	 <p>One 140 ml glass of 12% alcohol wine</p>	 <p>40 ml of hard liquor (e.g. waragi (ask about type), rum, vodka, whiskey, bond7)</p>
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Now I'm going to ask you about alcohol you took in the last **year**.

Note to RA: please describe the past 12 month timeline to the participant - this includes the current month, back to the same month one year prior. For example, if someone is interviewed in May 2023, the past 12 months would refer to the time between May of the past year (2022) through May of the current year (2023).

<p>1. In the past year, how often did you have a drink containing alcohol?</p>	<p> <input type="checkbox"/> Never (0) → <i>(skip to audit9a)</i> <input type="checkbox"/> Monthly or less (1) <input type="checkbox"/> 2 to 4 times/month (2) <input type="checkbox"/> 2 to 3 times/week (3) <input type="checkbox"/> 4 or more times/week (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9) </p>
<p>2. In the past year, how many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p><i>Remind participant about drink sizes if needed: One drink is equal to, one 140 milliliter glass of wine, one 300 ml bottle of beer or two-thirds of a 500 milliliter bottle of beer, or two-thirds of a 500 ml cup of home brew, a drink with 40 milliliters of hard liquor. Show participant standard drink card.</i></p>	<p> <input type="checkbox"/> None (0) <input type="checkbox"/> 1 or 2 (1) <input type="checkbox"/> 3 or 4 (2) <input type="checkbox"/> 5 or 6 (3) <input type="checkbox"/> 7 to 9 (4) <input type="checkbox"/> 10 or more (5) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9) </p>

3. In the past year, how often do you have six or more drinks on one occasion?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
4. How often during the past year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
5. How often during the past year have you failed to do what was normally expected from you because of drinking?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
7. How often during the past year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
9a. Have you or someone else ever been injured as a result of your drinking?	<input type="checkbox"/> No (0) → <i>(skip to Q10)</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Don't know (-8) → <i>(skip to Q10)</i> <input type="checkbox"/> Decline (-9) → <i>(skip to Q10)</i>
9b. When did this occur?	<input type="checkbox"/> In the past 3 months (0)

	<input type="checkbox"/> In the past 3 – 12 months (1) <input type="checkbox"/> Over a year ago (2) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
10a. Has a relative or friend or a doctor or other health worker ever in your life been concerned about your drinking or suggested you cut down?	<input type="checkbox"/> No (0) → <i>(skip to next section)</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Don't know (-8) → <i>(skip to next section)</i> <input type="checkbox"/> Decline (-9) → <i>(skip to next section)</i>
10b. When was this?	<input type="checkbox"/> In the past 3 months (0) <input type="checkbox"/> In the past 3 – 12 months (1) <input type="checkbox"/> Over a year ago (2) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)
10c. Who suggested you cut down? (choose all that apply)	<input type="checkbox"/> Spouse/partner(s) <input type="checkbox"/> Your child(ren) <input type="checkbox"/> Female family member(s) <input type="checkbox"/> Male family member(s) <input type="checkbox"/> Female friend(s) <input type="checkbox"/> Male friend(s) <input type="checkbox"/> Someone at work or school <input type="checkbox"/> A doctor or a health care worker <input type="checkbox"/> Other (specify) _ _ _ _ _ <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined

SECTION 9: AUDIT-C

Asked at all timepoints

Now I'm going to ask you about alcohol you took in the last **3 months**.

In the past 3 months , how often did you have a drink containing alcohol?	<input type="checkbox"/> Never (0) → <i>(skip to next section)</i> <input type="checkbox"/> Monthly or less (1) <input type="checkbox"/> 2 to 4 times/month (2) <input type="checkbox"/> 2 to 3 times/week (3) <input type="checkbox"/> 4 or more times/week (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>How many drinks containing alcohol did you have on a typical day when you were drinking in the past 3 months?</p> <p><i>Remind participant about drink sizes if needed:</i> One drink is equal to, one 140 milliliter glass of wine, one 300 ml bottle of beer or two-thirds of a 500 milliliter bottle of beer, or two-thirds of a 500 ml cup of home brew, a drink with 40 milliliters</p>	<input type="checkbox"/> None (0) <input type="checkbox"/> 1 or 2 (1) <input type="checkbox"/> 3 or 4 (2) <input type="checkbox"/> 5 or 6 (3) <input type="checkbox"/> 7 to 9 (4) <input type="checkbox"/> 10 or more (5) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)

of hard liquor. <i>Show participant standard drink card.</i>	
How often did you have six or more drinks on one occasion in the past 3 months?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Less than monthly (1) <input type="checkbox"/> Monthly (2) <input type="checkbox"/> Weekly (3) <input type="checkbox"/> Daily or almost daily (4) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9)

SECTION 10: ALCOHOL USE - 30 DAY TIME-LINE FOLLOWBACK

Asked at all study visits

Now I'm going to ask you about your even more recent alcohol use, how much alcohol you took in the past 30 days.

<p>In the past 30 days how many days in total did you drink any wine, beer, hard liquor, tonto, mukumbot, omuramba, kwete, malwa, or any beverage that contains alcohol? Please do not include small amounts of communion wine or wine that you received at church or a religious ceremony.</p> <p><i>If answer = 0, skip to next section</i></p>	<p>__ __ days (-8 Don't Know, -9 Decline)</p>
<p>How many drinks did you usually take on those days that you took any alcohol?</p>	<p>__ __ drinks (-8 Don't Know, -9 Decline)</p>
<p>In the past 30 days, can you try to remember which days did you take any alcohol? Approximately how many drinks did you drink on those days?</p> <p>NOTE TO RA: Identify the days the respondent took any alcohol on the calendar, prompting about weekends, public holidays, personal celebrations, etc. to try to help the participant remember. Then ask if they know approximately how many drinks each time – refer back to the drink size definitions if needed. Fill in the number of drinks. OK to put 1.5 if the participant says 1-2.</p>	<p>Day 30: __ __ / __ __ / __ __ __ __ dd/mm/yyyy</p> <p>Day 1 (yesterday): __ __ / __ __ / __ __ __ __ dd/mm/yyyy</p> <p>(continue to fill in the alcohol timeline follow-back on paper)</p>

<i>alcfb1</i>	<i>alcfb2</i>	<i>alcfb3</i>	<i>alcfb4</i>	<i>alcfb5</i>	<i>alcfb6</i>	<i>alcfb7</i>
1	2	3	4	5	6	7
<i>alcfb8</i>	<i>alcfb9</i>	<i>alcfb10</i>	<i>alcfb11</i>	<i>alcfb12</i>	<i>alcfb13</i>	<i>alcfb14</i>
8	9	10	11	12	13	14

<i>alcfb15</i>	<i>alcfb16</i>	<i>alcfb17</i>	<i>alcfb18</i>	<i>alcfb19</i>	<i>alcfb20</i>	<i>alcfb21</i>
15	16	17	18	19	20	21
<i>alcfb22</i>	<i>alcfb23</i>	<i>alcfb24</i>	<i>alcfb25</i>	<i>alcfb26</i>	<i>alcfb27</i>	<i>alcfb28</i>
22	23	24	25	26	27	28
<i>alcfb29</i>	<i>alcfb30</i>					
29	30					

SECTION 11: READINESS TO QUIT: ALCOHOL

Asked at baseline and 6-month visit

Which option best describes how you feel <i>right now</i> ?	<input type="checkbox"/> Never think about my drinking (1) <input type="checkbox"/> Sometimes I think about drinking less (2) <input type="checkbox"/> I have decided to drink less (3) <input type="checkbox"/> I am already trying to cut back on my drinking (4) <input type="checkbox"/> I have quit drinking and I will never drink again (5) <input type="checkbox"/> Declined (-9)
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SECTION 12: SOCIAL DESIRABILITY SCALE

Asked at 3-month visit

Now I am going to read a number of statements concerning personal attitudes and traits. Please decide whether each statement is true or false as it relates to you personally.

	True (1)	False (2)	Don't Know (-8)	Decline (-9)
1. It is sometimes hard for me to go on with my work if I am not encouraged.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I sometimes feel resentful when I don't get my way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. On a few occasions, I have given up doing something because I thought I couldn't do it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. There have been times when I felt like rebelling against people in charge even though I knew they were right.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. No matter whom I'm talking to, I'm always a good listener.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. There have been times when I used someone for my own benefit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I'm always willing to admit it when I make a mistake.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I sometimes try to get even, rather than forgive and forget.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. I am always courteous, even to people who are disagreeable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have never been annoyed when people expressed ideas very different from my own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. There have been times when I was quite jealous of the good luck of others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I am sometimes irritated by people who ask favors of me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I have never deliberately said something that hurt someone's feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I never hesitate to go out of my way to help someone who is in trouble.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I have never intensely disliked anyone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. On occasion I had doubts about my ability to succeed in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am always careful about my manner of dress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I like to gossip at times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I can remember "playing sick" to get out of something.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I always try to practice what I preach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I don't find it particularly difficult to get along with loud mouthed, obnoxious people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. When I don't know something, I don't at all mind admitting it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. At times I have really insisted on having things my own way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. There have been occasions when I felt like smashing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I would never think of letting someone else be punished for my wrongdoings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I never resent being asked to return a favor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I have never felt that I was punished without cause.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I sometimes think when people have a misfortune they only got what they deserved.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 13: Lifetime Drinking History

Asked at 3 or 6-month visit

I'm going to ask you about your drinking history. I'd like to start with the year that you began to drink regularly and work forward to the present. Please give me information as accurately as you can about what type of beverage you were drinking, how much, and how often.

Note to RA: Continue through phases until current phase is reached. Use additional forms as needed

0. How old were you the first time you had a drink? By "first drink" I mean the first full drink of alcohol excluding tastes or small sips.	__ __ (age in years) <input type="checkbox"/> Never had a drink → GO TO NEXT SECTION
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Phase 1 of Drinking

Now I am going to ask you about your drinking during the first year that you began to have at least one drink per month. Consider a "drink" to be 300ml of beer, 140ml of 12% alcohol wine, or (e.g. waragi (ask about type), rum, vodka, whiskey, bond7). (RA: Show standard drink diagram).

1A. How old were you when you began to drink at least one drink per month (regular drinking)?	__ __ . __ Age at first drink (age in years) <input type="checkbox"/> Never had more than one drink a month → GO TO NEXT SECTION
1B. How many drinks would you have on a typical day when you were drinking? (RA: Show standard drink diagram).	__ __ __ typical # drinks/day (quantity)
1C. How many days per month would you generally drink at this level (i.e. typical # of drinks)?	__ __ days/month (frequency)
1D. What is the maximum number of drinks that you <u>would have</u> in any one day?	__ __ __ maximum # drinks/day (quantity) <i>(This is the maximum # of drinks the subject actually drank, not his/her potential)</i>
1E. In one month during this phase, on how many days would you usually drink <(1D Max Qty)> drinks?	__ __ days/month (frequency)
1F. Which of the following 4 patterns most closely describes your drinking during this phase	<input type="checkbox"/> You were a light to moderate drinker, up to 2 to 4 drinks a day or per occasion, and almost never became drunk (1) <input type="checkbox"/> You drank 4 or more drinks per occasion primarily on weekends (2) <input type="checkbox"/> You drank 4 or more drinks almost every day, that is on more days than not (3) <input type="checkbox"/> You would keep on drinking for two days or more without sobering up, except for sleeping; that is, you would go on a drinking binge. (4) <input type="checkbox"/> Declined
1G. During this phase, did you have times when you ended up drinking more, or longer, than you intended?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

1H. During this phase, did you more than once want to cut down or stop drinking, or tried to, but couldn't?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1I. During this phase, did you spend a lot of time drinking? Or being sick or getting over other aftereffects?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1J. During this phase, did you want a drink so badly you couldn't think of anything else?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1K. During this phase, did you find that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1L. During this phase, did you continue to drink even though it was causing trouble with your family or friends?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1M. During this phase, did you give up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1N. During this phase, did you more than once get into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1O. During this phase, did you continue to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1P. During this phase, did you have to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
1Q. During this phase, did you find that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

You told me about your drinking habits at the point when you first began to drink regularly. You said you began to drink when you were ____ (1A) years old, that you typically drank ____ (1B) drinks per occasion, ____ (1C) times a month.

EVENTS that changed drinking

Now I want you to think about when your drinking behavior changed in a significant way from this time. This change in your drinking might have occurred 6 months after you started drinking regularly or perhaps 2 or 5 years later. I would like you to think of any event or events in your life that may have changed your drinking habits. Examples of events could be the death of someone close to you, marital or family problems, medical problems, jail, or any other event that affected your drinking.

1R. Which of the following events changed your drinking pattern (select all that apply):	<input type="checkbox"/> Health-related event (1) <input type="checkbox"/> Non-health-related event (2)
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	<input type="checkbox"/> No change in my drinking pattern (3) (<i>Only select this option if no other option was selected, go to "final phase of drinking" section</i>) <input type="checkbox"/> Declined (-9)
1S. Which event was most important in you changing your drinking patterns?	<input type="checkbox"/> Health-related event (1) <input type="checkbox"/> Non-health-related event (2) <input type="checkbox"/> Declined (-9)
1T/2A. How old were you when this event happened, and your drinking changed?	__ __. __ Age when drinking changed (<i>age in years</i>)

Phase 2 of Drinking

2B. After this event (_____) happened, and your drinking changed, how many drinks would you have on a typical day when you were drinking?	__ __ __ typical # drinks/day (<i>quantity</i>) → If response = 0, only ask 2C, 2K, 2R, 2S, 2T, 2U (2T & 2U are dependent on branching logic of 2S)
2C. (only ask if value in 2B is less than 1B value or is "0"). You mentioned that your drinking pattern decreased from the previous phase. Why did your drinking pattern decrease?	<input type="checkbox"/> Health problems that my doctor said was caused by alcohol (1) <input type="checkbox"/> Health problems not related to alcohol (2) <input type="checkbox"/> Other reasons not related to health problems (3) <input type="checkbox"/> Declined (-9)
2D. How many days per month would you generally drink at this level (typical # of drinks)?	__ __ days/month (<i>frequency</i>)
2E. What is the maximum number of drinks that you <u>would have</u> in any one day?	__ __ __ maximum # drinks/day (<i>quantity</i>) (<i>This is the maximum # of drinks the subject actually drank, not his/her potential</i>)
2F. In one month during this phase, on how many days would you usually drink <(2E Max Qty)> drinks?	__ __ days/month (<i>frequency</i>)
2G. Which of the following 4 patterns most closely describes your drinking during this phase?	<input type="checkbox"/> You were a light to moderate drinker, up to 2 to 4 drinks a day or per occasion, and almost never became drunk (1) <input type="checkbox"/> You drank 4 or more drinks per occasion primarily on weekends (2) <input type="checkbox"/> You drank 4 or more drinks almost every day, that is on more days than not (3) <input type="checkbox"/> You would keep on drinking for two days or more without sobering up, except for sleeping; that is, you would go on a drinking binge. (4) <input type="checkbox"/> Declined
2H. During this phase, did you have times when you ended up drinking more, or longer, than you intended?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2I. During this phase, did you more than once want to cut down or stop drinking, or tried to, but couldn't?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

2J. During this phase, did you spend a lot of time drinking? Or being sick or getting over other aftereffects?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2K. During this phase, did you want a drink so badly you couldn't think of anything else?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2L. During this phase, did you find that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2M. During this phase, did you continue to drink even though it was causing trouble with your family or friends?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2N. During this phase, did you give up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2O. During this phase, did you more than once get into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2P. During this phase, did you continue to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2Q. During this phase, did you have to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2R. During this phase, did you find that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)

You told me that beginning at age ____ (2A) you typically drank ____ (2B) drinks per occasion, ____ (2D) times a month. Now I want you to think about when your drinking behavior changed in a significant way. Please think about any important event or events that occurred during this period that changed your usual drinking habits. Examples of events could be the death of someone close to you, marital or family problems, work problems, medical problems, jail, or any other event that affected your drinking.

2S. Which of the following events changed your drinking pattern (select all that apply):	<input type="checkbox"/> Health-related event (1) <input type="checkbox"/> Non-health-related event (2) <input type="checkbox"/> No change in my drinking pattern (3) (<i>Only select this option if no other option was selected, go to "final phase of drinking" section</i>) <input type="checkbox"/> Declined (-9)
2T. Which event was most important in you changing your drinking patterns?	<input type="checkbox"/> Health-related event (1) <input type="checkbox"/> Non-health-related event (2)

2U/3A. How old were you when this event happened, and your drinking changed?	____.____ Age when drinking changed (<i>age in years</i>)

Final Phase of Drinking

3B. So your drinking has remained the same to the present time?	<input type="checkbox"/> No (0) → go back to phase section and add a new phase <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
3C. When was the last time you had a drink? Can you tell me the day, month, and year?	____/____/_____ DD / MM / YYYY <input type="checkbox"/> Declined (-9)

SECTION 14: PERCEIVED ALCOHOL STIGMA

Asked at baseline, 6-, and 12-month visits

Now I am going to read you some statements about how people may think or act regarding a person who drinks alcohol. To what extent do you agree with these statements?

Most people would willingly accept a person with prior or current problematic alcohol use as a close friend.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people believe that a person with prior or current problematic alcohol use is just as intelligent as the average person.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people believe that a person with prior or current problematic alcohol use is just as trustworthy as the average person.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people would accept a person with prior or current problematic alcohol use as a teacher of young children in a school.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people feel that problematic alcohol use is a sign of personal failure.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4)

	<input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people would not allow a person with prior or current problematic alcohol use to take care of their children, even if they had been sober for at least several weeks.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people think less of a person who drinks heavily or who previously drank heavily.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most employers will hire a person with prior or current problematic alcohol use if he or she is qualified for the job.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most employers will pass over the application of a person with prior or current problematic alcohol use in favor of another applicant.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people in my community would treat a person with prior or current problematic alcohol use just as they would treat anyone else.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people would be reluctant to date a person who has prior or current problematic alcohol use.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Once they know a person has or has had problematic drinking, most people will take their opinion less seriously.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)

Now I am going to read you some statements about alcohol use and HIV. To what extent do you agree with these statements?

Drinking alcohol when you are HIV positive is shameful.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Refused (-9)
People who are HIV positive and stop drinking alcohol are more responsible.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Refused (-9)
People who are HIV positive should not be allowed to drink alcohol.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Refused (-9)
Providers should scold HIV positive people who drink alcohol.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Refused (-9)
People who drink alcohol should not be allowed to take ART.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Refused (-9)

SECTION 15: TOBACCO USE

Asked at baseline, 6-, 12-, and 18-month visits

Now I'm going to ask you about smoking tobacco cigarettes or pipes.

<p>Do you currently smoke tobacco on a daily basis, less than daily, or not at all?</p> <p><i>NOTE TO RA: "daily" means smoking at least one cigarette or tobacco pipe every day or nearly every day over a period of one month or more. Rare instances of smoking or experimental smoking (tried once or twice in lifetime) should be counted as "not at all".</i></p>	<input type="checkbox"/> Daily (1) (<i>skip to cigs_ndaily</i>) <input type="checkbox"/> Less than daily (2) (<i>skip to cigs_dailypast</i>) <input type="checkbox"/> Not at all (3) (<i>skip to cigs_freqpast</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to secondhand smoke</i>) <input type="checkbox"/> Decline (-9) (<i>skip to secondhand smoke</i>)
Have you smoked tobacco daily in the past?	<input type="checkbox"/> Yes (1) (<i>skip to cigs_nwklly</i>)

	<input type="checkbox"/> No (0) (<i>skip to cigs_nwkly</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to cigs_nwkly</i>) <input type="checkbox"/> Declined (-9) (<i>skip to cigs_nwkly</i>)
<p>In the past, have you smoked tobacco on a daily basis, less than daily, or not at all?</p> <p><i>NOTE TO RA: If participant has done both "daily" and "less than daily" in the past, select "daily". If in between categories, select the higher category.</i></p>	<input type="checkbox"/> Daily (1) (<i>skip to secondhand smoke</i>) <input type="checkbox"/> Less than daily (2) (<i>skip to secondhand smoke</i>) <input type="checkbox"/> Not at all (3) (<i>skip to secondhand smoke</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to secondhand smoke</i>) <input type="checkbox"/> Declined (-9) (<i>skip to secondhand smoke</i>)
<p><i>(if current daily smoker:)</i> On average, how many tobacco cigarettes or pipefuls do you currently smoke, per day?</p> <p><i>NOTE TO RA: verify that the participant is answering in # of cigarettes, rather than # of packs</i></p>	<p>__ __ cigarettes per day</p> <input type="checkbox"/> Less than daily (1) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Declined (-9) (888 less than daily; -8 Don't Know; -9 Decline)
<p><i>(if current less than daily smoker:)</i> On average, how many tobacco cigarettes or pipefuls do you currently smoke, per week? Also, let me know if you smoke tobacco, but not every week.</p> <p><i>NOTE TO RA: verify that the participant is answering in # of cigarettes, rather than # of packs</i></p>	<p>__ __ cigarettes per week</p> (888 less than weekly; -8 Don't Know; -9 Decline)

Now I'm going to ask you some questions about tobacco smoke in your home, at your work, and some other places.

<p>How often does <u>anyone</u> smoke tobacco inside your home? Would you say daily, weekly, monthly, less than monthly, or never?</p> <p><i>NOTE TO RA: This question is about <u>inside</u> the participant's home. This only includes enclosed areas of the home – areas outside the home including patios, porches, etc that are not fully enclosed should not be included.</i></p> <p><i>If in between categories, please select the higher category. "daily" means more than once per week; "weekly" means about once per week; "monthly" means a couple times a month but not every week; "less than monthly" means less than once per month</i></p>	<input type="checkbox"/> Daily (1) <input type="checkbox"/> Weekly (2) <input type="checkbox"/> Monthly (3) <input type="checkbox"/> Less than monthly (4) <input type="checkbox"/> Never (5) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>Do you usually work indoors or outdoors?</p>	<input type="checkbox"/> Indoors (1) <input type="checkbox"/> Outdoors (2) (<i>skip to shs_bus</i>)

	<input type="checkbox"/> Both (3) <input type="checkbox"/> Don't work (4) (<i>skip to shs_bus</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to shs_bus</i>) <input type="checkbox"/> Decline (-9) (<i>skip to shs_bus</i>)
<p>During the past 30 days, did anyone smoke tobacco in indoor areas where you work?</p>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>How often do you take public transportation? Public transport is where you pay to share transportation with other people. Some examples are taxis, buses, saloon cars.</p> <p><i>NOTE TO RA: We mean enclosed vehicles here (not shared boda bodas).</i></p> <p><i>If in between categories, please select the higher category. "daily" means more than once per week; "weekly" means about once per week; "monthly" means a couple times a month but not every week; "less than monthly" means less than once per month</i></p>	<input type="checkbox"/> Daily (1) <input type="checkbox"/> Weekly (2) <input type="checkbox"/> Monthly (3) <input type="checkbox"/> Less than monthly (4) <input type="checkbox"/> Never (5) (<i>skip to shs_barin</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to shs_barin</i>) <input type="checkbox"/> Decline (-9) (<i>skip to shs_barin</i>)
<p>During the past 30 days, while you were taking public transportation, was anyone smoking?</p>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>How often do you spend time indoors at bars or nightclubs?</p> <p><i>NOTE TO RA: If in between categories, please select the higher category. "daily" means more than once per week; "weekly" means about once per week; "monthly" means a couple times a month but not every week; "less than monthly" means less than once per month</i></p>	<input type="checkbox"/> Daily (1) <input type="checkbox"/> Weekly (2) <input type="checkbox"/> Monthly (3) <input type="checkbox"/> Less than monthly (4) <input type="checkbox"/> Never (5) (<i>skip to shs_barout</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to shs_barout</i>) <input type="checkbox"/> Decline (-9) (<i>skip to shs_barout</i>)
<p>When you are at bars or nightclubs, how crowded are these places?</p> <p><i>NOTE to RA: By very crowded we mean that there are so many people that it is difficult to walk around freely.</i></p>	<input type="checkbox"/> Not crowded at all (1) <input type="checkbox"/> Somewhat crowded (2) <input type="checkbox"/> Very crowded (3) <input type="checkbox"/> Don't Know (-8) <input type="checkbox"/> Decline (-9)
<p>During the past 30 days, while you were indoors at a bar or nightclub, was anyone smoking?</p>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (-8)

	<input type="checkbox"/> Decline (-9)
<p>How often do you spend time outdoors at bars or nightclubs?</p> <p><i>NOTE TO RA: If in between categories, please select the higher category. "daily" means more than once per week; "weekly" means about once per week; "monthly" means a couple times a month but not every week; "less than monthly" means less than once per month</i></p>	<input type="checkbox"/> Daily (1) <input type="checkbox"/> Weekly (2) <input type="checkbox"/> Monthly (3) <input type="checkbox"/> Less than monthly (4) <input type="checkbox"/> Never (5) (<i>skip to shs_barinout</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to shs_barinout</i>) <input type="checkbox"/> Decline (-9) (<i>skip to shs_barinout</i>)
<p>During the past 30 days, while you were outdoors at a bar or nightclub, was anyone smoking?</p>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>When you are at bars or nightclubs, do you usually spend your time indoors, outdoors, or both equally?</p> <p><i>(skip over this question if never spends time indoors or outdoors at bars or nightclubs)</i></p>	<input type="checkbox"/> Indoors (1) <input type="checkbox"/> Outdoors (2) <input type="checkbox"/> Both equally (3) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>When you are at bars or nightclubs, how much cigarette smoke is there at these places?</p>	<input type="checkbox"/> None (0) <input type="checkbox"/> A bit (1) <input type="checkbox"/> A lot (2) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
<p>When you drink alcohol, how crowded are the places where you usually drink?</p> <p><i>NOTE TO RA: By very crowded we mean that there are so many people that it is difficult to walk around freely.</i></p>	<input type="checkbox"/> Not crowded at all (1) <input type="checkbox"/> Somewhat crowded (2) <input type="checkbox"/> Very crowded (3) <input type="checkbox"/> Don't Know (-8) <input type="checkbox"/> Decline (-9)
<p>How often do you spend time at an indoor church, mosque, or house of worship?</p> <p><i>NOTE TO RA: If in between categories, please select the higher category. "daily" means more than once per week; "weekly" means about once per week; "monthly" means a couple times a month but not every week; "less than monthly" means less than once per month</i></p>	<input type="checkbox"/> Daily (1) <input type="checkbox"/> Weekly (2) <input type="checkbox"/> Monthly (3) <input type="checkbox"/> Less than monthly (4) <input type="checkbox"/> Never (5) (<i>skip to next section</i>) <input type="checkbox"/> Don't know (-8) (<i>skip to next section</i>) <input type="checkbox"/> Decline (-9) (<i>skip to next section</i>)

During the past 30 days, while you were at an indoor church, mosque, or house of worship, was anyone smoking?	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (-8) <input type="checkbox"/> Decline (-9)
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SECTION 16: READINESS TO QUIT: TOBACCO

Asked at baseline and 6-month visits

Here are some thoughts that smokers have about quitting. Please indicate the sentence that shows what you think about quitting. Please listen to each sentence carefully before deciding.

1. Have you ever smoked cigarettes?

- No → *Skip to HIV testing section*
- Yes
- Declined

Please indicate the sentence that shows what you think about quitting.	<input type="checkbox"/> I have quit smoking and I will never smoke again. (10) <input type="checkbox"/> I have quit smoking, but I still worry about slipping back, so I need to keep working on living smoke free. (9) <input type="checkbox"/> I still smoke, but I have begun to change, like cutting back on the number of cigarettes I smoke. I am ready to set a quit date. (8) <input type="checkbox"/> I definitely plan to quit smoking within the next 30 days. (7) <input type="checkbox"/> I definitely plan to quit smoking in the next 6 months. (6) <input type="checkbox"/> I often think about quitting smoking, but I have no plans to quit. (5) <input type="checkbox"/> I sometimes think about quitting smoking, but I have no plans to quit. (4) <input type="checkbox"/> I rarely think about quitting smoking, and I have no plans to quit. (3) <input type="checkbox"/> I never think about quitting smoking, and I have no plans to quit. (2) <input type="checkbox"/> I enjoy smoking and have decided not to quit smoking for my lifetime. I have no interest in quitting. (1) <input type="checkbox"/> Declined (-9)
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SECTION 17: SMOKING QUIT ATTEMPTS

Asked at baseline and 6-month visits

Skip section if "no" was selected in section 16 (readiness to quit tobacco), question 1.

1. Have you <u>stopped smoking for one day</u> or longer because you were trying to quit smoking?	<input type="checkbox"/> No (0) → go to next section <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9) → go to next section
2. Why did you attempt to stop smoking?	<input type="checkbox"/> For lung health related reasons <input type="checkbox"/> For other health reasons <input type="checkbox"/> For non-health reasons <input type="checkbox"/> Declined

SECTION 18: HIV TESTING

Asked at baseline visit only

Now I am going to ask some questions about HIV.

When did you first test positive for HIV?	_____ / _____ (Month/Year) <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
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SECTION 19: ART MEDICATION HISTORY AND ADHERENCE

Asked at baseline, 6-, 12-, and 18-month visits

Now I am going to ask you about anti-HIV medications.

1. Have you ever taken anti-retroviral medications for treating HIV? <i>At Follow-Up Visits: In the last 6 months, have you taken anti-retroviral medications for treating HIV?</i>	<input type="checkbox"/> No (0) skip to next section <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
2. When did you first receive anti-HIV medication? <i>[If month unknown, put 01]</i>	_____ / _____ (Month/Year) <input type="checkbox"/> Don't know month <input type="checkbox"/> Don't know year <input type="checkbox"/> Declined (-9)
3. Are you currently taking ART?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
4. How many pills a day of anti-HIV medications are you supposed to take (not counting Septrin and multivitamin pills).	_____ pills <input type="checkbox"/> Declined (-9)
5. <i>RA only question:</i> Which medications has the participant taken for HIV? Check all that apply. Consult the medical chart.	<input type="checkbox"/> TDF/3TC/DTG (Tenofovir, Lamivudine, Dolutegravir) (TLD) (13) <input type="checkbox"/> ABC/3TC/DTG (Abacavir, Lamivudine, Dolutegravir) (16) <input type="checkbox"/> AZT/3TC/DTG (Zidovudine, Lamivudine, Dolutegravir) (17) <input type="checkbox"/> TDF/3TC/EFV (Tenofovir, Lamivudine, Efavirenz) (1) <input type="checkbox"/> AZT/3TC/EFV (Zidovudine, Lamivudine, Efavirenz) (2) <input type="checkbox"/> AZT/3TC/LPV/r (Zidovudine, Lamivudine, Lopinavir/ritonavir) (6)

	<input type="checkbox"/> AZT/3TC/ATV/r (Zidovudine, Lamivudine, Atazanavir/ritonavir) (7) <input type="checkbox"/> TDF/3TC/LPV/r (Tenofovir, Lamivudine, Lopinavir/ritonavir) (8) <input type="checkbox"/> TDF/3TC/ATV/r (Tenofovir, Lamivudine, Atazanavir/ritonavir) (9) <input type="checkbox"/> ABC/3TC/LPV/r (Abacavir, Lamivudine, Lopinavir/ritonavir) (10) <input type="checkbox"/> ABC/3TC/ATV/r (Abacavir, Lamivudine, Atazanavir/ritonavir) (11) <input type="checkbox"/> TDF/FTC/EFV (Tenofovir, Emtricitabine, Efavirenz) (Atripla) (12) <input type="checkbox"/> ABC/3TC/EFV (Abacavir, Lamivudine, Efavirenz) (14) <input type="checkbox"/> AZT/3TC/NVP (Zidovudine, Lamivudine, Nevirapine) (Combipack, Duovir-N) (3) <input type="checkbox"/> TDF/3TC/NVP (Tenofovir, Lamivudine, Nevirapine) (4) <input type="checkbox"/> ABC/3TC/NVP (Abacavir, Lamivudine, Nevirapine) (5) <input type="checkbox"/> Other (15) (specify) _ _ _ _ _ _ _ <i>art_othr</i> <input type="checkbox"/> No records
6. <i>RA only question:</i> Did the participant's ART medication change when they started treatment for TB?	<input type="checkbox"/> No (0) <i>skip to question 7</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
6a. <i>RA only question:</i> What was the participant's new ART medication(s) when they started treatment for TB?	<input type="checkbox"/> TDF/3TC/DTG (Tenofovir, Lamivudine, Dolutegravir) (TLD) (13) <input type="checkbox"/> ABC/3TC/DTG (Abacavir, Lamivudine, Dolutegravir) (16) <input type="checkbox"/> AZT/3TC/DTG (Zidovudine, Lamivudine, Dolutegravir) (17) <input type="checkbox"/> TDF/3TC/EFV (Tenofovir, Lamivudine, Efavirenz) (1) <input type="checkbox"/> AZT/3TC/EFV (Zidovudine, Lamivudine, Efavirenz) (2) <input type="checkbox"/> AZT/3TC/LPV/r (Zidovudine, Lamivudine, Lopinavir/ritonavir) (6) <input type="checkbox"/> AZT/3TC/ATV/r (Zidovudine, Lamivudine, Atazanavir/ritonavir) (7) <input type="checkbox"/> TDF/3TC/LPV/r (Tenofovir, Lamivudine, Lopinavir/ritonavir) (8) <input type="checkbox"/> TDF/3TC/ATV/r (Tenofovir, Lamivudine, Atazanavir/ritonavir) (9) <input type="checkbox"/> ABC/3TC/LPV/r (Abacavir, Lamivudine, Lopinavir/ritonavir) (10) <input type="checkbox"/> ABC/3TC/ATV/r (Abacavir, Lamivudine, Atazanavir/ritonavir) (11)

	<input type="checkbox"/> TDF/FTC/EFV (Tenofovir, Emtricitabine, Efavirenz) (Atripla) (12) <input type="checkbox"/> ABC/3TC/EFV (Abacavir, Lamivudine, Efavirenz) (14) <input type="checkbox"/> AZT/3TC/NVP (Zidovudine, Lamivudine, Nevirapine) (Combipack, Duovir-N) (3) <input type="checkbox"/> TDF/3TC/NVP (Tenofovir, Lamivudine, Nevirapine) (4) <input type="checkbox"/> ABC/3TC/NVP (Abacavir, Lamivudine, Nevirapine) (5) <input type="checkbox"/> Increased Dolutegravir dose <input type="checkbox"/> Decreased Dolutegravir dose <input type="checkbox"/> No change <input type="checkbox"/> Other (15) (specify) __ __ __ __ <p style="text-align: center;"><i>art_othr</i></p>
7. Have you finished treatment for TB?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
8. Did the participant's ART medication change once they stopped treatment for TB?	<input type="checkbox"/> No (0) <i>skip to question 9</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Treatment not completed (2) <input type="checkbox"/> Declined (-9)
8a. What was the participant's new ART medication(s) when they stopped treatment for TB?	<input type="checkbox"/> TDF/3TC/DTG (Tenofovir, Lamivudine, Dolutegravir) (TLD) (13) <input type="checkbox"/> ABC/3TC/DTG (Abacavir, Lamivudine, Dolutegravir) (16) <input type="checkbox"/> AZT/3TC/DTG (Zidovudine, Lamivudine, Dolutegravir) (17) <input type="checkbox"/> TDF/3TC/EFV (Tenofovir, Lamivudine, Efavirenz) (1) <input type="checkbox"/> AZT/3TC/EFV (Zidovudine, Lamivudine, Efavirenz) (2) <input type="checkbox"/> AZT/3TC/LPV/r (Zidovudine, Lamivudine, Lopinavir/ritonavir) (6) <input type="checkbox"/> AZT/3TC/ATV/r (Zidovudine, Lamivudine, Atazanavir/ritonavir) (7) <input type="checkbox"/> TDF/3TC/LPV/r (Tenofovir, Lamivudine, Lopinavir/ritonavir) (8) <input type="checkbox"/> TDF/3TC/ATV/r (Tenofovir, Lamivudine, Atazanavir/ritonavir) (9) <input type="checkbox"/> ABC/3TC/LPV/r (Abacavir, Lamivudine, Lopinavir/ritonavir) (10) <input type="checkbox"/> ABC/3TC/ATV/r (Abacavir, Lamivudine, Atazanavir/ritonavir) (11) <input type="checkbox"/> TDF/FTC/EFV (Tenofovir, Emtricitabine, Efavirenz) (Atripla) (12) <input type="checkbox"/> ABC/3TC/EFV (Abacavir, Lamivudine, Efavirenz) (14) <input type="checkbox"/> AZT/3TC/NVP (Zidovudine, Lamivudine, Nevirapine) (Combipack, Duovir-N) (3)

	<input type="checkbox"/> TDF/3TC/NVP (Tenofovir, Lamivudine, Nevirapine) (4) <input type="checkbox"/> ABC/3TC/NVP (Abacavir, Lamivudine, Nevirapine) (5) <input type="checkbox"/> Increased Dolutegravir dose <input type="checkbox"/> Decreased Dolutegravir dose <input type="checkbox"/> Other (15) (specify) _ _ _ _ _ _ _ _ _ _ _ _ <i>art_othr</i>
9. Has the participant had any change to their ART medications since their last study visit?	<input type="checkbox"/> No (0) <i>skip to question 10</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
9a. What are the participant's new ART medication(s)? Chart	<input type="checkbox"/> TDF/3TC/DTG (Tenofovir, Lamivudine, Dolutegravir) (TLD) (13) <input type="checkbox"/> ABC/3TC/DTG (Abacavir, Lamivudine, Dolutegravir) (16) <input type="checkbox"/> AZT/3TC/DTG (Zidovudine, Lamivudine, Dolutegravir) (17) <input type="checkbox"/> TDF/3TC/EFV (Tenofovir, Lamivudine, Efavirenz) (1) <input type="checkbox"/> AZT/3TC/EFV (Zidovudine, Lamivudine, Efavirenz) (2) <input type="checkbox"/> AZT/3TC/LPV/r (Zidovudine, Lamivudine, Lopinavir/ritonavir) (6) <input type="checkbox"/> AZT/3TC/ATV/r (Zidovudine, Lamivudine, Atazanavir/ritonavir) (7) <input type="checkbox"/> TDF/3TC/LPV/r (Tenofovir, Lamivudine, Lopinavir/ritonavir) (8) <input type="checkbox"/> TDF/3TC/ATV/r (Tenofovir, Lamivudine, Atazanavir/ritonavir) (9) <input type="checkbox"/> ABC/3TC/LPV/r (Abacavir, Lamivudine, Lopinavir/ritonavir) (10) <input type="checkbox"/> ABC/3TC/ATV/r (Abacavir, Lamivudine, Atazanavir/ritonavir) (11) <input type="checkbox"/> TDF/FTC/EFV (Tenofovir, Emtricitabine, Efavirenz) (Atripla) (12) <input type="checkbox"/> ABC/3TC/EFV (Abacavir, Lamivudine, Efavirenz) (14) <input type="checkbox"/> AZT/3TC/NVP (Zidovudine, Lamivudine, Nevirapine) (Combipack, Duovir-N) (3) <input type="checkbox"/> TDF/3TC/NVP (Tenofovir, Lamivudine, Nevirapine) (4) <input type="checkbox"/> ABC/3TC/NVP (Abacavir, Lamivudine, Nevirapine) (5) <input type="checkbox"/> Other (15) (specify) _ _ _ _ _ _ _ _ _ _ _ _ <i>art_othr</i> <input type="checkbox"/>
10. We understand that many people on anti-HIV medication find it very difficult to take it regularly and often miss doses. We won't be surprised if you have missed lots of doses as well. We need	_ _ _ _ % <input type="checkbox"/> Declined (-9)

to know how many doses you have missed. Please say the number that is your best guess about the percentage of medication you have taken in the last month. We would be surprised if this was 100% for most people, for example, 0% means you have taken no medication; 50% means you have taken half your medication; 100% means you have taken every single dose of medication.	
11. In the past 30 days, on how many days did you miss at least one dose of any of your HIV medicines?	___ ___ days <input type="checkbox"/> Declined (-9)
12. In the past 30 days, how good a job did you do at taking your HIV medicines in the way you were supposed to?	<input type="checkbox"/> Very poor (1) <input type="checkbox"/> Poor (2) <input type="checkbox"/> Fair (3) <input type="checkbox"/> Good (4) <input type="checkbox"/> Very Good (5) <input type="checkbox"/> Excellent (6) <input type="checkbox"/> Declined (-9)
13. During the past 30 days, how often did you take your HIV medicines in the way you were supposed to?	<input type="checkbox"/> Never (1) <input type="checkbox"/> Rarely (2) <input type="checkbox"/> Sometimes (3) <input type="checkbox"/> Usually (4) <input type="checkbox"/> Almost always (5) <input type="checkbox"/> Always (6) <input type="checkbox"/> Declined (-9)

SECTION 20: HIV STIGMA

Asked at baseline, 6-, and 12-month visits

These next questions ask about some experiences and feelings you may have had because of HIV. To what extent do you agree with the following statements?

I have been hurt by how people reacted to learning I have HIV.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
I have stopped socializing with some people because of their reactions to my HIV status.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
I have lost friends by telling them I have HIV.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
I am very careful who I tell that I have HIV.	<input type="checkbox"/> Strongly disagree (1)

	<input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
I worry that people who know I have HIV will tell others.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
I feel that I am not the same as others because I have HIV.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Having HIV makes me feel unclean.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Having HIV makes me feel that I'm a bad person.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
Most people think that a person with HIV is disgusting.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
People with HIV are often rejected when others find out about their HIV status.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
During the past 12 months , I have been hurt by how people reacted to learning I have HIV.	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)

<p>During the past 12 months, I have stopped socializing with some people because of their reactions to my HIV status.</p>	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)
<p>During the past 12 months, I have lost friends by telling them I have HIV.</p>	<input type="checkbox"/> Strongly disagree (1) <input type="checkbox"/> Somewhat disagree (2) <input type="checkbox"/> Neutral (3) <input type="checkbox"/> Somewhat agree (4) <input type="checkbox"/> Strongly agree (5) <input type="checkbox"/> Declined (-9)

SECTION 21: COMORBIDITIES

Asked at baseline only

The next set of questions will ask you about your medical history.

<p>Has your doctor ever told you that you have any of the following?</p>	<p>Congestive Heart Failure, also called weak heart or fluid on the lungs</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined <p>Chronic lung disease (emphysema, asthma, chronic bronchitis or chronic obstructive lung disease)</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined <p>General pneumonia</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined <p>Lung cancer</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined <p>Diabetes or high blood sugar or "sugar"</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined <p>Hypertension or high blood pressure</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined
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Chronic Hepatitis C

- No
- Yes
- Declined

Chronic Hepatitis B

- No
- Yes
- Declined

SECTION 22: COVID-19

Asked at all study visits

I will now ask you questions about COVID-19.

<p>1. Have you ever had COVID-19? <i>At all other follow-up visits: Since your last visit [date of last visit], have you had COVID-19?</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <i>skip to question 10</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
<p>2. Was the diagnosis confirmed by a doctor/healthcare facility?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
<p>3. Did you have a positive COVID test (PCR or antibody) for your most recent COVID case?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <i>skip to question 4</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
<p>3a. What was the date of your most recent positive COVID test?</p>	<p>__ __ / __ __ / __ __ __ __ (DD/MM/YYYY) <i>00 if don't know day or month</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
<p>4. How many times have you had COVID-19? <i>At follow-up visits: since your last study visit, how many times have you had COVID-19?</i></p>	<p>_____ (number)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Declined (-9)
<p>5. Were you ever hospitalized for COVID-19? <i>At follow-up: Since your last study visit, were you ever hospitalized for COVID-19?</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <i>skip to question 10</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
<p>5a. When were you last hospitalized?</p>	<p>__ __ / __ __ / __ __ __ __ (DD/MM/YYYY) <i>00 if don't know day or month</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
<p>6. Were you ever placed in the ICU for a COVID-19 hospitalization?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <i>skip to question 7</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
<p>6a. When were you last placed in the ICU during a COVID-19 hospitalization?</p>	<p>__ __ / __ __ / __ __ __ __ (DD/MM/YYYY) <i>00 if don't know day or month</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
<p>7. Were you ever given supplemental oxygen during a COVID-19 hospitalization?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
<p>8. Were you ever on a ventilator during a COVID-19 hospitalization?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1)

	<input type="checkbox"/> Declined (-9)
8a. How many total days were you on a ventilator during your COVID-19 hospitalization(s)?	___ ___ days <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
9. Were you ever put on corticosteroids (such as prednisolone, dexamethasone, etc.) during a COVID-19 hospitalization?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
10. Have you received a vaccine for COVID-19?	<input type="checkbox"/> No (0) <i>skip to question 13</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
11. Which vaccine did you receive (select all that apply)?	<input type="checkbox"/> Moderna (Spikevax) (1) → Number of doses: ___ <input type="checkbox"/> Pfizer (Comirnaty) (2) → Number of doses: ___ <input type="checkbox"/> Johnson & Johnson (Jcovden) (3) → Number of doses: ___ <input type="checkbox"/> Oxford/AstraZeneca (Vaxzevria) (4) → Number of doses: ___ <input type="checkbox"/> Sinovac (Coronovac) (5) → Number of doses: ___ <input type="checkbox"/> Other (6) _____ (specify) → Number of doses: ___ <input type="checkbox"/> Don't know <input type="checkbox"/> Declined (-9)
12. What was the date of your last dose?	___ ___ / ___ ___ / ___ ___ ___ ___ (DD/MM/YYYY) <i>00 if don't know day or month</i> <input type="checkbox"/> Don't know/remember <input type="checkbox"/> Declined
13. Please tell us why you did not receive the COVID-19 vaccine.	<input type="checkbox"/> I had the opportunity to receive a COVID-19 vaccine, but I did not want it. (1) <input type="checkbox"/> I did not have the opportunity to receive a COVID-19 vaccine. (2) <input type="checkbox"/> Declined (-9)

SECTION 23: MEDICATIONS

Asked at baseline, 6-, 12-, and 18-month visits

These questions will ask about both prescription and non-prescription medications that you have taken in the past 7 days. Please DO NOT include the ART medication you take for HIV infection or the antibiotic medications you take for your TB infection in this section.

1. Have you taken any prescription or non-prescription medications in the past 7 days?	<input type="checkbox"/> No (0) <i>skip to next section</i> <input type="checkbox"/> Yes (1) <input type="checkbox"/> Declined (-9)
MEDICATION #1	
2. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
3. RA enter: what type of medication is this?	<input type="checkbox"/> Statin

	<input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
4. Please tell me briefly why you took this medication.	_____ (short response)
5. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
6. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
7. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #2	
8. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
9. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
10. Please tell me briefly why you took this medication.	_____ (short response)
11. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
12. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
13. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #3	
14. What is the name of the medication?	_____ (short response)

	<input type="checkbox"/> Don't know
15. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
16. Please tell me briefly why you took this medication.	_____ (short response)
17. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
18. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
19. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #4	
20. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
21. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
22. Please tell me briefly why you took this medication.	_____ (short response)
23. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
24. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
25. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)

MEDICATION #5	
26. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
27. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
28. Please tell me briefly why you took this medication.	_____ (short response)
29. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
30. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
31. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #6	
32. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
33. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
34. Please tell me briefly why you took this medication.	_____ (short response)
35. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
36. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
37. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i>

	<input type="checkbox"/> Yes (1)
MEDICATION #7	
38. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
39. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
40. Please tell me briefly why you took this medication.	_____ (short response)
41. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
42. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
43. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #8	
44. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
45. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
46. Please tell me briefly why you took this medication.	_____ (short response)
47. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
48. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____

49. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #9	
50. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
51. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
52. Please tell me briefly why you took this medication.	_____ (short response)
53. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
54. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Other _____
55. Are you taking any additional medications?	<input type="checkbox"/> No (0) <i>form complete, go to next section of assessment</i> <input type="checkbox"/> Yes (1)
MEDICATION #10	
56. What is the name of the medication?	_____ (short response) <input type="checkbox"/> Don't know
57. RA enter: what type of medication is this?	<input type="checkbox"/> Statin <input type="checkbox"/> Anti-inflammatory drug <input type="checkbox"/> Anti-malaria <input type="checkbox"/> Anti-biotic <input type="checkbox"/> Multivitamin <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined (-9)
58. Please tell me briefly why you took this medication.	_____ (short response)
59. How long have you been taking this medication?	___ ___ (# of days, weeks, months, or years)
60. Route	<input type="checkbox"/> Inhalation <input type="checkbox"/> Oral

	<input type="checkbox"/> Injection <input type="checkbox"/> Other _____
Max number of medications that can be entered is 10.	

SECTION 24: DRUG USE

Asked at baseline, 6-, 12- and 18-month visits

Now I have some questions for you about tobacco and other substances. We ask everyone these questions even if they don't use tobacco or drugs. If you've never heard of a drug that I ask you about, let me know.

- Have you **ever in your life** used any of the following? *If no, go to next substance.*
If yes, Have you ever in your life injected it into your veins? (cocaine, heroin, and speed only)
If ever used, Have you used substance in the past 3 months? If no, go to next substance.
If used in past 90 days, Have you injected substance in the past 3 months? Go to next substance.
For tobacco (smoked and chewed), khat, and marijuana – ask days used in the past 30.

	a. Used Lifetime?	b. Ever injected?	c. Used Past 3 months?	d. Injected past 3 months?	Days used in the past 30 days?
Smoking tobacco (cigarettes)	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes →		_____
Chewing tobacco	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes		_____
E-cigarette (electronic cigarettes, smokeless cigarettes, vaping)	<input type="radio"/> No <input type="radio"/> Yes		<input type="radio"/> No <input type="radio"/> Yes		
Mairunji/Mairungi (Khat)	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes		_____
Marijuana	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes		_____
Hookah (shisha)	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes		_____
Powder (kuba)	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes		_____
Kerosene, petrol, glue, or paint thinner (for sniffing)	<input type="radio"/> No <input type="radio"/> Yes	→	<input type="radio"/> No <input type="radio"/> Yes		

7. I felt that everything I did was an effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I felt hopeful about the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I thought my life had been a failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I felt fearful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. My sleep was restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I was happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I talked less than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I felt lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. People were unfriendly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I enjoyed life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I had crying spells.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I felt sad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I felt that people disliked me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I could not get "going".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 26: Household Food Insecurity Access Scale (HFIAS)

Asked at baseline, 6-, and 12-month visits

These next questions are about access to food.

"In the past four weeks..."	No (0)	Rarely (1-2 times) (2)	Sometimes (3-10 times) (3)	Often (>10 times) (4)	Declined (-9)
1. Did you worry that the household would not have enough food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Were you or any household member not able to eat the kinds of foods you preferred because of a lack of resources?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you or any household member have to eat a limited variety of foods due to a lack of resources?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you or any household member have to eat some foods that you really did not want to eat because of a lack of resources to obtain other types of food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Did you or any household member have to eat a smaller meal than you felt you needed because there was not enough food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you or any household member have to eat fewer meals in a day because there was not enough food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Was there ever no food to eat of any kind in your household, granaries, or garden, because of a lack of resources to get food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Did you or any household member go to sleep at night hungry because there was not enough food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you or any household member go a whole day and night without eating because there was not enough food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 27: MALNUTRITION

Asked at baseline, 6-, and 12-month visits

These next questions are about your weight and food intake.

1. How much do you currently weigh?	_____ kg <input type="checkbox"/> Don't know <input type="checkbox"/> Declined
2. How tall are you?	_____ cm tall <input type="checkbox"/> Don't know <input type="checkbox"/> Declined
3. One month ago, how much did you weigh?	_____ kg <input type="checkbox"/> Don't know <input type="checkbox"/> Declined
4. Six months ago, how much did you weigh?	_____ kg <input type="checkbox"/> Don't know <input type="checkbox"/> Declined

5. During the past two weeks my weight has:	<input type="checkbox"/> Decreased (1) <input type="checkbox"/> Not changed (2) <input type="checkbox"/> Increased (3) <input type="checkbox"/> Declined (-9)
6. As compared to your normal intake, how would you rate your food intake during the past month?	<input type="checkbox"/> Unchanged (1) <i>skip to question 8</i> <input type="checkbox"/> More than usual (2) <i>skip to question 8</i> <input type="checkbox"/> Less than usual (3) <input type="checkbox"/> Declined (-9)
7. What kinds of food are you now eating?	<input type="checkbox"/> Normal food but less than normal amount (1) <input type="checkbox"/> Little solid food (2) <input type="checkbox"/> Only liquids (3) <input type="checkbox"/> Only nutritional supplements (4) <input type="checkbox"/> Very little of anything (5) <input type="checkbox"/> Only tube feedings or only nutrition by vein (6) <input type="checkbox"/> Declined (-9)
8. What problems kept you from eating enough during the past two weeks? Check all that apply.	<input type="checkbox"/> No problems eating (1) <input type="checkbox"/> No appetite, just did not feel like eating (2) <input type="checkbox"/> Nausea (3) <input type="checkbox"/> Vomiting (4) <input type="checkbox"/> Constipation (5) <input type="checkbox"/> Diarrhea (6) <input type="checkbox"/> Mouth sores (7) <input type="checkbox"/> Dry mouth (8) <input type="checkbox"/> Things taste funny or have no taste (9) <input type="checkbox"/> Problems swallowing (10) <input type="checkbox"/> Smells bother me (11) <input type="checkbox"/> Feel full quickly (12) <input type="checkbox"/> Fatigue (13) <input type="checkbox"/> Pain (14) → Where? _____ <input type="checkbox"/> Other (examples: depression, money, or dental problems) (15) → Specify: _____ <input type="checkbox"/> Declined (-9)
9. Over the past month, how would you rate your activity?	<input type="checkbox"/> Normal with no limitations (1) <input type="checkbox"/> Not my normal self, but able to be up and about with fairly normal activities (2) <input type="checkbox"/> Not feeling up to most things, but in bed or chair less than half the day (3) <input type="checkbox"/> Able to do little activity and spend most of the day in bed or chair (4) <input type="checkbox"/> Pretty much bed ridden, rarely out of bed (5) <input type="checkbox"/> Declined (-9)

SECTION 28: SOCIAL SUPPORT SCALE

Asked at baseline, 6-, and 12-month visits

Now I am going to ask you some questions about your social supports. For each of these questions, you may answer 'as much as I would like,' 'less than I would like', 'much less than I would like', or never.

	As much as I would like (1)	Less than I would like (2)	Much less than I would like (3)	Never (4)	Don't know (5)	Declined (-9)
Statement						

1	I get visits from friends and relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	I get useful advice about important things in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	I get chances to talk to someone about problems at work or with my housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	I get chances to talk to someone I trust about personal and family problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	I have people who care what happens to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I get love and/or affection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	I get help with household-related work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I get help with money in an emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	I get help when I need transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	I get help when I am sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 29: VR-12 HEALTH SURVEY

Asked at baseline and 12-month visits

Now I have some more questions about your health.

<p>In general, would you say your health is excellent, very good, good, fair, or poor?</p>	<p><input type="checkbox"/> Excellent (1)</p> <p><input type="checkbox"/> Very good (2)</p> <p><input type="checkbox"/> Good (3)</p> <p><input type="checkbox"/> Fair (4)</p> <p><input type="checkbox"/> Poor (5)</p> <p><input type="checkbox"/> Declined (-9)</p>
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Section 30: MOS-HIV

Asked at baseline and 12-month visits

How much of the time, during the past 4 weeks:

<p>1. Did you have difficulty reasoning and solving problems, for example, making plans, making decisions, learning new things?</p>	<p><input type="checkbox"/> All of the Time (1)</p> <p><input type="checkbox"/> Most of the Time (2)</p> <p><input type="checkbox"/> A Good Bit of the Time (3)</p> <p><input type="checkbox"/> Some of the Time (4)</p> <p><input type="checkbox"/> A Little of the Time (5)</p> <p><input type="checkbox"/> None of the Time (6)</p> <p><input type="checkbox"/> Declined (-9)</p>
---	--

2. Did you forget things that happened recently, for example, where you put things and when you had appointments?	<input type="checkbox"/> All of the Time (1) <input type="checkbox"/> Most of the Time (2) <input type="checkbox"/> A Good Bit of the Time (3) <input type="checkbox"/> Some of the Time (4) <input type="checkbox"/> A Little of the Time (5) <input type="checkbox"/> None of the Time (6) <input type="checkbox"/> Declined (-9)
3. Did you have trouble keeping your attention on any activity for long?	<input type="checkbox"/> All of the Time (1) <input type="checkbox"/> Most of the Time (2) <input type="checkbox"/> A Good Bit of the Time (3) <input type="checkbox"/> Some of the Time (4) <input type="checkbox"/> A Little of the Time (5) <input type="checkbox"/> None of the Time (6) <input type="checkbox"/> Declined (-9)
4. Did you have difficulty doing activities involving concentration and thinking?	<input type="checkbox"/> All of the Time (1) <input type="checkbox"/> Most of the Time (2) <input type="checkbox"/> A Good Bit of the Time (3) <input type="checkbox"/> Some of the Time (4) <input type="checkbox"/> A Little of the Time (5) <input type="checkbox"/> None of the Time (6) <input type="checkbox"/> Declined (-9)

Section 31: Middle Upper Arm Circumference

Assessed at baseline, 6-, and 12-month visits

We will now conduct a test to confirm your middle upper arm circumference.

1. Date completed:	____ ____ / ____ ____ / ____ ____ ____ ____ (DD/MM/YYYY)
2. Middle upper arm circumference:	____ ____ . ____ cm

Section 32: Grip Strength

Assessed at baseline, 6-, and 12-month visits

We will now test your grip strength.

1. Date completed	____ ____ / ____ ____ / ____ ____ ____ ____ (DD/MM/YYYY)
2. Grip strength 2a. Are you right-handed or left-handed?	<input type="checkbox"/> Right-handed (1) <input type="checkbox"/> Left-handed (2) <input type="checkbox"/> Ambidextrous (3) <input type="checkbox"/> Declined (-9)
2b. Result LEFT hand test 1	____ ____ ____ . ____ kg <input type="checkbox"/> Declined <input type="checkbox"/> Could not complete
2c. Result RIGHT hand test 1	____ ____ ____ . ____ kg <input type="checkbox"/> Declined <input type="checkbox"/> Could not complete
2d. Result LEFT hand test 2	____ ____ ____ . ____ kg <input type="checkbox"/> Declined <input type="checkbox"/> Could not complete

2e. Result RIGHT hand test 2	____ ____ ____ . ____ kg <input type="checkbox"/> Declined <input type="checkbox"/> Could not complete
2f. Result LEFT hand test 3	____ ____ ____ . ____ kg <input type="checkbox"/> Declined <input type="checkbox"/> Could not complete
2g. Result RIGHT hand test 3	____ ____ ____ . ____ kg <input type="checkbox"/> Declined <input type="checkbox"/> Could not complete

SECTION 33: 6-MINUTE WALK

Assessed at all study visits

We are now going to complete an exercise called the 6-minute walk. Before we begin, I am going to ask you a few health questions.

1. Date completed	____ ____ / ____ ____ / ____ ____ ____ ____ (DD/MM/YYYY)
2. Have you had a myocardial infarction (heart attack) in the past month?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) (<i>skip to question 8</i>) <input type="checkbox"/> Declined (-9)
3. Have you had chest pain at rest in the past month?	<input type="checkbox"/> No (0) <input type="checkbox"/> Yes (1) (<i>skip to question 8</i>) <input type="checkbox"/> Declined (-9)
4. Participant blood pressure	<input type="checkbox"/> Attempt #1: ____ ____ ____ / ____ ____ ____ mmHg <input type="checkbox"/> Attempt #2: ____ ____ ____ / ____ ____ ____ mmHg <input type="checkbox"/> Declined (-9) Computer generated: Average blood pressure: ____ ____ ____ / ____ ____ ____ mmHg
6. Resting heart rate	____ ____ ____ bpm <input type="checkbox"/> Declined
7. SpO ₂	____ ____ . ____ % <input type="checkbox"/> Declined
8. Computer generated: Does the 6MW need to be rescheduled? Rescheduling Key: <i>Myocardial infarction: Reschedule 6MW 1 month after event</i> <i>Chest pain: Refer to physician and reschedule 6MW 1 month after chest pain stops</i> <i>Average Systolic blood pressure of > 180mmHg: Refer to physician and reschedule for 2 weeks from today</i> <i>Average Diastolic blood pressure of > 120mmHg: Refer to physician and reschedule for 2 weeks from today</i>	<input type="checkbox"/> No (0) (<i>skip to question 10</i>) <input type="checkbox"/> Yes (1)

<i>Resting heart rate > 120bpm: Refer to physician and reschedule for 2 weeks from today</i>	
9. Was the 6MWT rescheduled?	<input type="checkbox"/> No → Reason: _____ <input type="checkbox"/> Yes
10. (If female): Are you pregnant?	<input type="checkbox"/> No → Go to question #11 <input type="checkbox"/> Yes <input type="checkbox"/> Declined
10a. How many weeks pregnant are you?	__ __ weeks <input type="checkbox"/> Declined <input type="checkbox"/> Don't know

RA: Walk participant over to start of course. Have a paper 6MWT form and Borg scale chart:

Scale	Severity
0	Nothing at all
0.5	Very, very slight (Just Noticeable)
1	Very Slight
2	Slight (light)
3	Moderate
4	Somewhat severe
5	Severe(heavy)
6	
7	Very Severe
8	
9	
10	Very, very severe (maximal)

11a. Pre-Test Dyspnea: Please grade your level of shortness of breath using the Borg scale:	__ __ (possible values: 0; 0,5; 1-10) <input type="checkbox"/> Declined
11b. Pre-Test Overall Fatigue: Please grade your level of fatigue using the Borg scale:	__ __ (possible values: 0; 0,5; 1-10) <input type="checkbox"/> Declined
12. RA: Was the test stopped for any of the following reasons:	<input type="checkbox"/> Test was not stopped (1) <input type="checkbox"/> Chest pain (2) <input type="checkbox"/> Confusion or staggering (3) <input type="checkbox"/> Light-headedness (4) <input type="checkbox"/> Extreme leg muscle fatigue or pain (5) <input type="checkbox"/> Excessive sweating (6) <input type="checkbox"/> Pale appearance (7) <input type="checkbox"/> Other clinically warranted reason (0) → Reason: _____
13. Post-test SpO ₂ :	__ __ % <input type="checkbox"/> Declined
14. Post-test heart rate:	__ __ __ bpm <input type="checkbox"/> Declined
15a. Post-Test Dyspnea: Please grade your level of shortness of breath using the Borg scale:	__ __ (possible values: 0; 0,5; 1-10) <input type="checkbox"/> Declined
15b. Post-Test Overall Fatigue: Please grade your level of fatigue using the Borg scale:	__ __ (possible values: 0; 0,5; 1-10) <input type="checkbox"/> Declined

16. RA: How long is one standard leg?	__ __ meters
17. RA: Final leg distance	__ __ meters (derived from the meter markers on the ground)
18. RA: Number of legs	__ __ (number)
19. Computer generated: Total distance walked:	__ __ __ meters
Comments (for example, interruption, rain disruption):	

Section 34: CT Scan tracking
Completed at baseline and 18-month visits

1. Were CT scan images sent to BEDAC?	<input type="checkbox"/> No (0) → Reason: _____ <input type="checkbox"/> Yes (1) → Date: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)
Comments:	

Section 35: Spirometry & DLCO tracking
Completed at baseline, 6-, 12-, and 18-month visits

Participant ID: __ __ __ __ Participant Initials (FML): __ __ __ Assessor Initials (FML): __ __ __

1. Check visit:	<input type="checkbox"/> Baseline <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> 18 months
2. Were spirometry results sent to BEDAC?	<input type="checkbox"/> No (0) → Reason: _____ <input type="checkbox"/> Yes (1)
3. Were DLCO results sent to BEDAC?	<input type="checkbox"/> No (0) → Reason: _____ <input type="checkbox"/> Yes (1)
Comments:	

Section 36: Spirometry & DLCO contraindications
Completed at baseline, 6-, 12-, and 18-month visits

Participant ID: __ __ __ __ Participant Initials (FML): __ __ __ Assessor Initials (FML): __ __ __

1. Date completed:	__ __ __ __ / __ __ __ __ / __ __ __ __ __ __ (DD/MM/YYYY)
2. Blood pressure:	__ __ __ __ / __ __ __ __ mmHg <i>[Computer generated: If >180/120mmHg or <90/60mmHg, refer to specialist and reschedule]</i>

	<i>spirometry at least 2 weeks later in the tracking website]</i>
3. Have you had a heart attack in the last week or chest pain that worsens with activity?	<input type="checkbox"/> Yes (1) → Date <u> </u> / <u> </u> / <u> </u> <i>[Computer generated: If yes, reschedule spirometry at least 1 week from the date event happened in the tracking website]</i> <input type="checkbox"/> No (0) <input type="checkbox"/> Declined
4. Have you had a head injury or brain surgery in the past four weeks?	<input type="checkbox"/> Yes (1) → Date <u> </u> / <u> </u> / <u> </u> <i>[Computer generated: If yes, reschedule spirometry at least 4 weeks from the date event happened in the tracking website]</i> <input type="checkbox"/> No (0) <input type="checkbox"/> Declined
5. Have you ever been told you have a cerebral aneurysm?	<input type="checkbox"/> Yes (1) → Computer: is the systolic blood pressure above 140mmHg? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>[Computer generated: If Yes, refer to a specialist and tell participant to call back to reschedule spirometry after 1 week of consistently taking hypertension medication in the tracking website.]</i> <input type="checkbox"/> No (0) <input type="checkbox"/> Declined
6. Have you had eye surgery in the past week?	<input type="checkbox"/> Yes (1) → Date <u> </u> / <u> </u> / <u> </u> <i>[Computer generated: If yes, reschedule spirometry at least 1 week from the date event happened in the tracking website]</i> <input type="checkbox"/> No (0) <input type="checkbox"/> Declined
7. Have you ever been told that you have air in the chest outside of your lungs (or pneumothorax)?	<input type="checkbox"/> Yes (1) b. Was this resolved? <input type="checkbox"/> Yes → When did this resolve? Date <u> </u> / <u> </u> / <u> </u> <i>[Computer generated: If yes, reschedule spirometry at least 2 weeks from the date of resolution in tracking website]</i> <input type="checkbox"/> No <i>[Computer generated: If no, refer to specialist and reschedule spirometry at least 2 weeks from the date of resolution in tracking website]</i> <input type="checkbox"/> No (0) <input type="checkbox"/> Declined
8. Have you had surgery on your chest or abdomen in the last month?	<input type="checkbox"/> Yes (1) → Date <u> </u> / <u> </u> / <u> </u> <i>[Computer generated: If yes, reschedule spirometry at least 4 weeks from the date event happened in the tracking website]</i> <input type="checkbox"/> No (0) <input type="checkbox"/> Declined
9. Have you had a stroke within the past month?	<input type="checkbox"/> Yes (1) → Date <u> </u> / <u> </u> / <u> </u>

	<p><i>[Computer generated: If yes, reschedule spirometry at least 4 weeks from the date event happened in the tracking website]</i></p> <p><input type="checkbox"/> No (0)</p> <p><input type="checkbox"/> Declined</p>
10. RA: Will the spirometry and DLCO occur as planned?	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No, it needs to be rescheduled</p> <p><input type="checkbox"/> No, but for another reason: _____</p>
Comments:	