NATIONAL STATISTICS OFFICE • MALTA

DIRECTORATE FOR HEALTH INFORMATION AND RESEARCH

EUROPEAN HEALTH INTERVIEW SURVEY

2019

EHIS QUESTIONNAIRE

NAME OF INDIVIDUAL	

1. REFERENCE NUMBER				
2. ID NUMBER				
3. Telephone number				
4. Mobile number				
5. E-mail				
6. Respondent's signature				

Confidential when completed.

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EUROPEAN HEALTH INTERVIEW SURVEY

2019

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REFERENCE NUMBER				

FOR OFFICIAL USE ONLY			
	Initials	**Name and Surname**	**Date**
Interviewer			
Vetter			
Data Entry Operator			

Confidential when completed.

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SECTION A: CORE SOCIAL VARIABLES

CS.1 What is your gender? (Tick one box ONLY)

- Male ☐ 1
- Female ☐ 2
- Transgender Male ☐ 3
- Transgender Female ☐ 4
- Gender-queer/Non-binary ☐ 5
- Other (specify) _____ ☐ 6

CS.2 What is your date of birth?

D	D	M	M	Y	Y	Y	Y

CS.3 Which is your country of birth? (Tick one box ONLY)

- Malta ☐ 1
- United Kingdom ☐ 2
- Italy ☐ 3
- Germany ☐ 4
- Serbia ☐ 5
- Russia ☐ 6
- Canada ☐ 7
- United States of America ☐ 8
- Australia ☐ 9
- Philippines ☐ 10
- Other (specify) _____ ☐ 11

CS.4 What is your main citizenship? (Tick one box ONLY)

- Maltese ☐ 1
- British ☐ 2
- Italian ☐ 3
- German ☐ 4
- Serbian ☐ 5
- Russian ☐ 6
- Canadian ☐ 7
- American ☐ 8
- Australian ☐ 9
- Philippine ☐ 10
- Other (specify) _____ ☐ 11
- Stateless ☐ 12

CS.5 In which country was your father born? (Tick one box ONLY)

Malta	☐ 1
United Kingdom	☐ 2
Italy	☐ 3
Germany	☐ 4
Serbia	☐ 5
Russia	☐ 6
Canada	☐ 7
United States of America	☐ 8
Australia	☐ 9
Philippines	☐ 10
Other (specify) _____	☐ 11
Do not know	☐ 12

CS.6 In which country was your mother born? (Tick one box ONLY)

Malta	☐ 1
United Kingdom	☐ 2
Italy	☐ 3
Germany	☐ 4
Serbia	☐ 5
Russia	☐ 6
Canada	☐ 7
United States of America	☐ 8
Australia	☐ 9
Philippines	☐ 10
Other (specify) _____	☐ 11
Do not know	☐ 12

CS.7 **What is the highest level of education that you have successfully completed? (Tick one box ONLY)**

- No formal education/Pre-primary ☐ 1
- Primary ☐ 2
- School for persons with a disability ☐ 3
- Secondary (general) ☐ 4
- Foundation or Introductory courses at MCAST of one (1) year or less ☐ 5
- Secondary (vocational)
  E.g. Trade School ☐ 6
- Post-secondary (general)
  E.g. Junior College ☐ 7
- Post-secondary (vocational) completed before the year 2000 (excluding ITS) ☐ 8
- Post-secondary (vocational) courses of less than two (2) years
  E.g. MCAST/MCAST National Diploma, ITS or similar institutions ☐ 9
- Post-secondary (vocational) courses two (2) years or more
  E.g. MCAST/MCAST National Diploma, ITS or similar institutions ☐ 10
- University level diploma/certificate or MCAST Higher National Diploma ☐ 11
- Bachelor degree or equivalent
  University of Malta, MCAST or other tertiary level institutions ☐ 12
- Postgraduate Diploma/Certificate ☐ 13
- Master's Degree ☐ 14
- Doctrate (PhD/DBA) ☐ 15
- Other (specify)_____ ☐ 16

CS.8 **What is your current labour status? (Tick one box ONLY)**

Where more than one status applies to the person, the respondent should select the category that best describes his/her situation.

- Employed
  Includes unpaid work for a family business, apprenticeship, paid traineeship, maternity/parental leave, sick leave and holiday leave ☐ 1
- Unemployed ☐ 2
- Student or pupil ☐ 3
- Retired ☐ 4
- Unable to work due to long-standing health problems ☐ 5 → CS.14
- Cannot work due to disability ☐ 6
- Taking care of the house and/or family ☐ 7
- Community service as ordered by court ☐ 8
- Other (specify)_____ ☐ 9

CS.9 **In your main job do you work full-time or part-time? (Tick one box ONLY)**

- Full-time ☐ 1
- Part-time ☐ 2

CS.10 **What is your employment status in your current main job? (Tick one box ONLY)**

- Employer (self-employed with employees) ☐ 1
- Own account worker (self-employed without employees) ☐ 2
- Employee ☐ 3
- Unpaid family worker ☐ 4
- Other (specify) _____ ☐ 5

CS.11 **Insert your current main job title**

E.g. Primary School Teacher, Carpenter, Clerk, etc.

_____

_____

CS.12 **Describe your main job:**

E.g. Teaching in a primary school, Making furniture, Work in an office, etc.

_____

_____

CS.13 **What is the economic activity of the establishment that you work for in your main job?**

E.g. Primary school, Kitchen making, Manufacture of toys, etc.

_____

_____

CS.14 **What is your legal marital status? (Tick one box ONLY)**

Single (never married or never in a registered partnership)	☐ 1
Married (or in a registered partnership)	☐ 2
Legally separated	☐ 3
Widowed (or persons whose registered partnership ended with the death of the partner)	☐ 4
Divorced (or persons whose registered partnership was legally dissolved)	☐ 5
Annulled	☐ 6

CS.15 **Do you currently live with a partner in the same household? (Tick one box ONLY)**

'Partner' includes husband, wife, civil partner or de facto partner (partner/cohabitant)

Yes	☐ 1
No	☐ 2

CS.16 **How many persons reside in this household (including selected individual)?**

_____

CS.17 **How many persons aged 13 years or less reside in the household?**

_____

CS.18 **What type of household do you live in? (Tick one box ONLY)**

Every household differs – Some households may consist of a couple with children or a couple without children. Other households may contain a single parent with children or consist of a group of friends living together.

One-person household	☐ 1
Lone parent with at least one resident child aged less than 25	☐ 2
Lone parent with all resident children aged 25 or more	☐ 3
Couple without resident children	☐ 4
Couple with at least one resident child aged less than 25	☐ 5
Couple with all resident children aged 25 or more	☐ 6
Other (specify)_____	☐ 7

SECTION B: EUROPEAN HEALTH STATUS MODULE

If questionnaire is answered by a proxy, go to question HS.2

HS.1 **How is your health in general? (Tick one box ONLY)**

- Very good ☐ 1
- Good ☐ 2
- Fair ☐ 3
- Bad ☐ 4
- Very bad ☐ 5

HS.2 **Do you have any longstanding illness or longstanding health problem? (By longstanding I mean illness or health problems which have lasted or are expected to last for six months or more). (Tick one box ONLY)**

E.g. asthma, diabetes, heart disease

- Yes ☐ 1
- No ☐ 2

HS.3 **Are you limited because of a health problem in activities people usually do? (Tick one box ONLY)**

- Yes, severely limited ☐ 1
- Yes, limited but not severely ☐ 2
- No, not limited at all ☐ 3 → CD.1

HS.4 **Have you been limited at least for the past 6 months? (Tick one box ONLY)**

- Yes ☐ 1
- No ☐ 2

CD.1 Which of the following diseases and/or conditions do you have, or have you had? (Tick ALL that apply)

- *Hand respondent show card 1*
- *The option 'None' can only be chosen on its own*

Asthma (including allergic asthma)	☐ 1
Chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema	☐ 2
Myocardial infarction (heart attack) or chronic consequences of myocardial infarction	☐ 3
Coronary heart disease (angina pectoris)	☐ 4
High blood pressure (hypertension)	☐ 5
Elevated blood cholesterol	☐ 6
Stroke (cerebral haemorrhage, cerebral thrombosis) or chronic consequences of stroke	☐ 7
Osteoarthritis (joint degeneration)	☐ 8
Lower back disorder or other chronic back defect	☐ 9
Neck disorder or other chronic neck defect	☐ 10
Diabetes	☐ 11
Allergy, such as rhinitis, eye inflammation, dermatitis, food allergy, or other (excluding asthma)	☐ 12
Stomach ulcer (gastric or duodenal ulcer)	☐ 13
Cirrhosis of the liver	☐ 14
Cancer (malignant tumour, also including leukaemia and lymphoma)	☐ 15
Urinary incontinence, problems in controlling the bladder	☐ 16
Kidney problems	☐ 17
Chronic anxiety	☐ 18
Chronic depression	☐ 19
Anorexia/Bulimia Nervosa	☐ 20
Other mental health conditions	☐ 21
Cataract	☐ 22
Osteoporosis	☐ 23
Other (specify)_____ _____ _____	☐ 24
None	☐ 25 → DH.1

Specify up to **three** only

CD.2 Which of these diseases and/or conditions were diagnosed by a medical doctor? (Tick ALL that apply)

- *The option 'None' can only be chosen on its own*

Asthma (including allergic asthma)	☐ 1
Chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema	☐ 2
Myocardial infarction (heart attack) or chronic consequences of myocardial infarction	☐ 3
Coronary heart disease (angina pectoris)	☐ 4
High blood pressure (hypertension)	☐ 5
Elevated blood cholesterol	☐ 6
Stroke (cerebral haemorrhage, cerebral thrombosis) or chronic consequences of stroke	☐ 7
Osteoarthritis (joint degeneration)	☐ 8
Lower back disorder or other chronic back defect	☐ 9
Neck disorder or other chronic neck defect	☐ 10
Diabetes	☐ 11
Allergy, such as rhinitis, eye inflammation, dermatitis, food allergy, or other (excluding asthma)	☐ 12
Stomach ulcer (gastric or duodenal ulcer)	☐ 13
Cirrhosis of the liver	☐ 14
Cancer (malignant tumour, also including leukaemia and lymphoma)	☐ 15
Urinary incontinence, problems in controlling the bladder	☐ 16
Kidney problems	☐ 17
Chronic anxiety	☐ 18
Chronic depression	☐ 19
Anorexia/Bulimia Nervosa	☐ 20
Other mental health conditions	☐ 21
Cataract	☐ 22
Osteoporosis	☐ 23
Other (specify)_____	
_____	☐ 24
_____	
Specify up to **three** only	
None	☐ 25

CD.3 Which diseases/conditions did you have during the past 12 months? (Tick ALL that apply)

- *The option 'None' can only be chosen on its own*

Asthma (including allergic asthma)	☐ 1
Chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema	☐ 2
Myocardial infarction (heart attack) or chronic consequences of myocardial infarction	☐ 3
Coronary heart disease (angina pectoris)	☐ 4
High blood pressure (hypertension)	☐ 5
Elevated blood cholesterol	☐ 6
Stroke (cerebral haemorrhage, cerebral thrombosis) or chronic consequences of stroke	☐ 7
Osteoarthritis (joint degeneration)	☐ 8
Lower back disorder or other chronic back defect	☐ 9
Neck disorder or other chronic neck defect	☐ 10
Diabetes	☐ 11
Allergy, such as rhinitis, eye inflammation, dermatitis, food allergy, or other (excluding asthma)	☐ 12
Stomach ulcer (gastric or duodenal ulcer)	☐ 13
Cirrhosis of the liver	☐ 14
Cancer (malignant tumour, also including leukaemia and lymphoma)	☐ 15
Urinary incontinence, problems in controlling the bladder	☐ 16
Kidney problems	☐ 17
Chronic anxiety	☐ 18
Chronic depression	☐ 19
Anorexia/Bulimia Nervosa	☐ 20
Other mental health conditions	☐ 21
Cataract	☐ 22
Osteoporosis	☐ 23
Other (specify)_____ _____ _____	☐ 24
None	☐ 25

Specify up to **three** only

CD.4 How old were you when you were first diagnosed with cancer?

- *Only applicable to those who marked option 15 in question CD.1.*

_____

DENTAL HEALTH

If questionnaire is answered by a proxy, go to question DH.2

DH.1 How would you describe the state of your teeth and gums? (Tick one box ONLY)

Very good	☐ 1
Good	☐ 2
Fair	☐ 3
Poor	☐ 4
Very poor	☐ 5

DH.2 **Adults can have up to 32 natural teeth. Which of the following best describes you? (Tick one box ONLY)**

- *Consider filled teeth as 'normal' own teeth*

I have all my own teeth – none missing ☐1

I have my own teeth, no dentures/implants – but some teeth are missing ☐2

I have dentures/implants as well as some of my own teeth ☐3

I only have dentures/implants ☐4

I have no teeth/dentures/implants ☐5

DH.3 **During the past 12 months, did you experience any difficulty when it came to eating or speaking as a result of dental and/or other mouth problems? (Tick one box ONLY)**

Not at all ☐1

A little ☐2

A fair amount ☐3

A lot ☐4

DH.4 **How often do you brush your teeth? (Tick one box ONLY)**

Never ☐1

Less than once a day ☐2

Once a day ☐3

Twice a day ☐4

More than two times a day ☐5

ACCIDENTS AND INJURIES

AC.1 **During the past 12 months, have you had a road traffic accident that resulted in injury (external or internal)? (Tick one box ONLY)**

Yes ☐1

No ☐2 → AC.3

AC.2 **Did you visit a doctor, a nurse or an emergency department of a hospital as a result of this accident? (Tick one box ONLY)**

Admission to the emergency department ☐1

Visit to a doctor or nurse ☐2

No intervention was needed ☐3

AC.3 **During the past 12 months, have you had an accident at home that resulted in injury (external or internal)? (Tick one box ONLY)**

Yes ☐1

No ☐2 → AC.5

AC.4 **Did you visit a doctor, a nurse or an emergency department of a hospital as a result of this accident? (Tick one box ONLY)**

Admission to the emergency department ☐1

Visit to a doctor or nurse ☐2

No intervention was needed ☐3

AC.5 **During the past 12 months, have you had an accident while conducting a leisure activity that resulted in injury (external or internal)? (Tick one box ONLY)**

Yes ☐1

No ☐2 → AW.1

AC.6 **Did you visit a doctor, a nurse or an emergency department of a hospital as a result of this accident? (Tick one box ONLY)**

- Admission to the emergency department ☐ 1
- Visit to a doctor or nurse ☐ 2
- No intervention was needed ☐ 3

ABSENCE FROM WORK DUE TO HEALTH PROBLEMS

*This section is only applicable to those who are **employed** (Question CS.8=1).*

For all other respondents go to PL.1.

AW.1 **During the past 12 months, have you been absent from work due to health problems? (Tick one box ONLY)**

All kinds of diseases, injuries and other health problems which resulted in absenteeism from work should be taken into account.

- Yes ☐ 1
- No ☐ 2 → PL.1

AW.2 **During the past 12 months, for how many days in total were you absent from work due to health problems? (Tick one box ONLY)**

If required, the interviewer is to ask for an approximate number.

- Specify _____ ☐ 1
- Proxy respondent ☐ 2

PHYSICAL AND SENSORY FUNCTIONAL LIMITATIONS

- *In this section, the respondent has to answer questions regarding general physical and mental health. These questions tackle ability of respondents to do different basic activities.*
- *Any temporary issues are to be ignored.*

PL.1 **Do you wear glasses or contact lenses? (Tick one box ONLY)**

If respondent is blind or cannot see at all, tick option 3 and go to PL.4

- Yes ☐ 1
- No ☐ 2 → PL.3
- I am blind ☐ 3 → PL.4

PL.2 **Do you have difficulty when it comes to seeing even <u>when wearing your glasses/contact lenses?</u> (Tick one box ONLY)**

- No difficulty ☐ 1
- Some difficulty ☐ 2
- A lot of difficulty ☐ 3
- Cannot do at all/Unable to do ☐ 4

→ PL.4

PL.3 **Do you have difficulty <u>seeing</u>? (Tick one box ONLY)**

- No difficulty ☐ 1
- Some difficulty ☐ 2
- A lot of difficulty ☐ 3
- Cannot do at all/Unable to do ☐ 4

PL.4 **Do you use a hearing aid? (Tick one box ONLY)**

If respondent is deaf, do not ask this question and tick option 3 and go to PL.9

Yes	☐ 1
No	☐ 2 → PL.6
I am profoundly deaf	☐ 3 → PL.9

PL.5 **Do you have difficulty hearing what is said in a conversation with another person in a <u>quiet room</u>, even <u>when using your hearing aid</u>? (Tick one box ONLY)**

No difficulty	☐ 1	→ PL.7
Some difficulty	☐ 2	
A lot of difficulty	☐ 3	
Cannot do at all/Unable to do	☐ 4	

PL.6 **Do you have difficulty hearing what is said in a conversation with another person in a <u>quiet room</u>? (Tick one box ONLY)**

No difficulty	☐ 1	→ PL.8
Some difficulty	☐ 2	
A lot of difficulty	☐ 3	
Cannot do at all/Unable to do	☐ 4	

PL.7 **Do you have difficulty hearing what is said in a conversation with another person in a <u>noisier room</u>, even <u>when using your hearing aid</u>? (Tick one box ONLY)**

No difficulty	☐ 1	→ PL.9
Some difficulty	☐ 2	
A lot of difficulty	☐ 3	
Cannot do at all/Unable to do	☐ 4	

PL.8 **Do you have difficulty hearing what is said in a conversation with another person in a <u>noisier room</u>? (Tick one box ONLY)**

No difficulty	☐ 1
Some difficulty	☐ 2
A lot of difficulty	☐ 3
Cannot do at all/Unable to do	☐ 4

PL.9 **Do you have difficulty walking 500 metres on flat terrain without a stick or other walking aid/assistance? (Tick one box ONLY)**

No difficulty	☐ 1
Some difficulty	☐ 2
A lot of difficulty	☐ 3
Cannot do at all/Unable to do	☐ 4

PL.10 **Do you have difficulty walking up or down a flight of 12 steps without a stick or other walking aid/assistance? (Tick one box ONLY)**

No difficulty	☐ 1
Some difficulty	☐ 2
A lot of difficulty	☐ 3
Cannot do at all/Unable to do	☐ 4

PL.11 **Do you have difficulty remembering or concentrating? (Tick one box ONLY)**

No difficulty	☐ 1
Some difficulty	☐ 2
A lot of difficulty	☐ 3
Cannot do at all/Unable to do	☐ 4

If respondent is aged less than 55 years, go to PN.1

PL.12 **Do you have difficulty biting and chewing on hard foods such as a firm apple? (Tick one box ONLY)**

No difficulty	☐ 1
Some difficulty	☐ 2
A lot of difficulty	☐ 3
Cannot do at all/Unable to do	☐ 4

PERSONAL CARE ACTIVITIES

- *These questions <u>do not</u> refer to temporary problems/situations.*

PC.1 **Indicate the level of difficulty usually experienced when doing the following without help/assistance: (Tick one box PER ROW)**

	No Difficulty	Some Difficulty	A lot of Difficulty	Not able to do it alone
Feed myself	☐ 1	☐ 2	☐ 3	☐ 4
Get in and out of bed/chair	☐ 1	☐ 2	☐ 3	☐ 4
Dress and undress myself	☐ 1	☐ 2	☐ 3	☐ 4
Use the toilet	☐ 1	☐ 2	☐ 3	☐ 4
Bathing/showering myself	☐ 1	☐ 2	☐ 3	☐ 4

If 'No Difficulty' is chosen for <u>all</u> options of PC.1, go to question HA.1.

PC.2 **Do you <u>usually get</u> help/assistance when carrying out any such personal care activities? (Tick one box ONLY)**

Yes, with at least one activity	☐ 1
No	☐ 2 → PC.4

If questionnaire is answered by a <u>proxy</u>, go to HA.1.

PC.3 **Would you <u>require more</u> help/assistance when carrying out such personal care activities? (Tick one box ONLY)**

Yes, with at least one activity	☐ 1→ HA.1
No	☐ 2

PC.4 **Would you <u>need</u> help/assistance to carry out any such personal care activities? (Tick one box ONLY)**

This question is about your opinion about whether or not you feel the need for help or assitance.

Yes, with at least one activity	☐ 1
No	☐ 2

HOUSEHOLD ACTIVITIES

- *These questions do not refer to temporary problems/situations.*

HA.1 Indicate the level of difficulty usually experienced when doing the following without help/assistance: (Tick one box PER ROW)

	No Difficulty	Some Difficulty	A lot of Difficulty	Not able to do it alone	Not Applicable
Preparing meals	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Using the telephone	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Shopping	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Managing medication	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Light housework	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Occasional heavy housework	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Managing finances and everyday administrative tasks	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

If 'No Difficulty' is chosen for all options of HA.1, go to question PN.1.

HA.2 Do you usually get help/assistance when carrying out any such household activities? (Tick one box ONLY)

Yes, with at least one activity ☐ 1

No ☐ 2 → HA.4

If questionnaire is answered by a proxy, go to Section C: European Health Care Module

HA.3 Would you require more help/assistance? (Tick one box ONLY)

Yes, with at least one activity ☐ 1→ PN.1

No ☐ 2

HA.4 Would you need help/assistance to carry out any such household activities? (Tick one box ONLY)

This question is about about the participants opinion on whether or not he or she feels the need for help or assitance which is already being provided or can be provided.

Yes, with at least one activity ☐ 1

No ☐ 2

PAIN

PN.1 Overall how much physical pain have you had during the past 4 weeks? (Tick one box ONLY)

None ☐ 1→ MH.1

Very mild ☐ 2

Mild ☐ 3

Moderate ☐ 4

Severe ☐ 5

Very severe ☐ 6

PN.2 **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Tick one box ONLY)**

Not at all	☐ 1
A little	☐ 2
Moderately	☐ 3
Quite a bit	☐ 4
Extremely	☐ 5

MENTAL HEALTH

The next questions are about how you feel and how you have been during the past 2 weeks. Please give the answer that comes closest to the way you have been feeling.

MH.1 **During the <u>past 2 weeks</u> did you …? (Tick one box PER ROW)**

	Not at all	Several days	More than half the days	Nearly every day
Have little interest or pleasure in doing things	☐ 1	☐ 2	☐ 3	☐ 4
Feel down, depressed or hopeless	☐ 1	☐ 2	☐ 3	☐ 4
Have trouble falling or staying asleep, or sleeping too much	☐ 1	☐ 2	☐ 3	☐ 4
Feel tired or have little energy	☐ 1	☐ 2	☐ 3	☐ 4
Have a poor appetite or overate	☐ 1	☐ 2	☐ 3	☐ 4
Feel bad about yourself or feel like a failure	☐ 1	☐ 2	☐ 3	☐ 4
Have trouble concentrating on things, such as reading the newspaper or watching television	☐ 1	☐ 2	☐ 3	☐ 4
Move or speak slowly/restlessly, that other people took notice	☐ 1	☐ 2	☐ 3	☐ 4

For each of the following five statements listed below, indicate which is closest to how you have been feeling over the last 2 weeks.

MH.2 **During the <u>past 2 weeks</u> did you …? (Tick one box PER ROW)**

	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
Feel cheerful and in good spirits	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feel calm and relaxed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feel active and vigorous	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Wake up feeling fresh and rested	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Feel your daily life was filled with things of interest to you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

SECTION C: EUROPEAN HEALTH CARE MODULE

- *In this section all types of hospitals are to be included.*
- *A 'day-patient' is a patient who is formally admitted to a hospital for treatment and/or care but stays for less than 24 hours and does not stay overnight.*
- *An 'in-patient' is a patient who is formally admitted to a hospital for treatment and/or care and stays for a minimum of one night or more.*
- *Both 'day-patient' and 'in-patient' care exclude emergency visits with no admission and exclude out-patient visits.*
- *The time spent in hospital for giving birth (without complications) should not be included in the number of hospital days in inpatient care.*
- *Time spent in hospital as an inpatient for reasons related to antenatal and postnatal period (e.g. complications during pregnancy, miscarriages and complications after giving birth) should be included.*

HC.1 **During the past 12 months, have you been in hospital as an inpatient? (Tick one box ONLY)**

Yes ☐1

No ☐2→ HC.4

HC.2 **How many separate stays in hospital as an inpatient have you had during the past 12 months?**
Only state number of stays which have come to an end during this period.

_____

HC.3 **How many nights in total did you spend in hospital as an inpatient, during the past 12 months?**

_____

HC.4 **During the past 12 months, have you been admitted to hospital for diagnostic treatment or other types of health care as a day-patient, but were not required to stay overnight? (Tick one box ONLY)**
Examples of diagnostic treatments are; colonoscopy, gastroscopy, operation for cataract and varicose veins, operation for D&C in females, dialysis, etc.

Yes ☐1

No ☐2→ HC.6

HC.5 **How many times have you been admitted as a day patient during the past 12 months?**

_____

- The next set of questions are about visits to orthodontists and dentists.

HC.6 **When was the last time you visited an orthodontist on your own behalf *(that is, not while only accompanying a child, spouse, etc.)*? (Tick one box ONLY)**

Less than 6 months ago ☐1

6 months ago or before, but less than 12 months ago ☐2

12 months ago, or before ☐3

Never ☐4

HC.7 **When did you last visit a dentist on your own behalf? (that is, not while accompanying a child, spouse, etc.)? (Tick one box ONLY)**

Less than 6 months ago ☐1

6 months ago or before, but less than 12 months ago ☐2

12 months ago, or before ☐3

Never ☐4→ HC.9

HC.8 **What was the reason for your last visit to the dentist? (Tick one box ONLY)**

Pain/trouble with teeth, gums or mouth	☐ 1
Treatment/follow-up treatment	☐ 2
Routine check-up	☐ 3
Do not know/do not remember	☐ 4
Specify _____	☐ 5

- The next set of questions are about consultations with your general practitioner or family doctor (private or public). Please include visits to your doctor's practice as well as home visits and consultations by telephone.

HC.9 **When was the last time you consulted a <u>private general practitioner (GP)/private family doctor</u>, on your own behalf? (Tick one box ONLY)**

Less than 12 months ago	☐ 1	
12 months ago, or before	☐ 2	→ HC.11
Never	☐ 3	

HC.10 **During the past 4 weeks, how many times did you consult a <u>private GP</u>/<u>private family doctor</u> on your own behalf?**

If none, write 0

_____

HC.11 **When was the last time you consulted a <u>government GP /health centre doctor</u> on your own behalf? (Tick one box ONLY)**

Less than 12 months ago	☐ 1	
12 months ago, or before	☐ 2	→ HC.18
Never	☐ 3	

HC.12 **During the past 4 weeks (up until yesterday), how many times did you consult a <u>government GP/health centre doctor</u> on your own behalf?**

If none, write 0

_____

All respondents who visited private or public GP in the last 12 months are to answer questions HC13 – HC17

HC.13 **During your last visit, did the GP or family doctor spend enough time with you? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	Do not know
Government GP/Health Centre doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Private Family doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

HC.14 **During your last visit, did the GP or family doctor explain things in a way that was easy to understand? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	No need to explain things	Do not know
Government GP/Health Centre doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Private Family doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

HC.15 **During your last visit, did the GP or family doctor give you an opportunity to ask questions or raise concerns about the recommended treatment? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	No need to ask question or raise concerns about recommended treatment	Do not know
Government GP/Health Centre doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Private Family doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

HC.16 **During your last visit, did the GP or family doctor involve you as much as you wanted to when it came to taking decisions about your care and treatment? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	Did not want to be involved	No decisions about care and treatment were made	Do not know
Government GP/Health Centre doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Private Family doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

HC.17 **Overall, how would you rate the quality of the consultation of your last visit with the GP/family doctor? (Tick one box PER ROW)**

	Very Good	Good	Fair	Bad	Very Bad	Do not know
Government GP/Health Centre doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Private Family doctor	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

- For the following questions consider consultations with medical or surgical specialists (public or private). Include visits to doctors as outpatient or visits to emergency departments both public and private. Visits to doctors at the workplace/school are to be included as well.
- Do not include contact while in hospital as an in-patient or day-patient.

HC.18 **When was the last time you consulted a <u>private medical or surgical specialist</u> on your own behalf? (Tick one box ONLY)**

Less than 12 months ago	☐ 1
12 months ago, or before	☐ 2 → HC.20
Never	☐ 3 → HC.20

HC.19 **During the past 4 weeks (up until yesterday), how many times did you consult a <u>private specialist</u> on your own behalf?**

If none, write 0

_____

HC.20 **When was the last time you consulted a <u>government medical or surgical specialist</u> on your own behalf? (Tick one box ONLY)**

Less than 12 months ago	☐ 1
12 months ago, or before	☐ 2 → HC.27
Never	☐ 3 → HC.27

HC.21 **During the past four weeks (up until yesterday), how many times did you consult a government specialist on your own behalf?**

If none, write 0

_____

All respondents who visited private or public medical or surgical specialist in the last 12 months are to answer questions HC22-HC26

HC.22 **During your last visit, did the specialist spend enough time with you? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	Do not know
Government specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Private specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

HC.23 **During your last visit, did this specialist explain things in a way that was easy to understand? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	No need to explain things	Do not know
Government specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Private specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

HC.24 **During your last visit, did this specialist give you an opportunity to ask questions or raise concerns about recommended treatment? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	No need to ask question or raise concerns about recommended treatment	Do not know
Government specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Private specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

HC.25 **During your last visit did this specialist involve you as much as you wanted to when it came to making decisions about your care and treatment? (Tick one box PER ROW)**

	Yes, definitely	Yes, to some extent	No, not really	No, definitely not	Did not want to be involved	No decisions about care and treatment were made	Do not know
Government specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
Private specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

HC.26 **Overall, how would you rate the quality of the consultation during your last visit? (Tick one box PER ROW)**

	Very Good	Good	Fair	Bad	Very Bad	Do not know
Government specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Private specialist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

HC.27 **During the past 12 months, which of the following have you visited on your own behalf? (Tick ALL that apply)**

The option 'None' can only be chosen on its own.

Physiotherapist	☐ 1
Chiropractor/Osteopath	☐ 2
Dietician/Nutritionist	☐ 3
Optometrist/Ophthalmic nurse	☐ 4
Psychologist or psychotherapist	☐ 5
Psychiatrist	☐ 6
Podiatrist/podologist	☐ 7
Acupuncturist	☐ 8
Other (specify) _____	☐ 9
None	☐ 10

HC.28 **During the past 12 months, have you yourself used or received any home care services? (Tick one box ONLY)**

Yes	☐ 1
No	☐ 2 → MD.1

HC.29 **During the past 12 months, have you yourself used any of the following home care services provided by the private and/or public sector? (Tick ALL that apply)**

	Private		Public	
	Yes	No	Yes	No
Home care service provided by a nurse	☐ 1	☐ 2	☐ 1	☐ 2
Home help by a carer (non-nursing services)	☐ 1	☐ 2	☐ 1	☐ 2
"Meals on wheels"	☐ 1	☐ 2	☐ 1	☐ 2
Handyman service	☐ 1	☐ 2	☐ 1	☐ 2
Telecare	☐ 1	☐ 2	☐ 1	☐ 2
Other (specify) _____	☐ 1	☐ 2	☐ 1	☐ 2

MD.1 **During the past two weeks, have you used any medicines that were prescribed to you by a doctor? (Tick one box ONLY)**

Exclude contraceptives pills/hormones used solely for contraception.

Yes	☐ 1
No	☐ 2 → MD.3

MD.2 **What were the medicines for? (Tick ALL that apply)**

Hand respondent show card 2

Asthma	☐ 1
Chronic bronichitis, chronic obstructive pulmonary disease, emphysema	☐ 2
High blood pressure	☐ 3
Lowering the blood cholesterol level	☐ 4
Pain relief	☐ 5
Heart disease	☐ 6
Diabetes	☐ 7
Allergic symptoms (eczema, rhinitis, hay fever)	☐ 8
Heart burn	☐ 9
Cancer treatment	☐ 10
Depression	☐ 11
Tension/anxiety	☐ 12
Osteoporosis	☐ 13
Sleeping tablets	☐ 14
Antibiotics (such as penicillin)	☐ 15
Hypothyroidism	☐ 16
Other (specify) _____	☐ 17

MD.3 **During the past two weeks, have you used any medicines, dietary supplements, herbal medicines, vitamins or other supplements <u>not</u> prescribed or recommended by a doctor? (Tick one box ONLY)**

Yes	☐ 1
No	☐ 2 → PA.1

MD.4 **What were the medicines/supplements for? (Tick ALL that apply)**

Hand respondent show card 3

Pain relief	☐ 1
Cold, flu or sore throat	☐ 2
Allergic symptoms (Eczema, rhinitis, hay fever)	☐ 3
Heart burn	☐ 4
Bone/joint care supplements	☐ 5
Omega-3/fish oils	☐ 6
Any other vitamins, minerals or tonics	☐ 7

PA.1 **When was the last time you were vaccinated against influenza? (Tick one box ONLY)**

Specify month _____ ☐1

Specify year _____

Too long ago (before 31st December 2017) ☐2

Never ☐3 → PA.3

PA.2 **Did you buy the vaccine yourself or did you get the free one supplied by the Ministry for Health? (Tick one box ONLY)**

Bought it ☐1

Got it for free ☐2

PA.3 **When was the last time a health professional …? (Tick one box PER ROW)**

	Within the past 12 months	12 months or more, but less than 3 years ago	3 years or more, but less than 5 years ago	5 years ago or more	Never
Measured your blood pressure	☐1	☐2	☐3	☐4	☐5
Measured your blood cholesterol	☐1	☐2	☐3	☐4	☐5
Measured your blood glucose	☐1	☐2	☐3	☐4	☐5

PA.4 **When was the last time you had a stool sample tested for blood (faecal occult blood test)? (Tick one box ONLY)**

Within the past 12 months ☐1

12 months or more, but less than 2 years ago ☐2

2 years or more, but less than 3 years ago ☐3

3 years or more ☐4 → PA.6

Never ☐5 → PA.6

PA.5 **Where did you have the latest stool sample (FOB) tested for blood? (Tick one box ONLY)**

National Screening Centre ☐1

Mater Dei Hospital/Gozo General Hospital ☐2

Private Hospital/Private Clinic ☐3

PA.6 **When was the last time you had a colonoscopy? (Tick one box ONLY)**

Within the past 12 months ☐1

12 months or more, but less than 5 years ago ☐2

5 years or more, but less than 10 years ago ☐3

10 years ago or more ☐4

Never ☐5

*If respondent is **male**, go to question UN.1.*

PA.7 **When was the last time you had a mammogram (breast X-ray)? (Tick one box ONLY)**

Within the past 12 months	☐ 1
More than 12 months ago, but not more than 2 years ago	☐ 2
More than 2 years ago, but less than 3 years ago	☐ 3
More than 3 years ago	☐ 4
Never	☐ 5 → PA.10
Not applicable	☐ 6

PA.8 **During your last mammogram, was an ultrasound of the breast also conducted? (Tick one box ONLY)**

Yes	☐ 1
No	☐ 2

PA.9 **Where did your most recent mammogram take place? (Tick one box ONLY)**

National Screening Centre	☐ 1
Mater Dei Hospital/Gozo General Hospital	☐ 2
Private Hospital/Private Clinic	☐ 3

PA.10 **When was the last time you had a cervical smear test? (Tick one box ONLY)**

Within the past 12 months	☐ 1
More than 12 months ago, but not more than 2 years ago	☐ 2
More than 2 years ago, but less not more than 3 years ago	☐ 3
More than 3 years ago	☐ 4
Never	☐ 5 → UN.1
Not applicable	☐ 6

PA.11 **Where did you have the most recent cervical smear test conducted? (Tick one box ONLY)**

National Screening Centre	☐ 1
Mater Dei Hospital/Gozo General Hospital	☐ 2
Private Hospital/Private Clinic	☐ 3
Government Polyclinic	☐ 4

UN.1 **During the past 12 months, did you need any health care services? (Tick one box ONLY)**

All forms of healthcare including in-patient, outpatient, day-patients, emergency, specialist and GP visits as well as private and public consultations and hospitals should all be included.

Yes ☐1

No ☐2 → SA.1

UN.2 **During the past 12 months, have you experienced delay in getting health care /because of any of the following reasons? (Tick one box PER ROW)**

	Yes	*No*
Date of appointment given was too far off	☐1	☐2
Distance/transporting problems	☐1	☐2
Family related commitments	☐1	☐2
Work related commitments	☐1	☐2

UN.3 **During the past 12 months, did you find yourself needing any of the following health care services, but could not afford to get them? (Tick one box PER ROW)**

	Yes	*No*	No need for this type of care in past 12 months
Medical examination or treatment	☐1	☐2	☐3
Dental examination or treatment	☐1	☐2	☐3
Prescribed medicines	☐1	☐2	☐3
Mental health care (e.g. psychologist or psychiatrist)	☐1	☐2	☐3

HEALTH INSURANCE

SA.1 **Are you covered by a private health insurance? (Tick one box ONLY)**

Yes ☐1

No ☐2 → BMI.1

SA.2 **Who pays for this insurance? (Tick one box ONLY)**

Myself ☐1

Employer ☐2

Both (myself and the employer) ☐3

Do not know ☐4

Other (specify) _____ ☐5

SA.3 **What does this insurance cover? (Tick ALL that apply)**

Consultations/outpatient ☐1

Hospital treatment, local ☐2

Hospital treatment, abroad ☐3

SECTION D: EUROPEAN HEALTH DETERMINANTS MODULE

*If questionnaire is being answered by **proxy**, go to FV.1*

BMI.1 **How tall are you without shoes? (Tick one box ONLY)**

Specify_____ cm ☐1

Do not know ☐2

BMI.2 **How much do you weigh without clothes and shoes? (Tick one box ONLY)**

Specify_____ kg ☐1

Do not know ☐2

PHYSICAL ACTIVITY

- *Next, I am going to ask you about the time you spend doing different types of physical activity in a typical week.*
- *In this section, when referring to work, keep in mind any sort of paid/unpaid work (e.g. houseowork, studying or training etc.) is included.*
- *Please answer these questions even if you do not consider yourself to be a physically active person.*

PE.1 **When you are working, which of the following best describes what you do? (Tick one box ONLY)**

Mostly sitting or standing ☐1

Mostly walking or tasks of moderate physical effort ☐2

Mostly heavy labour or physically demanding work ☐3

Not performing any working tasks ☐4

- *The next questions exclude the work-related physical activities that you have already mentioned.*
- *Now I would like to ask you about the way you usually get to and from places, for example to work, to school or for shopping.*

PE.2 **During a typical week, on how many days do you walk for at least 10 minutes continuously to get to and from places? (Tick one box ONLY)**

Specify_____ days ☐1

I never carry out such physical activities ☐2→ PE.4

PE.3 **How much time do you spend walking in a continuous manner in order to get to and from places on a typical day? (Tick one box ONLY)**

10 minutes or more but less than 30 minutes per day ☐1

30 minutes or more but less than 1 hour per day ☐2

1 hour or more, but less than 2 hours per day ☐3

2 hours or more, but less than 3 hours per day ☐4

3 hours or more per day ☐5

PE.4 **During a typical week, on how many days do you ride a bicycle for at least 10 minutes continuously to get to and from places? (Tick one box ONLY)**

Specify_____ days ☐1

I never carry out such physical activities ☐2→ PE.6

PE.5 **How much time do you spend bicycling in a continuous manner in order to get to and from places on a typical day? (Tick one box ONLY)**

10 minutes or more but less than 30 minutes per day	☐ 1
30 minutes or more but less than 1 hour per day	☐ 2
1 hour or more, but less than 2 hours per day	☐ 3
2 hours or more, but less than 3 hours per day	☐ 4
3 hours or more per day	☐ 5

- *The next questions exclude the work and transport activities that you have already mentioned. Now I would like to ask you about sports, fitness and recreational (leisure) physical activities.*
- *Now I will ask you about activities that make you breathe somewhat harder than normal such as brisk walking, cycling at a regular pace or tennis.*

PE.6 **During a typical week, on how many days do you carry out sports, fitness or recreational (leisure) physical activities that cause at least a small increase in breathing or heart rate, for at least 10 minutes continuously? (Tick one box ONLY)**

Specify_____ days	☐ 1
I never carry out such physical activities	☐ 2 → PE.8

PE.7 **How much time in total do you spend on such sporting activities during a typical week? (Tick one box ONLY)**

Indicate in hours or minutes

Specify_____ hours	☐ 1
Specify_____ minutes	☐ 2

- *Now I will ask you about vigorous activities which make you breathe much harder than normal such as fast cycling or aerobics. Remember I refer only to sports, fitness and recreational (leisure) physical activities.*

PE.8 **During a typical week, on how many days do you carry out vigorous sports, fitness or recreational (leisure) physical activities that make you breathe much harder than normal for at least 10 minutes continuously? (Tick one box ONLY)**

Specify_____ days	☐ 1
I never carry out such physical activities	☐ 2 → PE.10

PE.9 **How much time in total do you spend on such vigorous sporting activities during a typical week? (Tick one box ONLY)**

Indicate in hours or minutes

Specify_____ hours	☐ 1
Specify_____ minutes	☐ 2

PE.10 **In a typical week, on how many days do you carry out physical activities designed to strengthen your muscles such as resistance training, weight lifting, push-ups, sit ups etc? Include all such activities even if you have mentioned them before. (Tick one box ONLY)**

Specify_____ days	☐ 1
I never carry out such physical activities	☐ 2

- *For the next set of questions, I will ask you about leisure walking. Exclude any walking done to get to and from places and brisk walking and focus only on leisure (non-brisk) walks.*

PE.11 **In a typical week, on how many days do you go for leisure walks (not brisk) for at least 10 minutes continuously for fitness or recreation (leisure)? (Tick one box ONLY)**

Specify_____ days ☐1

I never carry out such physical activities ☐2→ PE.13

PE.12 **How much time in total do you spend walking (not brisk) for recreation (leisure) during a typical week? (Tick one box ONLY)**

Indicate in hours or minutes
If exact number of days is not known, give an approximation

Specify_____ hours ☐1

Specify_____ minutes ☐2

PE.13 **How much time do you spend sitting and reclining on a typical day (exclude time spent sleeping)? (Tick one box ONLY)**

Indicate in hours or minutes

Specify_____ hours ☐1

Specify_____ minutes ☐2

NUTRITION

FV.1 **How often do you eat fruit, excluding juice squeezed from fresh fruit or made from concentrate? (Tick one box ONLY)**

*Frozen, dried, canned, etc. fruits should be **included***
*Any fruit juices should be **excluded***

Daily ☐1

4 to 6 times a week ☐2

1 to 3 times a week ☐3

Less than once a week ☐4

Never ☐5

→ FV.3

FV.2 **How many portions of fruit of any sort, excluding juice, do you eat per day?**

Hand respondent show card 4
To answer in number of portions

_____

FV.3 **How often do you eat vegetables or salad, excluding potatoes and fresh soup/juice or soup/juice made from concentrate? (Tick one box ONLY)**

*Frozen, dried, canned, etc. vegetables should be **included***
*Any kind of vegetable juices or soups (warm and cold) should be **excluded***

Daily ☐1

4 to 6 times a week ☐2

1 to 3 times a week ☐3

Less than once a week ☐4

Never ☐5

→ FV.5

FV.4 **How many portions of vegetables or salad, of any sort excluding soup/juice and potatoes do you eat each day?**

Hand respondent show card 4
To answer in number of portions

_____

FV.5 **How often do you drink 100% pure fruit, vegetable juice or freshly made vegetable soup?**
Excluding soup/juice made from concentrate or sweetened juice? **(Tick one box ONLY)**

- Daily ☐ 1
- 4 to 6 times a week ☐ 2
- 1 to 3 times a week ☐ 3
- Less than once a week ☐ 4
- Never ☐ 5

NU.1 **Is salt added to your meals during cooking (excluding cubes)? (Tick one box ONLY)**

- Almost always ☐ 1
- Occasionally ☐ 2
- Never (or low salt alternative) ☐ 3
- Do not know ☐ 4

NU.2 **Do you add salt to your meals whilst eating? (Tick one box ONLY)**

- Almost always ☐ 1
- Occasionally ☐ 2
- Never (or low salt alternative) ☐ 3

NU.3 **How often do you drink sugar free soft drinks? (Tick one box ONLY)**

- Daily ☐ 1
- 4 to 6 times a week ☐ 2
- 1 to 3 times a week ☐ 3
- Less than once a week ☐ 4
- Never ☐ 5

→ NU.5

NU.4 **How many glasses do you drink each day? (Tick one box ONLY)**
Hand respondent show card 5

NU.5 **How often do you drink regular soft drinks? (Tick one box ONLY)**

- Daily ☐ 1
- 4 to 6 times a week ☐ 2
- 1 to 3 times a week ☐ 3
- Less than once a week ☐ 4
- Never ☐ 5

→ NU.7

NU.6 **How many glasses do you drink each day? (Tick one box ONLY)**
Hand respondent show card 5

NU.7 **On how many days during the last week (7-day period) have you consumed the following foods? (Tick one box PER ROW)**

	Never	1-2 days	3-5 days	6-7 days
Chicken/rabbit	☐ 1	☐ 2	☐ 3	☐ 4
Fish	☐ 1	☐ 2	☐ 3	☐ 4
Meat	☐ 1	☐ 2	☐ 3	☐ 4
Meat products	☐ 1	☐ 2	☐ 3	☐ 4
Sweet pastries (Including biscuits, cakes, fancy cakes, gateaux etc.)	☐ 1	☐ 2	☐ 3	☐ 4
Sweets (Including chocolates etc.)	☐ 1	☐ 2	☐ 3	☐ 4

NU.8 **Do you have children aged between 0 and 3 years? (Tick one box ONLY)**

Yes ☐1

No ☐2 → EN.1

NU.9 **Was your child breastfed? (Tick one box ONLY)**

If more than one child is aged 0 to 3 years, these questions should be answered in relation to the eldest child

Yes, child is still breast feeding
Including partial breastfeeding ☐1

Yes, child was breastfed
Including partial breastfeeding ☐2 → NU.11

No, never breastfed ☐3 → EN.1

Do not know ☐4 → EN.1

NU.10 **How old is your child?**

Age in number of weeks

_____weeks → NU.12

NU.11 **For how many weeks was your child breastfed?**

_____

NU.12 **At what age did your child start to consume foods or liquids other than breast milk? (Tick one box ONLY)**

To be answered in number of weeks

E.g. of liquids; water, herbal teas, juices, animal milk etc.

_____weeks ☐1

Child has not started to consume other liquids apart from breast milk ☐2

ENVIRONMENT WHERE YOU LIVE

EN.1 **State whether you have any of the following problems/issues in your current accommodation: (Tick one box PER ROW)**

	Yes	No
Overcrowding	☐1	☐2
Leaking roof, damp floors/walls/foundation, or rot in window frames/floor	☐1	☐2
Too dark/not enough light	☐1	☐2
Noise from neighbours or noise from outside E.g. Traffic, business, factories, etc.	☐1	☐2
Pollution, grime or other environmental problems in the area	☐1	☐2
Crime, violence or vandalism in the area	☐1	☐2
Insufficient ventilation	☐1	☐2
Insufficient privacy	☐1	☐2

*If questionnaire is being answered by a proxy the **Interviewer** is to go to **Section E***
and the proxy is to go to the self-completion questionnaire

SOCIAL SUPPORT AND INFORMAL CARE

SS.1 **How many people in your life are so close to you that you can count on them if you have a serious problem? (Tick one box ONLY)**

- None ☐ 1
- 1 or 2 ☐ 2
- 3 to 5 ☐ 3
- 6 or more ☐ 4

SS.2 **How much concern and positive interest do you feel people show you? (Tick one box ONLY)**

- A lot of concern and interest ☐ 1
- Some concern and interest ☐ 2
- Not sure ☐ 3
- Little concern and interest ☐ 4
- No concern and interest ☐ 5

SS.3 **How easy is it to get practical help from neighbours should you need it? (Tick one box ONLY)**

- Very easy ☐ 1
- Easy ☐ 2
- Possible ☐ 3
- Difficult ☐ 4
- Very difficult ☐ 5

IC.1 **Do you provide care or assistance to one or more persons suffering from an age-related problem, chronic health condition or infirmity, for at least once a week? (Tick one box ONLY)**

Respondent should exclude any care provided as part of their profession

- Yes ☐ 1
- No ☐ 2 → SC.1

IC.2 **Is/Are this/these person(s) members of your family? (Tick one box ONLY)**

Respondent is to answer in relation to whom they are providing most care

- Yes ☐ 1
- No ☐ 2

IC.3 **For how many hours per week do you provide care or assistance? (Tick one box ONLY)**

- Less than 10 hours per week ☐ 1
- 10 hours or more, but less than 20 hours per week ☐ 2
- 20 hours per week or more ☐ 3

→ SC.1

This section is to be filled by the interviewer.

SECTION E: TECHNICAL SURVEY VARIABLES

TS.1 Date of interview:

D	D	M	M	Y	Y	Y	Y

TS.2 Language used to complete questionnaire: (Tick one box ONLY)

English ☐1

Maltese ☐2

TS.3 The questionnaire was answered by: (Tick one box ONLY)

Selected Individual ☐1→ TS.5

Proxy – another member of the selected individual's household ☐2

Proxy – someone not from the same household as the selected individual ☐3

TS.4 What is the reason for having a proxy respondent answer this questionnaire? (Tick ALL that apply)

Sample person has a cognitive impairment ☐1

Sample person is physically debilitated ☐2

Sample person has a hearing/speech problem ☐3

Sample person cannot speak English or Maltese ☐4

Other (specify) _____ ☐5

TS.5 Indicate the amount of time it took to complete the questionnaire.

Specify in hours and minutes.

_____

TS.6 Locality of residence of respondent:

_____

TS.7 Name and Surname of interviewer:

_____

TS.8 Interviewer ID Card:

_____

TS.9 Questionnaire Number:

_____

TS.10 The self-completion form is answered via (Tick one box ONLY):

Printed questionnaire ☐1

Tablet ☐2

TS.11 **Where there any difficulties in answering any of the questions (Tick one box ONLY):**

Yes ☐1

No ☐2

If yes, specify here:

_____

_____

TS.12 **Where there any questions which the respondent was particularly reluctant to answer? (Tick one box ONLY):**

Yes ☐1

No ☐2

If yes, specify here:

_____

_____