



CANCER PATIENTS AND CANCER SURVIVORS QUESTIONNAIRE

COUNTYREGION/ CODE: _____ / _____ /

HEALTH FACILITY CODE: _____ / _____ /

FACILITY LEVEL: _____ / _____

SECTION I: Socio-demographic section

1.	Sex		Male		Female	
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No	Questions	Categories
2.	Are you on treatment?	
		Yes
		No
3.	Age (or birth date) _____	18-24 years old
		25-34 years old
		35-44 years old
		45-54 years old
		55-64 years old
		65-74 years old
		75 years or older
		refused to answer
4.	What is the highest level of school you have completed?	1. Never attended school
		2. Nursery to class 5
		3. Class 6 to 7
		4. Form 1 to 2
		5. Form 3 to 4
		6. Form 5 to 6
		7. Trade/technical/ vocational training

		8. First Degree
		9. Higher degree
		10. Other (Specify)
5.	What is your marital status?	Single (never married)
		Married
		Cohabiting
		Widowed
		Divorced/ Separated
		Other (specify) _____
6.	How many people live with you?	Adult
		Children
7.	What is your current occupation?	1. Student
		2. Employed/Professional (Teacher, doctor, nurse, manager, accountant etc.)
		3. Casual worker (attendant in hotel, bar, shop, house help, gardener)
		4. Housewife
		5. Business (self-employed)
		6. Farmer (large scale, subsistent farming, gardening)
		7. Unemployed
		8. Other(specify) _____
8.	What was your occupation prior to the illness?	1. Student
		2. Employed/Professional (Teacher, doctor, nurse, manager, accountant etc.)
		3. Casual worker (attendant in hotel, bar,

		shop, house help, gardener) 4. Housewife 5. Business (self-employed) 6. Farmer (large scale, subsistent farming, gardening) 7. Unemployed 8. Other(specify)
9.	What is your main source of income?	
10.	Approximately how much is your household income per month?	
11.	Where is your home town/city/village?	Write out patient' answer: village/town/city _____
		Don't know
		Refused to answer

SECTION II: PATIENTS CARE PATHWAYS

11. We are now going to talk about your journey since you first felt unwell until now. Tell me when did you first feel you were unwell?

How long ago?	What happened next?	What did you do?	Where was this?	What was done?	How much did you pay? (note down if they paid it with their own funds or received help from other people)	Did any insurance cover part of the cost? Which?	How did you travel (if in location, patient only says local healer, or local market, ask how long it took to get there)	How much did transport cost (if mode of transport prompt incurrence of costs)

Patient's perspective on their experiences

12.	<p>Was there anything you needed which you did not get?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes,</p> <table border="1" data-bbox="248 562 1466 709"> <thead> <tr> <th data-bbox="248 562 573 604">What?</th> <th data-bbox="573 562 792 604">Not available</th> <th data-bbox="792 562 1011 604">Too expensive</th> <th data-bbox="1011 562 1214 604">Too far</th> <th data-bbox="1214 562 1466 604">unacceptable</th> </tr> </thead> <tbody> <tr> <td data-bbox="248 604 573 636"></td> <td data-bbox="573 604 792 636"></td> <td data-bbox="792 604 1011 636"></td> <td data-bbox="1011 604 1214 636"></td> <td data-bbox="1214 604 1466 636"></td> </tr> <tr> <td data-bbox="248 636 573 667"></td> <td data-bbox="573 636 792 667"></td> <td data-bbox="792 636 1011 667"></td> <td data-bbox="1011 636 1214 667"></td> <td data-bbox="1214 636 1466 667"></td> </tr> <tr> <td data-bbox="248 667 573 709"></td> <td data-bbox="573 667 792 709"></td> <td data-bbox="792 667 1011 709"></td> <td data-bbox="1011 667 1214 709"></td> <td data-bbox="1214 667 1466 709"></td> </tr> </tbody> </table>	What?	Not available	Too expensive	Too far	unacceptable															
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13.	<p>Was there anything you decided not to do because it was unacceptable to you? Yes, no</p> <p>If yes, give details</p> <p>_____</p> <p>—</p> <p>(check if they consulted alternative health systems)</p> <p>If they did:</p>																				
14.	<p>Why did you resort to alternative options?</p> <p>If they did not?</p> <p>Did you ever consider alternative medicine options? Yes _____, No _____</p> <p>If no, why not? _____</p> <p>—</p>																				
15.	<p>Given the story you have just told, what was done well?</p>	<table border="1" data-bbox="1079 1396 1466 1864"> <tr> <td data-bbox="1079 1396 1466 1438">Early diagnosis;</td> </tr> <tr> <td data-bbox="1079 1438 1466 1480">Rapid diagnosis;</td> </tr> <tr> <td data-bbox="1079 1480 1466 1522">Short wait for test;</td> </tr> <tr> <td data-bbox="1079 1522 1466 1564">Short wait for surgery;</td> </tr> <tr> <td data-bbox="1079 1564 1466 1648">Good attitude of professionals</td> </tr> <tr> <td data-bbox="1079 1648 1466 1690">Effective treatment;</td> </tr> <tr> <td data-bbox="1079 1690 1466 1732">Good pain management;</td> </tr> <tr> <td data-bbox="1079 1732 1466 1864">Insurance coverage available;</td> </tr> </table>	Early diagnosis;	Rapid diagnosis;	Short wait for test;	Short wait for surgery;	Good attitude of professionals	Effective treatment;	Good pain management;	Insurance coverage available;											
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		Other specify.....
16.	Has this experience impacted on your work? [check all that apply] <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A ____ Unable to work____. ____ Less time working, how much time? _____ ____ Changed own activity, please specify_____ ____ Changed activity by someone else, please specify_____	
17.	Have you told your friends or family about your illness?	My family
		My friends
		Both
		Neither
18.	Who are your main sources of support?	Community health workers
		Volunteers
		Family
		Friends
		Support groups
		Faith groups
	Other _____	
	Thank you very much. Anything else you would like to tell us	
