

Project title "Understanding gut-microbiome interactions following mass deworming against soil-transmitted helminths (STHs) among young Ethiopian schoolchildren."

SCHOOL, CHILD, AND INTERVIEWER IDENTIFICATION

School name <u>Seto yido</u>	Child Name <u>Simegn Delife</u>	ID <u>15</u>
GRADE <u>7 E</u>	Interviewer Name <u>Abeba T.</u>	Child data <input checked="" type="checkbox"/>
		Family data <input checked="" type="checkbox"/>
		DATE OF INTERVIEW (dd/mm/yyyy) <u>28/7/13</u>

ELIGIBILITY REQUIREMENTS

A. Has the parent consented?	<input checked="" type="checkbox"/> Yes Go to question B	<input type="checkbox"/> No Stop interview
B. Has the child assented?	<input checked="" type="checkbox"/> Yes Go to question 1	<input type="checkbox"/> No Stop interview

MEASURES/OBSERVATIONS TAKEN BY THE INTERVIEWER

1. Indicate if child attends morning, afternoon, or evening Class	<input type="checkbox"/> Morning (1) <input checked="" type="checkbox"/> Afternoon (2) <input type="checkbox"/> Evening (3)
1. What is the sex of the child?	<input checked="" type="checkbox"/> Girl (1) <input type="checkbox"/> Boy (0)
2. What is age of the child? (in year)	Age <u>14</u> <input type="checkbox"/> Don't know (99)
3. Weight of the child?	<u>46</u> kg <input type="checkbox"/> Not measured
4. Height of the child?	<u>1.46</u> Meters <input type="checkbox"/> Not measured
5. What was the mode of delivery of the child?	<input checked="" type="checkbox"/> Vaginal (1) <input type="checkbox"/> C-section (2) <input type="checkbox"/> Don't know (99)
6. How many people live in your house? Enumerate them...	<u>4</u> (including you) <input type="checkbox"/> Don't know (99)
7. How many older brothers/sisters does your child have who are alive now?	<u>1</u>
8. How many children younger than 12 years old live in your house?	<u>1</u> Children <input type="checkbox"/> Don't know (99)
9. Has your child ever had vaccination	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
10. Is there BCG scar (please see the right arm)	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
11. In the past two weeks, has your child had fever	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
12. If yes, Q 11. How many times per week	
13. in the past two weeks has your child has diarrhea	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
14. If yes, Q 13. How many times per week	
15. in the past two weeks has your child has cough	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
16. If yes, Q 115. How many times per week	
17. The child's fingernails trimmed?	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
18. Are the child's fingernails dirty?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
19. How often do you trim your fingernail	<input checked="" type="checkbox"/> Once/week (1) <input type="checkbox"/> Once /two weeks (2) <input type="checkbox"/> Less than once per month (0) <input type="checkbox"/> Don't know (99)
20. A. Presence of toilet in the school?	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
B. If yes, does the latrine have doors?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
C. Flies observed in/around latrine	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
D. Visible stool observed on latrine floor	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)

LEVEL OF KNOWLEDGE ON SOIL-TRANSMITTED HELMINTHS

I. Which names have you heard before? Multiple answers possible.	<input checked="" type="checkbox"/> Ascaris (0) <input type="checkbox"/> Trichuris (1) <input type="checkbox"/> Hookworms (2) <input checked="" type="checkbox"/> HIV/AIDS (3) <input checked="" type="checkbox"/> Intestinal worms (4) <input checked="" type="checkbox"/> Malaria (5) <input checked="" type="checkbox"/> Tuberculosis (6) <input type="checkbox"/> Schistosoma/bilharzia (7) <input type="checkbox"/> Don't know (99)
II. Who told you about these names? Multiple answers possible.	<input checked="" type="checkbox"/> Family member (0) <input type="checkbox"/> Health professional (1) <input type="checkbox"/> Teachers (2) <input type="checkbox"/> Media (3) <input type="checkbox"/> Others <input type="checkbox"/> Don't know (99)
III. A- Do you know how intestinal worms / parasites are transmitted?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
B- If yes, how?	1. 2.
<input type="checkbox"/> Not Applicable (NA)	

		3. 4.
IV.	A- Do you know why worms / parasites are bad for your health?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- If yes, how? <input type="checkbox"/> Not Applicable (NA)	1. 2. 3. 4.
V.	A- Do you know how you can avoid getting these worms / parasite infection?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- If yes, how? <input type="checkbox"/> Not Applicable (NA)	1. 2. 3. 4.

QUESTIONNAIRE ON RISK FACTORS*

1.	A- Where do you live?	<input checked="" type="checkbox"/> Urban (0) <input type="checkbox"/> Suburb (1) <input type="checkbox"/> Rural (2) <input type="checkbox"/> Don't know (99)
	B- Where do you live (kebele, street, passage, sector, block, lot)?	Address <u>Seto</u> <input type="checkbox"/> Not Applicable (NA) <input type="checkbox"/> Don't know (99)
	C- Family occupation	<u>Employed (missionary)</u>
2.	Maternal educational status? <input type="checkbox"/> Not Applicable (NA)	<input checked="" type="checkbox"/> Illiterate(0) <input type="checkbox"/> Primary school (1) <input type="checkbox"/> High school (2) <input type="checkbox"/> Higher Education (3) <input type="checkbox"/> Don't know (99)
3.	What materials your house ground made from?	<input checked="" type="checkbox"/> Cemented (1) <input type="checkbox"/> Plastic covered (2) <input type="checkbox"/> Dust (0) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
4.	Is your kitchen within your house or separated?	<input type="checkbox"/> Within house (0) <input checked="" type="checkbox"/> Separated (2) <input type="checkbox"/> Don't know (99)
5.	If separated, What materials your house ground made from?	<input type="checkbox"/> Cemented (1) <input type="checkbox"/> Plastic covered (2) <input checked="" type="checkbox"/> Dust (0) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
6.	If separated, which of the following house structures does your kitchen have? Multiple answers possible	<input checked="" type="checkbox"/> Roof (1) <input checked="" type="checkbox"/> Wall (2) <input type="checkbox"/> None (0) <input type="checkbox"/> Don't know (99)
7.	In your house, do you Cook with gas, kerosene, coal, or wood?	<input checked="" type="checkbox"/> Wood (0) <input type="checkbox"/> Gas (1) <input checked="" type="checkbox"/> Coal (2) <input type="checkbox"/> Kerosene (3) <input type="checkbox"/> Electric(4) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
8.	Do you have electricity at your house?	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
9.	Does your family own a radio?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
10.	Does your family own a television?	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
11.	A- Does your family member own a phone?	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- How your family uses the phone?	<input checked="" type="checkbox"/> Call only (0) <input type="checkbox"/> Call/radio/internet (1) <input type="checkbox"/> Don't know (99)
12.	Is there any animal in your house/compound?	<input checked="" type="checkbox"/> Cattles (0) <input type="checkbox"/> Sheep/cattle (1) <input type="checkbox"/> Chicken (2) <input checked="" type="checkbox"/> Pet animals (3) <input type="checkbox"/> None (4) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
13.	A- Do you have potable water in your house?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	C- If not, where do you get your water from? <input type="checkbox"/> Not Applicable (NA)	<input type="checkbox"/> Neighbour (0) <input type="checkbox"/> River (1) <input type="checkbox"/> Well (2) <input type="checkbox"/> Truck (3) <input type="checkbox"/> Tank (4) <input checked="" type="checkbox"/> Public fountain (4) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
14.	A- In your house do you drink your water directly or do you treat it (boiling or bleaching)?	<input checked="" type="checkbox"/> Directly(1) <input type="checkbox"/> Treated (0) <input type="checkbox"/> Don't know (99)
	B- If you treat, how you treat water	<input type="checkbox"/> Boil (0) <input type="checkbox"/> Chemical (1) <input type="checkbox"/> Filter (2) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
15.	A- Do your family own latrine?	<input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- Is your latrine inside or outside the house?	<input type="checkbox"/> Inside (1) <input checked="" type="checkbox"/> Outside (0) <input type="checkbox"/> Don't know (99)
	C- If outside, distance from your house? (Approximate)	<u>20</u> meters <input type="checkbox"/> Don't know (99)
	D- Distance between latrine and kitchen? (Approximate)	<u>20</u> meters <input type="checkbox"/> Don't know (99)

	Is your latrine connected with the sewage system, a ditch, the river, or a well?	<input type="checkbox"/> Sewage (0) <input type="checkbox"/> Ditch (1) <input type="checkbox"/> River (2) <input checked="" type="checkbox"/> Well (3) <input type="checkbox"/> Others _____ <input type="checkbox"/> Don't know (99)
17.	Do you bath in river – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input type="checkbox"/> Sometimes (1) <input checked="" type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
18.	Do you wash clothes in river – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input checked="" type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
19.	Do you defecate in the open field – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input type="checkbox"/> Sometimes (1) <input checked="" type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
20.	Do you use school latrine – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input checked="" type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
21.	Do you use toilet paper to wipe your bum after you have defecated – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input checked="" type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
22.	A- Do you wash your hands after going to the toilet – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input checked="" type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
	B- How do you wash your hands after going to the toilet – with water only or with soap and water?	<input type="checkbox"/> Water (0) <input checked="" type="checkbox"/> Soap and water (1) <input type="checkbox"/> Don't know (99)
	C- If with soap and water, do you use soap always, sometimes, or never?	<input checked="" type="checkbox"/> Always (0) <input type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
23.	A- Do you wash your hands before eating – always, sometimes, or never?	<input checked="" type="checkbox"/> Always (0) <input checked="" type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
	B- How do you wash your hands before eating – with water only or with soap and water?	<input type="checkbox"/> Water (0) <input checked="" type="checkbox"/> Soap and water (1) <input type="checkbox"/> Don't know (99)
	C- If with soap and water, do you use soap always, sometimes, or never?	<input checked="" type="checkbox"/> Always (0) <input type="checkbox"/> Sometimes (1) <input type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
24.	Do you eat soil – always, sometimes, or never?	<input type="checkbox"/> Always (0) <input type="checkbox"/> Sometimes (1) <input checked="" type="checkbox"/> Never (2) <input type="checkbox"/> Don't know (99)
25.	A- What is your favorite fruit that you eat?	Fruit <u>Banana</u>
	B- Do you wash your fruits before eating - always, sometimes, or never?	<input type="checkbox"/> Never (0) <input checked="" type="checkbox"/> Sometimes (1) <input type="checkbox"/> Always (2) <input type="checkbox"/> Don't know (99)
26.	A- Do you eat raw/undercooked vegetables	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- If yes, do you wash your vegetables before eating - always, sometimes, or never?	<input type="checkbox"/> Never (0) <input type="checkbox"/> Sometimes (1) <input type="checkbox"/> Always (2) <input type="checkbox"/> Don't know (99)
27.	Do you walk barefoot - always, sometimes, or never?	<input checked="" type="checkbox"/> Never (0) <input type="checkbox"/> Sometimes (1) <input type="checkbox"/> Always (2) <input type="checkbox"/> Don't know (99)
28.	When you are at home do you prefer to use sandals or shoes?	<input type="checkbox"/> Does not use any (0) <input checked="" type="checkbox"/> Sandals (1) <input type="checkbox"/> Shoes (2) <input type="checkbox"/> Don't know (99)
29.	In which activities of the day are you barefoot? <input type="checkbox"/> Not Applicable (NA)	A- Activity: B- Activity: <u>At home</u> C- Activity:
30.	A- Did your parents, teachers or health professionals gave you a deworming pill?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- If yes, when was the last time they gave you such deworming pill?	_____ Months <input type="checkbox"/> More than a year (1) <input type="checkbox"/> Don't know (99)
31.	Did your parents or health professionals gave you other antibiotics in the last 3 months?	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
32.	What food do you eat/consume most?	Food <u>Ingira</u>
33.	A- Has your child taken any drug prescribed by the health institution for any illnesses currently? (Other than paracetamol/panadol/aspirin)	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	B- If Yes, please observe and write the name and type of the drugs of which the child currently taking.	_____
34.	In the past three months, has your child taken any antimalaria drug	<input type="checkbox"/> Yes (1) <input checked="" type="checkbox"/> No (0) <input type="checkbox"/> Don't know (99)
	Comments:	

QUESTIONNAIRE ON Allergy Characteristics of a child

G01	Has your child ever had wheezing or whistling in their chest? if you have answered "no" please skip to question 6	Yes	1		WHZL6A
		No	2		
G02	In the last 2 years, has your child had wheezing or whistling in their chest?	Yes	1		WHZT6A
		No	2		
G03	In the last 1 year, has your child had wheezing or whistling in their chest?	Yes	1	→ G04 → G05	WHZ6A
		No	2		
G04	How many times in the last year has your child had an attack of wheezing?	0	1		WHZFRQ6A
		1-3	2		
		4-12	3		
		>12	4		
G05	Has your child ever had Asthma?	Yes	1		ASTL6A
		No	2		
G06	In the last 2 years, has your child had Asthma?	Yes	1		ASTT6A
		No	2		
G07	Has your child had Asthma in the last year?	Yes	1	→ G08 → G09	AST6A
		No	2		
G08	Has this been confirmed by a doctor?	Yes	1		ASTHDR6A
		No	2		
G09	Has your child ever had an itchy skin rash which has affected the skin creases (eg, the folds of the elbow or behind the knees)?	Yes	1		RASHL6A
		No	2		
G10	In the last 2 years, has your child had an itchy skin condition affecting the skin creases (front of the elbow, behind the knees, the front of the ankles, around the neck, or around the eyes)?	Yes	1		RASHT6A
		No	2		
G11	In the last 1 year, has your child had an itchy skin condition affecting the skin creases (front of the elbow, behind the knees, the front of the ankles, around the neck, or around the eyes)?	Yes	1	→ G11A → G12	RASH6A
		No	2		
G11 A	If yes, has this rash affected any of the following places? (Multiple Answers possible)	The elbow folds		1	RASHL6AA
				2	
		Behind the knees		1	RASHL6AB
				2	
		In front of the ankles		1	RASHL6AC
				2	
		Under the buttocks		1	RASHL6AD
				2	
		Around the neck		1	RASHL6AE
				2	
		Around the eyes/ears		1	RASHL6AF
				2	
G12	Has your child ever had hay fever or persistent sneezing attacks?	Yes	1		HAYFL6A
		No	2		
G13	In the last 2 years, has your child had hay fever or persistent sneezing with sneezing or running nose (excluding colds or flu), or problems with itchy watery eyes?	Yes	1		HAYFT6A
		No	2		
G14	In the last year, has your child had hay fever or persistent sneezing with sneezing or running nose (excluding colds or flu), or problems with itchy watery eyes?	Yes	1		HAYF6A
		No	2		