SARS-COV-2 HDSS sero-surveys– Questionnaire

Study: S-COV-2 HDSS sero-surveys	**1. Location (LOC): (check one)** □ **Korogocho (KOR)** □ **Viwandani (VIW)**	**2. Patient ID (0001-0999)** **SS-**|___|___|___| - |___|___|___|___| **LOC** **S/N**
3. Date of collection (DD/MMM/YYYY): |___|___| / |___|___|___| / |___|___|___|___|		**4. Staff initials: |__|__|__|**

Form completed by: ____ _____ _(Signature) \|__\|__\|/\|__\|__\|__\|/\|_2_\|_0_\|__\|__ \|(Date (dd/MMM/yyyy))

5.1 First name: _____ **5.2** Middle name: _____	**5.3** Surname:_____ 5.4 Ethnicity: Add APHRC standard list 5.5 Education: 1=No formal education; 2=Primary; 3= Secondary; 4+ Tertiary 5.6 Religion: 1= Catholic, 2=Protestant; 3= Other christtians; 4=Muslim
6.1 Estimated age in years: |__|__|__|	**6.2** if <5 years, DOB |__|__|/|__|__|__|/|__|__| (dd/MMM/yy)
Sex at birth:	**|__|** (Fill in 0= Female , 1=Male)

Usual place of residence (**NOT ancestral home**)

7.1 County: _____ **7.2** Sub-county: _____ **7.3** Division: _____	**7.4** Location: _____ **7.5** Sub-location: _____ **7.6** Village/estate: _____

How accessible are COVID-19 prevention services in this community including …….. ?

Prevention services	Highly accessible (Tick)	Moderately accessible (Tick)	Rarely accessible (Tick)	Not acces at all (Tick
Information & Education				
Hand washing (water & soap)				
Face masks				
Hand Sanitizers				

FOR 18 & ABOVE: How do you rate your own risk of getting infected with the virus that causes COVID-19?	1=Nil; 2= Low, 3=Moderate, 4= High

Have you had a contact with anyone with suspected or confirmed COVID-19 or SARS-CoV-2 infection?	|__| (Fill in 0= No , 1=Yes, 3=Probably, 4= Don't know) If yes, month of last contact: |__|__|__|/|__|__| (MMM/yy)

In the past 6 months, have you experienced any of the following (check all reported symptoms):

□ History of fever/ chills
□ General weakness
□ Cough
□ Sore throat
□ Runny nose
□ Loss of taste
□ Loss of smell
□ Other, specify _____

□ Shortness of breath
□ Diarrhoea
□ Nausea/vomiting
□ Headache
□ Irritability/Confusion

□ Pain (check all that apply)
( ) Muscular ( ) Chest
( ) Abdominal ( ) Joint

□ UNKNOWN (all)
□ NO SYMPTOMS_____

If you answered yes, Q9,	**10.1** Did any of these symptoms require you to seek medical attention? |__| (Fill in 0= No , 1=Yes, 2= Don't know) **10.2** Did any of these symptoms cause you to miss work? |__| (Fill in 0= No , 1=Yes, 2= Don't know) **10.3** Did any of these symptoms require you to be hospitalised? |__| (Fill in 0= No , 1=Yes, 2= Don't know)
In the last 6 months, has any member of your household been sick?	**1=Yes** **2=No** **3+ Don't know**

If yes, complete the symptom table below for each person

Symptoms	Name: Age (years):	Name: Age (years):	Name: Age (years):	Name: Age (years):
Fever/ chills (Y/N/D)				
General weakness (Y/N/D)				
Cough (Y/N/D)				
Sore throat (Y/N/D)				
Runny nose (Y/N/D)				
Loss of taste (Y/N/D)				
Loss of smell (Y/N/D)				
Shortness of breath (Y/N/D)				
Diarrhoea (Y/N/D)				
Nausea/vomiting (Y/N/D)				
Headache (Y/N/D)				
Irritability/Confusion				
Pain (Y/N/D)				
Other, specify	……	……	……	……
Reported cause of symptoms	……	……	……	……

In the last 6 months, has any member of your household died?	1=Yes 2=No

If yes, complete the symptom table below

Symptoms	Name: Age (years):	Name: Age (years):	Name: Age (years):	Name: Age (years):
Fever/ chills (Y/N/D)				
General weakness (Y/N/D)				
Cough (Y/N/D)				
Sore throat (Y/N/D)				
Runny nose (Y/N/D)				
Loss of taste (Y/N/D)				
Loss of smell (Y/N/D)				
Shortness of breath (Y/N/D)				
Diarrhoea (Y/N/D)				
Nausea/vomiting (Y/N/D)				
Headache (Y/N/D)				
Irritability/Confusion				
Pain (Y/N/D)				
Other, specify	……	……	……	……
Reported cause of death	……	……	……	……

Have you or any of your household member been unable to access and use healthcare services they would normally have access to in the last 6 months?	1=Yes, myself 2= Yes, another household member 3= Don't know

If 1 or 2, which services were missed?

Missed services	Name: Age (years):	Name: Age (years):	Name: Age (years):	Name: Age (years):
Antenatal care				
Delivery				
Child health care services-immunization, treatment etc.				
Treatment for chronic conditions -DM, CVD, HT				
Reasons for missed service	……	……	……	……

Have any of your household member lost a job or source livelihood in the last 6 months?	1=Yes, myself 2= Yes, another household member 3= Don't know
If YES (1 or 2), why?	……

Has any of your household members left this household in the last 6 months?	1=Yes, one or more adults 2= Yes, one or more children 3= No

If YES (1 or 2), where did they migrate to?

Out-migration destination	Name: Age (years):	Name: Age (years):	Name: Age (years):	Name: Age (years):
Different household in same area				
Different Urban area				
Different rural area				
Don't know				
Reason for migration	……	……	……	……

Has any new member joined your household in the last 6 months?	1=Yes, one or more adults 2= Yes, one or more children 3= No

If 1 or 2, where did they migrate from?

In-migration origin	Name: Age (years):	Name: Age (years):	Name: Age (years):	Name: Age (years):
Different household in same area				
Different Urban area				
Different rural area				
Don't know				
Reason for migration	……	……	……	……

Socioeconomic status	(Fill in 0= No , 1=Yes, 2= Don't know) **11.1** Does your household/homestead have: a) Electricity? |__| b) A television? |__| c) A sofa? |__| d) A cupboard? |__| e) A DVD player? |__| f) A radio? |__| g) A table? |__| h) A clock? |__| (Choose one option) **11.2** What is the main material of the floor of your dwelling/house? a) Cement [ ] b) Earth/sand [ ] c) Other [ ] **11.3** What is the main material of the external walls of your dwelling/house? a) Dung/mud/soil [ ]

	b) Other [ ] **11.4** What is the main material of the roof of your dwelling/house? a) Thatch/grass/Makuti [ ] b) Other [ ] **11.5** What type of fuel does your household mainly use for cooking? a) Wood. [ ] b) LPG/natural gas [ ] c) Other [ ] **11.6** What kind of toilet facility do members of your household usually use? a) No facility/bush/field [ ] b) Other [ ]
Check for BCG scar (first look at the left, then the right shoulder)	**12.1** Does the participant have a BCG scar? **|**__| (Fill in 0= No , 1=Yes, 2= Don't know)
For children < 5 years, vaccination information from health card	(Fill in 0= No , 1=Yes, 2= Don't know) **13.1** BCG **|**__| **13.2** Penta 1 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.3** Penta 2 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.4** Penta 3 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.5** PCV 1 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.6** PCV 2 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.7** PCV 3 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.8** MCV1 **|**__| if yes, fill in date |_d_|_d_|/|_m_|_m_|_m_|/|_y_|_y_| **13.9**
Check willingness participate in follow-up studies	**14.1** Will you be willing to be sampled again a few times over the coming months to see what happens to you test results? **|**__| (Fill in 0= No , 1=Yes, 2= Don't know)
Time of sample collection (hh:mm; 24hr clock)	____:___ or **|**__| N/A sample not taken

To be completed by the laboratory -

LABORATORY REPORT	**Tech initials**	**Date (dd/mm/yyyy)**	**Time (24 Hour)**
Blood group test done? ☐ Yes, *RESULT ☐ No☐	_____	_____ /_____ /_____	____:____
Whole blood stored? ☐ Yes ☐ No	_____	_____ /_____ /_____	____:____
Serum & clot stored? ☐ Yes ☐ No	_____	_____ /_____ /_____	____:____
Lab Technologist verification (Initials)	_____	_____ /_____ /_____	____:____
Review by surveillance coordinator (Initials)	**_____**	**_____ /_____ /_____**	**____:____**

*Options are A+, A-, AB+, AB-, B+, B-, O+, O-