SCHISTOSOMIASIS SURVEY QUESTIONNAIRE FOR SCHOOLS

A] SCHOOL/COMMUNITY DETAILS:

Observer initials|___|___| District_____Sub County_____
School/Community Name_____
GPS :_____
_____
_____
Date (DD/MM/YYYY) |___|___| / |___|___| / |___|___|___|___|
School/Community Code |____|____|____|____|

	Girls	Boys	Total
a) Enrolment			
b) Number of Latrines available(Stance)			
c) Availability of Hand washing facilities with water			

B]MDA IN SCHOOLS(FOR TEACHER IN CHARGE OF MDA):

1. **Do you implement Mass Drug Administration (MDA) for NTDs in this school for**

I. Bilharzia	Yes	No	If yes, for how many years now	
II. Worms	Yes	No	If yes, for how many years now	

2. If yes to Qn. 1 Have you been receiving treatment every year	Yes	No
3. If yes to Qn. 1 which medicines did you administer to the pupils		
i. Albendazole		
ii. Praziquantel		
4. Have you been treating every year since you started MDA	Yes	No
5. If No to Qn.3 why?		
6. When was the last time this school was treated with Praziquantel(state month & Year)		

C].HUMAN WATER CONTACT & BILHARZIA TRANSMISSION:

1. Is there a transmission source nearby (such as swamps, river, lake)	Yes	No

2. If Yes, Name them.....
.....

3. What is the approximate location in km/m of the nearest water source from the School/ Community?
.....

4. Do you get in contact with the above mentioned water body?	Yes	No

5. If yes, which activities do you do in the water.....
.....

VECTOR CONTROL DIVISION (MoH)
APPROVED
VALID UNTIL
31 DEC 2020
RESEARCH & ETHICS COMMITTEE
P. O. BOX 1661, KAMPALA

Participant Code	Participant Initials	Sex (M/F)	Age	Date

TrypanoGEN+ : Schistosomiasis Study
CASE Report Form (CRF)

ELIGIBILITY

A INCLUSION CRITERIA (FILL IN YES OR NO)

Participant is resident in the schistisomiasis endemic area	.....
Participant is 10-15 years of age	.....
The parent/guardian has signed the consent form and the child has signed the assent form	.....

CONTINUE IF ALL RESONSES TO THE ABOVE ARE « YES »

B EXCLUSION CRITERIA (RESPOND WITH YES OR NO)

It is not possible to obtain urine, stool sample and 6 ml of blood	.....

CONTINUE IF THE RESPONSE IN B IS « NO »

C RESULTS OF ELIGIBILITY

- **IF ANSWERS FOR INCLUSION CRITERIA ARE « YES » AND EXCLUSION IS « NO » THE PARTICIPANT IS ELIGIBLE**
- **IF PARTICIPANT IS CCA POSITIVE, INCLUDE AS CASE (T)**
- **IF THE PARTICIPANT IS CCA negative, INCLUDE AS Control (C)**

.....

Participant Code	Participant Initials	Sex (M/F)	Age	Date

PARTICIPANT IDENTIFICATION

Names :.....

Date of Birth: ..... **Age :** ..... **Sex** ..... **(M / F)**

Height :.....**cm** **Weight :**.....**kg**

Names of parent/guardian: .....

Telephone : .....

Residence of participant

LCI :.....**LCII**.....

LCIII :.....**LCV :**.....

Mother tongue of participant :.....

Mother tongue of participant's father :.....

Mother tongue of participant's mother:.....

CLINICAL EXAMINATION UPON INCLUSION

Clinical Symptoms and signs

Fever	✎ pos	✎ neg	✎ none
Abdominal pain	✎ pos	✎ neg	✎ not done
Blood in stool	✎ pos	✎ neg	✎ not done
Distended abdomen	✎ pos	✎ neg	✎ not done
Stunted growth	✎ pos	✎ neg	✎ not done

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Names :.....

Date of Birth: ..... **Age :** .... **Sex** ..... **(M / F)**

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Telephone : .....

Residence of participant

LCI :.....**LCII**.....

LCIII :.....**LCV :**.....

Mother tongue of participant :.....

Mother tongue of participant's father :.....

Mother tongue of participant's mother:.....

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STOOL EXAMINATION FORM

Date of receipt of Sample: |__|__|/|__|__|/|__|__|__|__| DATE

Please indicate required processing:

Stool for immediate Kato Katz? (1=yes, 2=no) |__| KK

Stool for storage (1=yes, 2=no) |__| STORE

STOOL SAMPLE LAB NUMBER LS |__|__|__|__|__| SLABNO

Has the sample been fixed with Ethanol? (1=yes, 2=No) |__| FIXED

Date of fixing |__|__| / |__|__| / |__|__|__|__| FDATE

KATO KATZ results

Stool Consistency (1=watery 2=loose 3=normal 4=hard) |__| CONS

Kato-Katz (eggs per slide)

Slide done? (1=yes 2=No) |__| DONEA |__| DONEB

A. S.mansoni	|__|__|__|__|__|	KASA	B. |__|__|__|__|__|	KASB
Ascaris	|__|__|__|__|__|	KAAA	|__|__|__|__|__|	KAAB
hookworm	|__|__|__|__|__|	KAHA	|__|__|__|__|__|	KAHB
Trichuris	|__|__|__|__|__|	KATA	|__|__|__|__|__|	KATB
Strongyloides	|__|__|__|__|__|	KASTA	|__|__|__|__|__|	KASTB
Trichostrongylus	|__|__|__|__|__|	KATRA	|__|__|__|__|__|	KATRB
Other	|__|__|__|__|__|	KAOA	|__|__|__|__|__|	KAOB

If other, Specify: _____

Technician please enter your initials and write your name below

|__|__|__| TECHA |__|__|__| TECHB

Technician A: ..... **Technician B:** .....

Participant Code	Participant Initials	Sex (M/F)	Age	Date

COLLECTED SAMPLES

	Date	Number
✂ Whole blood in paxygene (2.5 ml)		
✂Plasma (1-2 ml)		
✂Blood sediment after centrifugation (1-2ml)		
✂Stool		
✂FTA Card		