

APPENDIX: DATA COLLECTION TOOLS

A. Quantitative survey

General information

VILL. Village name: _____

HAM. Hamlet name: _____

A0. Concession code: |_|_|_|_|

A1. Household code: |_|_|_|

ID. Individual ID: |_|_|_|_| |_|_|_|_| |_|_|_|_|

DVIS. Date of visit: |_|_| |_|_| |_|_|

Day Month Year

ENQ. Investigator: _____

Gender ☐ 1. Male ☐ 2. Female

Date of birth |_|_|_| |_|_|_| |_|_|_|_|_|
Day Month Year

What is your marital status?

☐ 1. Married ☐ 2. Single ☐ 3. Widow(er) ☐ 4. Divorced

If you are married, are you in a union...

☐ 1. Monogamous ☐ 2. Polygamous

How many children do you have? |_|_|_|

(Note 0 if the person has no children)

In the past 12 months, how much time did you spend in the household? |_|_| month |_|_| days

Are you currently studying or training? ☐ 1. Yes ☐ 2. No

What education/training are you pursuing?

☐ 1. Middle school ☐ 2. High School ☐ 3. Higher education (university)
☐ 4. Professional training ☐ 5. Other => Specify: _____

Where are you undertaking this education/training?

☐ 1. In the Fatick region => **Do you go back to your household every night?** ☐ 1. Yes ☐ 2. No
☐ 2. In Dakar ☐ 3. In another region of Senegal (outside of Dakar) ☐ 4. In another country

Health status and health functioning

SELF-REPORTED HEALTH

In the past 3 months, how would you rate the impact of your health on your ability to work?

Consider days when you were limited in the amount or type of work you could have done, such as if you had to work less time or could not work as well as usual.

- ☐ 1. My health problems have had no effect on my work (or I have no health problems)
- ☐ 2. Because of my health problems, I have had some difficulty working
- ☐ 3. Because of my health problems, I had a lot of difficulty working
- ☐ 4. Because of my health problems, I have not been able to work at all

In the past 3 months, how would you rate the impact of your health on your ability to perform your usual daily activities?

By usual daily activities, we mean activities that you do on a regular basis, such as housework, shopping, childcare, studying, etc. Consider days when you were limited in the amount or type of activity you could have done, for example if you did less than you would have liked.

- ☐ 1. My health problems have had no effect on my daily activities (I have no health problems)
- ☐ 2. Because of my health problems, I have had some difficulties in performing my daily activities
- ☐ 3. Because of my health problems, I had a lot of difficulty performing my daily activities
- ☐ 4. Because of my health problems, I have not been able to do my daily activities at all

SF12 SCALE (VERSION 2 ADAPTED)

Overall, do you think your health is:

- ☐ 1. Excellent
- ☐ 2. Very good
- ☐ 3. Good
- ☐ 4. Fair
- ☐ 5. Poor

Here is a list of activities you may have to do in your daily life:

(For each of these, indicate whether you are bothered by your current health condition)

- **Moderate physical effort** such as moving a table, sweeping the floor, walking slowly for about 20 minutes on level ground

- ☐ 1. Limited a lot
- ☐ 2. Limited a little
- ☐ 3. Not limited at all

- **Climb several flights of stairs, walk up a steep hill for a few minutes, or walk quickly for 100 meters**

- ☐ 1. Limited a lot
- ☐ 2. Limited a little
- ☐ 3. Not limited at all

In the past 4 weeks, and due to your physical condition:

- Did you do less than you would have liked?

- ☐ 1. All of the time
- ☐ 2. Most of the time
- ☐ 3. Some of the time
- ☐ 4. A little of the time
- ☐ 5. None of the time

- Did you have to stop doing certain things?

- ☐ 1. All of the time
- ☐ 2. Most of the time
- ☐ 3. Some of the time
- ☐ 4. A little of the time
- ☐ 5. None of the time

In the past 4 weeks, and due to your emotional state (feeling sad, nervous or depressed):

- Did you do less than you would have liked?

- ☐ 1. All of the time
- ☐ 2. Most of the time
- ☐ 3. Some of the time
- ☐ 4. A little of the time
- ☐ 5. None of the time

- Did you find it difficult to do what you had to do with such care and attention?

- ☐ 1. All of the time
- ☐ 2. Most of the time
- ☐ 3. Some of the time
- ☐ 4. A little of the time
- ☐ 5. None of the time

In the past 4 weeks, how much have your physical aches and pains interfered with your work or home activities?

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

In the past 4 weeks, have there been times when your health condition, either physical or emotional, has interfered with your life and your relationships with others, family, friends, acquaintances?

- ☐ 1. All of the time ☐ 2. Most of the time ☐ 3. Some of the time
☐ 4. A little of the time ☐ 5. None of the time

The following questions are about how you have felt over the past 4 weeks.

In the past 4 weeks, were there times when:

- You felt calm and relaxed

- ☐ 1. All of the time ☐ 2. Most of the time ☐ 3. Some of the time
☐ 4. A little of the time ☐ 5. None of the time

- You felt energized

- ☐ 1. All of the time ☐ 2. Most of the time ☐ 3. Some of the time
☐ 4. A little of the time ☐ 5. None of the time

- You felt sad and downcast

- ☐ 1. All of the time ☐ 2. Most of the time ☐ 3. Some of the time
☐ 4. A little of the time ☐ 5. None of the time

FATIGUE

Now I'm going to ask you to rate your current level of fatigue.

- ☐ 1. I don't feel tired at all / I don't feel any fatigue ☐ 2. I feel a little tired
☐ 3. I feel very tired ☐ 4. I am exhausted/I feel extremely tired

Approximately how long have you been feeling tired? |__|__| Days |__|__| Weeks |__|__| Month |__|__| Years

Are you bothered by the fatigue you feel at the moment when carrying out your daily activities or work?

- ☐ 1. Not at all: the fatigue I feel does not hinder me at all in my activities or my work
☐ 2. A little / sometimes: sometimes the fatigue I feel hinders me from carrying out my activities or my work
☐ 3. A lot / often: the fatigue I feel bothers me a lot / often
☐ 4. Because of the fatigue I feel, I am unable to perform my daily tasks or work

DISABILITY

Do you currently have a disability? ☐ 1. Yes ☐ 2. No

What is your disability?

- ☐ 1. Alteration or loss of vision ☐ 2. Speech impairment
☐ 3. Inability to walk or move (paralysis or amputation of a lower limb)
☐ 4. Inability to use an upper limb (paralysis or amputation of an upper limb)
☐ 5. Other => **Specify:** _____

ONLY FOR CHB PATIENTS – ADMINISTERED BY THE AMBASS STUDY PHYSICIAN

BODY-MASS INDEX & CURRENT HEALTH CONDITIONS

Weight: |__|__|__| kg

Height: |__| m |__|__| cm

Blood pressure: |__|__| |__|

Fever (over 38 degrees) ☐ 1. Yes => |__| |__| degrees ☐ 2. No

Current chronic condition? ☐ 1. Yes ☐ 2. No

☐ 1. Diabetes ☐ 2. AVC ☐ 3. Sickle cell disease ☐ 4. HTA
☐ 5. Heart failure ☐ 6. Renal insufficiency ☐ 7. Other => **Specify** _____

Current acute condition?

☐ 1. Yes => **Specify:** _____ ☐ 2. No

CHB-RELATED HISTORY & SYMPTOMS

CHB STATUS (as a result of home-based testing using)

☐ 1. AgHBs+ (CHB patient) ☐ 2. AgHBs-

Have you been vaccinated against hepatitis B? ☐ 1. Yes ☐ 2. No

If yes: How many doses did you receive? |__|

Has anyone close to you ever had any of the following diseases?

Spouse

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

Father

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

Mother

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

Brothers/sisters

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

Father's parents

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

Mother's parents

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

Other family member => Specify: _____

☐ 1. Liver cirrhosis ☐ 2. Liver cancer ("big belly") ☐ 3. Viral hepatitis ☐ 4. Stroke

CLINICAL EXAMINATION

Presumptive evidence of liver disease (current or past)

Digestive haemorrhages ☐ 1. Yes => ☐ 1. Hematemesis ☐ 2. Melaena ☐ 3. Rectorrhagia ☐ 2. No

Edema ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Ascites ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Icterus ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Cirrhosis ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Encephalopathy ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Presumptive evidence of extrahepatic disease (current or past)

Vasculitides ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Cryoglobulinemia ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Vascular purpura ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Arthromyalgia ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Kidney damage ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Livedo ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

Mono-polyneuritis ☐ 1. Yes, in the past ☐ 2. Yes, on-going ☐ 3. No, never

RISKS FACTORS FOR CHB EVOLUTION OR TRANSMISSION**- ALCOHOL USE****In the past 6 months, have you ever consumed alcohol?**

- ☐ 1. Never ☐ 2. Once a month or less ☐ 3. Two to four times a month
☐ 4. Two to three times a week ☐ 5. Four to six times a week ☐ 6. Every day

On the days you drank alcohol, how many drinks did you have?

Number of traditional alcoholic drinks |__|__| Number of large bottles of beer (6 3cl) |__|__|

Number of small bottles of beer (33 cl) |__|__| Number of alcohol packages |__|__|

Number of glasses of other alcohol |__|__| => Specify which other alcohol and its content: _____

In the past 6 months, have you ever had 6 or more drinks (and/or 3 or more large bottles of beer) on one occasion?

- ☐ 1. Never ☐ 2. At least once a month ☐ 3. Several times a month
☐ 4. Once a week ☐ 5. Every day or so

- TOBACCO**Do you smoke conventional cigarettes?**

- ☐ 1. Never ☐ 2. Yes, I have smoked in the past, but I stopped ☐ 2. Yes, I currently smoke

When did you start smoking? |__|__| years ago**How many cigarettes do you smoke per day?** |__|__|**SEXUAL BEHAVIORS****Now I'm going to talk about intimate issues, which may put you at risk of transmission. Everything we talk about is strictly confidential and your answers are anonymous.****In the past six months, have you had sexual intercourse?** ☐ 1. Yes ☐ 2. No**If yes, how many partners have you had in the past 6 months?** |__|__|**In the past 6 months, have you used a condom with your spouse (husband/wife) or fiancé(e)/boyfriend (if not married)?**

- ☐ 1. Yes always ☐ 2. Yes sometimes ☐ 3. No never ☐ 4. Not applicable

In the past 6 months, have you used a condom with your other partners?

- ☐ 1. Yes always ☐ 2. Yes sometimes ☐ 3. No never ☐ 4. Not applicable

Do you ever have casual sexual partners (including prostitutes) while traveling for work?

- ☐ 1. Yes ☐ 2. No ☐ 3. Not applicable (no travel for work)

If yes, the last time you had a casual partner, did you use a condom? ☐ 1. Yes ☐ 2. No

Health-related knowledge

GENERAL KNOWLEDGE ON CHB

Have you ever heard of liver diseases (also called fat bellies or yellow eyes)?

☐ 1. Yes (at least one of these) ☐ 2. No

If yes, do you or someone you know suffer from any of these diseases?

Yourself ☐ 1. Yes ☐ 2. No

A member of your household ☐ 1. Yes ☐ 2. No

A family member (not living in your household) ☐ 1. Yes ☐ 2. No

An acquaintance ☐ 1. Yes ☐ 2. No

Have you ever heard of hepatitis B? ☐ 1. Yes ☐ 2. No, today is the first I've heard of it.

If yes, do you think there is a link between liver disease and hepatitis B? ☐ 1. Yes ☐ 2. No

Do you think a person who has hepatitis B can transmit the disease in the following situations?

During unprotected sex ☐ 1. Yes ☐ 2. No

When talking with another person ☐ 1. Yes ☐ 2. No

By contact with blood ☐ 1. Yes ☐ 2. No

Through saliva ☐ 1. Yes ☐ 2. No

From mother to child during pregnancy/childbirth ☐ 1. Yes ☐ 2. No

Is there is a vaccine that protects against hepatitis B? ☐ 1. Yes ☐ 2. No

Have you ever been tested for CHB? ☐ 1. Yes ☐ 2. No

=> If possible, ask to consult the health record to verify this information

Date of last CHB testing? Month: |__|__| Year: |__|__|

Do you know what your test result was?

☐ 1. Yes positive ☐ 2. Yes negative ☐ 3. No (don't know)

=> If never tested: **Why were you never tested for CHB?**

☐ 1. Had never heard of it/been offered a test ☐ 2. No money to pay for it
☐ 3. Didn't want to know ☐ 4. Afraid of discriminations / confidentiality breaches
☐ 5. Other => Specify: _____

Health seeking skills and beliefs, and self-efficacy

PERCEIVED COMPETENCY

Please respond to each of the following items in terms of how true it is for you with respect to dealing with your health.

- I feel confident in my ability to manage my health

☐ 1. Fully agree ☐ 2. Agree ☐ 3. Neither agree nor disagree ☐ 4. Disagree ☐ 5. Fully disagree

- I am capable of handling my health now

☐ 1. Fully agree ☐ 2. Agree ☐ 3. Neither agree nor disagree ☐ 4. Disagree ☐ 5. Fully disagree

- I am able to control my behaviors to achieve positive

☐ 1. Fully agree ☐ 2. Agree ☐ 3. Neither agree nor disagree ☐ 4. Disagree ☐ 5. Fully disagree

- I feel able to meet the challenges of remaining healthy

☐ 1. Fully agree ☐ 2. Agree ☐ 3. Neither agree nor disagree ☐ 4. Disagree ☐ 5. Fully disagree

Self-governance and self-management and perceived self-governance and management to achieve health outcomes

PERCEPTION OF EMPOWERMENT

Imagine a ten step ladder, where on the bottom, the first step, stand people who are completely coerced or powerless, and on the highest step, the tenth step, stand those with the most ability to advance goals that they value in their own homes and in the world.

On which step are you today? |__|__|

Intrinsic motivation to achieve desirable health outcomes

RELATIVE AUTONOMY INDEX

When you go to the dispensary, or the hospital for a health issue or a question about your health you do it...

- | | | |
|--|-----------------------------------|--------------------------------------|
| - Because it is your duty/responsibility | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - Because you will get in trouble otherwise | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - Because it corresponds to your preferences | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - Because that is what your family members tell you to do | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - Because you want to | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - So your family members won't get angry with you | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - Because you personally believe it's the right thing to do whether or not your family members agree | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |
| - Because you want your family members to like you | <input type="checkbox"/> 1. Agree | <input type="checkbox"/> 2. Disagree |

Social norms

DECISION-MAKING LATITUDE

In your household, when a decision has to be made about...

Who has the last word?

- | | | | |
|------------------------------------|---------------------------------------|---|--|
| ... your health | <input type="checkbox"/> 1. You alone | <input type="checkbox"/> 2. You along with someone else | <input type="checkbox"/> 3. Someone else |
| ... daily needs | <input type="checkbox"/> 1. You alone | <input type="checkbox"/> 2. You along with someone else | <input type="checkbox"/> 3. Someone else |
| ... large household purchases | <input type="checkbox"/> 1. You alone | <input type="checkbox"/> 2. You along with someone else | <input type="checkbox"/> 3. Someone else |
| ... visits to family and relatives | <input type="checkbox"/> 1. You alone | <input type="checkbox"/> 2. You along with someone else | <input type="checkbox"/> 3. Someone else |

Material circumstances

ECONOMIC ACTIVITY

In the past 12 months, have you been involved in your household's farming activities? ☐ 1. Yes ☐ 2. No

If no, during the previous winter, were you hired by another household to work in the fields?

☐ 1. Yes ☐ 2. No

How much did you earn for the entire farming period? |__|__| |__|__| CFA

In addition to the common fields in your household, do you cultivate a field (peanut, niebe, bissap, watermelon, ...) that belongs to you? ☐ 1. Yes ☐ 2. No

During the last 12 months, other than working in the fields, did you engage in any other economic activity?

- ☐ 1. Yes ☐ 2. No

If yes, which activity?

- ☐ 1. Fisherman - Breeder
☐ 2. Street trade
☐ 3. Small business (donuts in front of the house, doorstep business, ...)
☐ 4. Established business (business with a store, restaurant owner - refreshment stand)
☐ 5. Health personnel (nurse, lab technician, midwife...)
☐ 6. Educator/Teacher
☐ 7. Domestic worker/gardener/cook
☐ 8. Craftsman/Mechanic/Mason
☐ 9. Community health worker/matron/traditional birth attendant
☐ 10. Clerk /employee
☐ 11. Driver, chauffeur
☐ 12. Seamstress / Laundry
☐ 13. Other => **Specify:** _____

In the past 12 months, how much did you earn for this activity?

|_|_|_|_|_|_| CFA

🔗 FOR THE INACTIVE

If in the past 12 months you have not worked/been economically active, what is your current situation?

- ☐ 1. Looking for a job ☐ 2. Elderly person no longer working/retired
☐ 3. Study/training ☐ 4. Disability/ permanent disability/ long-term illness
☐ 5. Other (homemaker)

HOUSEHOLD AGRICULTURAL RESOURCES

Does your household have an agricultural activity? ☐ 1. Yes ☐ 2. No

If yes, how much income did your household get from the sale of all its crops for the year 2017 (January-December)? |_|_|_|_|_|_|_| CFA

Does your household grow peanuts? ☐ 1. Yes ☐ 2. No

If yes, how much was produced for the year 2017 (January-December)? |_|_|_|_|_|_| kg

Did your household sell any of it? ☐ 1. Yes ☐ 2. No

If yes, how much income did your household get from the sale of peanuts for the year 2017 (January-December)? |_|_|_|_|_|_|_| CFA

How many animals do you estimate you have in your kitchen (livestock)?

- **Poultry** (chickens, ducks, etc.)

- ☐ 1. None ☐ 2. Less than 10 heads ☐ 3. ≥ 10 heads

- **Small livestock** (goats, sheep, pigs)

- ☐ 1. None ☐ 2. Less than 10 heads ☐ 3. ≥ 10 heads

- **Large livestock** (cows, horses, donkeys)

- ☐ 1. None ☐ 2. Less than 10 heads ☐ 3. ≥ 10 heads

In 2017, did you sell any animals (poultry, small livestock, large livestock)?

- ☐ 1. Yes ☐ 2. No

If yes, how much money was obtained from the sale of these animals? |_|_|_|_|_|_|_| CFA

How many of the following animals or farm equipment do you own? (code 0 if the person does not own the animal or equipment listed)

Horse	_ _	Donkey	_ _
Cow	_ _	Seeding drill	_ _
Hoe	_ _	Tractor	_ _
Plough	_ _	Mill	_ _
Other => Specify: _____ _ _			

OTHER SOURCES OF INCOME

In 2017, did you receive money from relatives/family living in Senegal or abroad? ☐ 1. Yes ☐ 2. No

How much did you receive (for the year 2017)? |_|_| |_|_|_| |_|_|_| CFA

Have you ever applied for the Family Security Grant from the Government of Senegal? ☐ 1. Yes ☐ 2. No

If yes, what was the result?

☐ 1. Recipient ☐ 2. Waiting List => **Since when** |_|_| Month |_|_| Year ☐ 3. Not eligible

If not, why did you not apply?

☐ 1. Did not know about this grant / never heard of it ☐ 2. Application too long/complicated
☐ 3. Don't need it/don't think the household is eligible ☐ 4. Other. **Specify:** _____

🔑 *Only for recipients of the Government Family Security Grant*

When did you receive the first payment? |_|_|_| Month |_|_| Year

How many payments have you received? |_|_|

Amount of your last payment: |_|_|_|_| |_|_|_|_| CFA

FOOD SECURITY

During the May-November 2017 agricultural season, did your kitchen grow millet? ☐ 1. Yes ☐ 2. No

Did you start eating the new millet before the 2018 harvest ended? ☐ 1. Yes ☐ 2. No

During the last lean season (May-June 2018), did you need to buy millet?

☐ 1. Yes ☐ 2. No

If yes, how much millet did you buy? |_|_| TAC

If yes, for what amount? |_|_|_|_| |_|_|_| CFA

With what money did you buy this millet? (several answers possible)

☐ 1. By selling other agricultural crops ☐ 2. By selling animals
☐ 3. With the help of income from off-farm activities ☐ 4. Through a loan (from a relative, neighbor)
☐ 5. Barter ☐ 6. With the help of savings (money set aside)
☐ 7. Other => **Specify:** _____

During the year 2017, did you receive food aid? ☐ 1. Yes ☐ 2. No

If yes, how much millet did you receive? |_|_|_| TAC

Source of food aid

☐ 1. Donation of a related or neighboring kitchen ☐ 2. Loan of grain from a related or neighboring kitchen
☐ 3. State Food Assistance Program ☐ 4. Other => **Specify:** _____

During the year 2017, did you give or lend money to another kitchen? (several answers possible)

☐ 1. Yes, donating money to another kitchen ☐ 2. Yes, lending money to another kitchen ☐ 3. No

If donations or loans to another kitchen

2017 donations |__|__|__| |__|__| CFA

2017 loans |__|__|__| |__|__| CFA

HOUSING & EQUIPMENT

Does your household have the following goods?

- | | | |
|---|--|--|
| <input type="checkbox"/> 1. Radio | <input type="checkbox"/> 2. TV | <input type="checkbox"/> 3. DVD payer or CD/MP3 player |
| <input type="checkbox"/> 4. Mobile phone/cell phone | <input type="checkbox"/> 5. Bicycle | <input type="checkbox"/> 6. Motorbike |
| <input type="checkbox"/> 7. Solar panels or generator | <input type="checkbox"/> 8. Fan | <input type="checkbox"/> 9. Air conditioner |
| <input type="checkbox"/> 10. Mosquito net | <input type="checkbox"/> 11. Living room furniture | |

Does your household have any of the following goods that can generate income through rental?

(assets on site and in working order)

- | | | |
|---|---|--|
| <input type="checkbox"/> 1. Car | <input type="checkbox"/> 2. Truck or bus | <input type="checkbox"/> 3. Cart |
| <input type="checkbox"/> 4. Refrigerator or freezer | <input type="checkbox"/> 5. Sewing machine | <input type="checkbox"/> 6. Shelling machine |
| <input type="checkbox"/> 7. Oil mill/press | <input type="checkbox"/> 8. Millet mill | <input type="checkbox"/> 9. Computer/tablet |
| <input type="checkbox"/> 10. Storage warehouse | <input type="checkbox"/> 11. Equipment for a craft activity (mason, cabinetmaker, welder) | |

Does your kitchen have a small store? ☐ 1. Yes ☐ 2. No

What is the main source of water for your household?

- | | |
|--|--|
| <input type="checkbox"/> 1. Drilling in the concession | <input type="checkbox"/> 2. Faucet in the concession |
| <input type="checkbox"/> 3. Drilling / fountain in the village | <input type="checkbox"/> 4. Well in the concession |
| <input type="checkbox"/> 5. Well in a neighboring concession | |

What energy source do you use for lighting?

- | | | |
|---|--|---|
| <input type="checkbox"/> 1. Wood/straw/candle fires | <input type="checkbox"/> 2. Lamp (oil / gas / oil) | <input type="checkbox"/> 3. Flashlight (with batteries) |
| <input type="checkbox"/> 4. Grid electricity | <input type="checkbox"/> 5. Solar panel | <input type="checkbox"/> 6. Generator |

What is the main source of energy for cooking meals in your kitchen?

- | | | |
|--|--|---|
| <input type="checkbox"/> 1. Grid electricity | <input type="checkbox"/> 2. Gas cylinder | <input type="checkbox"/> 3. Oil, gasoline |
| <input type="checkbox"/> 4. Manure, dung | <input type="checkbox"/> 5. Charcoal | <input type="checkbox"/> 6. Wood |

How many rooms (huts or bedrooms) does the household's compound have for sleeping? |__|__|

Does the household have room(s) for rent? ☐ 1. Yes ☐ 2. No

How many rooms for rent does the household have? |__|__| rooms

In 2017, what revenue was generated from the rental of this(ese) room(s)? |__|__|__| |__|__| CFA

Please indicate for the main living area, the composition of the roof, walls and floor *(to be completed by the interviewer)*

- Roof

- | | | | |
|-----------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> 1. Straw | <input type="checkbox"/> 2. Sheet metal | <input type="checkbox"/> 3. Fibrocement | <input type="checkbox"/> 4. Cement |
|-----------------------------------|---|---|------------------------------------|

- Walls

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> 1. Millet stems | <input type="checkbox"/> 2. Banco or clay | <input type="checkbox"/> 3. Stabilized banco | <input type="checkbox"/> 4. Cement |
| <input type="checkbox"/> 5. Wood | <input type="checkbox"/> 6. Sheet metal | | |

- Floor

- | | | | |
|-----------------------------------|------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 1. Banco | <input type="checkbox"/> 2. Cement | <input type="checkbox"/> 3. Sand | <input type="checkbox"/> 4. Tile |
|-----------------------------------|------------------------------------|----------------------------------|----------------------------------|

Political, economic and social security

JOB QUALITY AND SECURITY

Is farming your main activity (the one you spend the most time on)?

- ☐ 1. Yes, it's my main activity ☐ 2. No, I have a secondary activity ☐ 3. No, I do not farm

During the last 12 months, did you engage in an economic activity other than farming? ☐ 1. Yes ☐ 2. No

If yes, in this activity, you work as a:

- ☐ 1. Civil servant ☐ 2. Employee (written contract) ☐ 3. Employee (oral agreement)
☐ 4. Self-employed (no employees) ☐ 5. Contractor/ boss with employee(s) ☐ 6. Apprentice
☐ 7. Home help

In the past 12 months, how many months did you work for this activity? |__|__| months

On average, how many days did you work in a month of activity? |__| full days |__| half days

As part of this activity, did you have to leave your home to work (at least 7 days away)?

- ☐ 1. Yes => How long (over the past 12 months)? |__|__| days OR |__|__| months ☐ 2. No

HEALTH INSURANCE

Do you have health insurance or a community health insurance plan? ☐ 1. Yes ☐ 2. No

If yes, what type of health insurance do you have?

- ☐ 1. Community health insurance ☐ 2. Health insurance through your employer
☐ 3. Other types of insurance => **Specify:** _____

Are you the primary member? (Primary member = person who pays the membership fee)

- ☐ 1. Yes (= I pay the fee) ☐ 2. No (= my spouse or other household member pays the contribution)

If yes, how much do you pay? |__|__|__|__| CFA Period: ☐ 1. Monthly ☐ 2. Annual

If no, who pays? |__|__|__|__| *Interviewer instruction: find the individual identifier from the kitchen grid*

Who is covered by this insurance/mutual? (multiple answers possible)

- ☐ 1. Yourself ☐ 2. Your children ☐ 3. Your spouse(s)
☐ 4. Other members of the kitchen

Are you up to date with your dues? ☐ 1. Yes ☐ 2. No

CERTIFICATES OF INDIGENCE

Have you ever heard of the indigent status or of the certificates of indigence? ☐ 1. Yes ☐ 2. No

Have you, or anyone in your kitchen, ever applied for indigent status/certificate?

- ☐ 1. Yes, me personally ☐ 2. Yes, another member my kitchen ☐ 3. No/don't know

To whom? ☐ 1. Village chief ☐ 2. Services of the Prefecture ☐ 3. Social Services at the hospital

☐ 4. Other. **Specify:** _____

When did you apply? (if multiple requests, date of last request) Month: |__|__| Year: |__|__|

Did you get it? ☐ 1. Yes ☐ 2. No

If yes, were you able to receive free or reimbursed (covered) care because of this certificate?

☐ 1. Yes, only once ☐ 2. Yes, many times ☐ 3. No

If yes, for what total amount? (consider all care obtained free of charge or reimbursed since obtaining the certificate) |__|__|__| |__|__|__| |__|__|__| CFA

Access and utilization of healthcare services

In the past 12 months, have you been hospitalized? ☐ 1. Yes ☐ 2. No

In the past 3 months, have you had a health problem (illness or injury)? ☐ 1. Yes ☐ 2. No

Because of this health problem, how many days in the last 3 months have you been unable to work? |__|__| days

Because of this health problem, how many days in the last 3 months have you not been able to do your daily activities? |__|__| days

Have you consulted for this illness? ☐ 1. Yes ☐ 2. No

Who did you consult? (*several answers possible*)

☐ 1. Healer-marabou / Malongo center ☐ 2. Case / health post ☐ 3. Dispensary
☐ 4. Health Center ☐ 5. Hospital ☐ 6. Other => **Specify:** _____

If you did not consult, why not?

☐ 1. Not a serious illness ☐ 2. Too expensive ☐ 3. No doctor
☐ 4. Health services too far ☐ 5. Waiting time too long ☐ 6. Not well received
☐ 7. Didn't need anyone ☐ 8. No treatment available ☐ 9. Other => **Specify:** _____

For this illness, did you use self-medication? (= taking medication without consulting a caregiver/healthcare professional authorized to prescribe them) ☐ 1. Yes ☐ 2. No

If yes, where did you get these medications?

☐ 1. Grocery store ☐ 2. Drug depot or pharmacy ☐ 3. Store
☐ 4. Market ☐ 5. Friend/Family ☐ 6. Other => **Specify:** _____

👉 FOR WOMEN

Have you ever had a pregnancy carried to term?

☐ 1. Yes => **Number of pregnancies (carried to term):** |__|__| ☐ 2. No

Did you have a cesarean section for any of your deliveries? ☐ 1. Yes ☐ 2. No

Are you currently pregnant (for at least 3 months)? ☐ 1. Yes ☐ 2. No

If yes, for your current pregnancy, did you go to antenatal care visits (ANC) at a health facility?

☐ 1. Yes => **How many ANC visits did you go to?** |__|__| ☐ 2. No

For your last full-term pregnancy, did you go to antenatal care visits (ANC) at a health facility?

☐ 1. Yes => **How many ANC visits did you go to?** |__|__| ☐ 2. No

When did you last give birth? |__|__| (month) |__|__| (year)

Did you give birth in a health facility? ☐ 1. Yes ☐ 2. No

✉ TO ALL

In the past 3 months, have you used the following healthcare services:

- Medication

☐ 2. No

☐ 1. Yes => **Who paid for it?** ☐ 1. You ☐ 2. Your spouse ☐ 3. A household member ☐ 4. Someone else
=> **Was this care (or part of this care) covered by your insurance?** ☐ 1. Yes ☐ 2. No

If yes, amount covered: |__|__| |__|__| |__|__| CFA

- Consultation with health professionals

☐ 2. No

☐ 1. Yes => **Who paid for it?** ☐ 1. You ☐ 2. Your spouse ☐ 3. A household member ☐ 4. Someone else
=> **Was this care (or part of this care) covered by your insurance?** ☐ 1. Yes ☐ 2. No

If yes, amount covered: |__|__| |__|__| |__|__| CFA

- Medical exams (laboratory, radiology, ...)

☐ 2. No

☐ 1. Yes => **Who paid for it?** ☐ 1. You ☐ 2. Your spouse ☐ 3. A household member ☐ 4. Someone else
=> **Was this care (or part of this care) covered by your insurance?** ☐ 1. Yes ☐ 2. No

If yes, amount covered: |__|__| |__|__| |__|__| CFA

- Hospitalization

☐ 2. No

☐ 1. Yes => **Who paid for it?** ☐ 1. You ☐ 2. Your spouse ☐ 3. A household member ☐ 4. Someone else
=> **Was this care (or part of this care) covered by your insurance?** ☐ 1. Yes ☐ 2. No

If yes, amount covered: |__|__| |__|__| |__|__| CFA

- During the last 3 months, have you had expenses for travel (transportation: cab, bus, etc.) related to your health care (going to the hospital/health center/dispensary ... to consult, to have exams, to buy medicine, ...)?

☐ 1. Yes => **What was the amount?** |__|__|__| |__|__|__| CFA ☐ 2. No

ONLY FOR CHB PATIENTS – follow-up post-survey (PeCSEN study)

Retrieved CHB testing results ☐ 1. Yes ☐ 2. No

Undertook further examination to assess stage of liver disease ☐ 1. Yes ☐ 2. No

Referral to a healthcare facility for follow-up

☐ 1. No referral ☐ 2. Niakhar healthcare center ☐ 3. Fatick healthcare center
☐ 4. Fatick hospital ☐ 5. Sen-B cohort (Fann hospital) ☐ 6. Other => **Specify** _____

Follow-up visits: |__| visits (July 2019-September 2021)

PERCEIVED ABILITY TO OVERCOME BARRIERS TO HEALTHCARE SEEKING

Many different factors can prevent someone from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?

- Knowing where to go is...** ☐ 1. Not a problem ☐ 2. A small problem ☐ 3. A big problem
Getting permission to go is... ☐ 1. Not a problem ☐ 2. A small problem ☐ 3. A big problem
Getting the money to pay is... ☐ 1. Not a problem ☐ 2. A small problem ☐ 3. A big problem
The distance to the health facility is... ☐ 1. Not a problem ☐ 2. A small problem ☐ 3. A big pb
Having to take transport is... ☐ 1. Not a problem ☐ 2. A small problem ☐ 3. A big problem
Not wanting to go alone is... ☐ 1. Not a problem ☐ 2. A small problem ☐ 3. A big problem
Concern that you might be discriminated is... ☐ 1. Not a proble ☐ 2. A small problem ☐ 3. A big pb
| -> For which reason? ☐ 1. Ethical or cultural identity ☐ 2. Gender ☐ 3. Sexual orientation
☐ 4. Age ☐ 5. Illness or disability ☐ 6. Religion ☐ 7. Socio-economic group
8. Education level ☐ 9. Other => **Specify** _____

B. One-on-one interviews

Check-list to guide questions and document the entirety of the profile for each participant

<i>Themes</i>	<i>Possible questions</i>
Health status and health functioning – How is your health?	
<input type="checkbox"/> General health (physical and mental health, fatigue) <input type="checkbox"/> Hepatitis B status <input type="checkbox"/> Other diseases	Can you tell me about your health (pain, emotional problems, fatigue...)? Do you know if you have hepatitis B? Do you have any other diseases?
Health knowledge – What do you know of hepatitis B?	
<input type="checkbox"/> Own CHB status <input type="checkbox"/> CHB transmission and course of the disease <input type="checkbox"/> Prevention of infection (vaccine) and complications (treatment) <input type="checkbox"/> Risk behaviors (alcohol, tobacco, food) <input type="checkbox"/> Sources/search for good information	Do you know if you have chronic hepatitis B infection? What is chronic hepatitis B infection? How does one get it? What happens when someone has chronic hepatitis B? Can we protect ourselves from chronic hepatitis B? Is there a vaccine? a medication? tests? Are there things that should be done (or avoided) in relation to hepatitis B? How do you get credible information about health? about hepatitis B? (WHO, Ministry of Health, Hepatitis Program, radio, health post, healer, internet, etc.)
Health-seeking skills and beliefs, self-efficacy – For you, is it easy to be healthy?	
<input type="checkbox"/> Confidence in avoiding disease and avoiding CHB infection and complications <input type="checkbox"/> Ability to learn about health and/or CHB <input type="checkbox"/> Ability to change health behavior in relation to CHB	Is it easy for you to avoid getting sick? Is it easy to avoid getting sick with CHB? Have you ever learned any health-related skills (e.g., how to take a medication, how to prevent, or how to monitor a health problem such as CHB)? Have you ever changed your habits for health reasons (for example, going on a diet, or stopping drinking or smoking)? for CHB?
Health values and goals – How important is health to you?	
<input type="checkbox"/> Health goals in general, compared to other priorities <input type="checkbox"/> Disease/CHB goals <input type="checkbox"/> Goals in relation to habits and health <input type="checkbox"/> Conflicting goals in the family	How often do you think about your health? Do you think about it more or less than your work, or your family? Is it important to you not to get sick with CHB? Do you think about it often? Is it important/do you often think about changing things in your habits for your health or for CHB? Do people around you not want some of the things you do in relation to health or CHB? How do you react?
(Perceived) self-governance & self-management to achieve health outcomes – How do you organize your life in relation to health?	
<input type="checkbox"/> Organization in everyday life <input type="checkbox"/> Domestic and extra-familial tasks <input type="checkbox"/> Controlling health behaviors <input type="checkbox"/> Help and resources available for health	Can you tell me about a normal day, and explain how you organize your life between family, work, etc.? Is it hard to manage things at home and things outside (work, health)? How do you do it? Are you stopping yourself from doing things for your health/CHB? Do you ever ask for help from family or neighbors and get money or transportation for example, in relation to your health?
Effective health decision-making – How do/did you make decisions about your health, and CHB?	

<input type="checkbox"/> Searching for and using information about CHB <input type="checkbox"/> Changes in CHB habits <input type="checkbox"/> CHB symptoms, consultation and treatment route <input type="checkbox"/> Prevention of CHB infection and complications	Where did you look for information about CHB? Did it help you? How did you use the information? Have you decided to change any of your habits regarding CHB (<i>diet, alcohol consumption</i>)? Do you have any signs of CHB-related disease? Have you decided to go see people about the disease (<i>healer, doctors</i>)? Take medication or have tests (<i>screening, follow-up</i>)? Do you do anything to protect yourself or your family (<i>vaccine, hygiene</i>)?
Intrinsic motivation – Why did you make these decisions?	
<input type="checkbox"/> Internal motivation <input type="checkbox"/> External motivation	Why do you decide to do things (or not do things) for your health or in relation to CHB? Is this important to you? Is someone telling you to do this? Is it important to that person or group?
Positive expectations – How do you see your future?	
<input type="checkbox"/> Expectations and concerns about CHB <input type="checkbox"/> Expectations and concerns about health in general	Are you afraid of CHB (e.g., getting or being very sick with CHB)? Are you confident? Do you fear for your health (e.g. getting sick, dying young)? Do you have confidence?
<i>I am now going to ask you about your environment: the things and people around you, in your village, in the area and the region.</i>	
Social norms – What do people in the area think of CHB, and what do they do about it?	
<input type="checkbox"/> Social norms on hepatitis B, vaccine, blood sampling <input type="checkbox"/> Social norms on chronic carriers, alcohol, tobacco <input type="checkbox"/> Quantification of people who engage in these behaviors <input type="checkbox"/> Discrimination and stigmatization of CHB patients and others in health facilities <input type="checkbox"/> Social norms on health and CHB decision-making in the family <input type="checkbox"/> Changes in social norms related to CHB	What do people think about CHB in the area? of hepatitis B vaccines? of people doing blood sampling? What do they think of people with big bellies? of people who drink alcohol? of people who smoke? Does it concern many people (see behaviors listed in 1. and 2.) or specific people? Which ones? Are some people or groups of people unable to get vaccinated or tested? Are some people not well received at the health center (e.g., if they have CHB, if they drink alcohol)? In a household, how does someone decide to go to the hospital if they are sick? Do you decide alone, or with the head of the household, or with someone else? Have people changed their minds about vaccination or alcohol or CHB? Do you think this is a good thing?
Social networks and social capital for achieving positive health outcomes – Do you have help for your health and CHB?	
<input type="checkbox"/> Help available to do things <input type="checkbox"/> Help available to talk about hepatitis B <input type="checkbox"/> Health information sharing processes <input type="checkbox"/> Poor health information related to hepatitis B	Are there people who can help you if you need to go to the clinic for a health problem? Is there anyone you could talk to about your health problems, for example, about CHB? How do people share information about health and CHB (radio, marketplace, social networks)? Are there people who share rumors about CHB or about certain behaviors, such as drinking a lot of alcohol...?
Group membership influences – What do people close to you think of, and do about CHB?	
<input type="checkbox"/> Membership in groups/associations <input type="checkbox"/> Social norms of these groups on hepatitis B	Are you part of a group? an association? a political party? a team? What do people in these groups think about CHB?
Material circumstances – Can you tell me about your living conditions?	
<input type="checkbox"/> Economic situation: work (quantity, quality) and monetary resources <input type="checkbox"/> Neighborhood: noise, cleanliness, facilities	Do you have a job (temporary, permanent)? Do you earn money? Enough to live on? What do you think of your hamlet (cleanliness, noise, facilities and access to the road/Fatick)?

<input type="checkbox"/> Water (cleanliness, access), hygiene, waste <input type="checkbox"/> Housing: comfort, heat protection <input type="checkbox"/> Food (quantity, diversity, quality) <input type="checkbox"/> Environment: pollution, disease	Where do you get water to drink? To go to the bathroom? To wash yourself? Is the water clean? What do you do with the garbage? Where do you live? Is your home comfortable (heat protection, number of inhabitants)? Do you eat well? Who is in charge of choosing and cooking the food? What happens if there is not enough to eat? Are there any pollution problems around you (e.g. air pollution or pesticides)? Are there many diseases (including CHB)?
Economic, political and social security – <i>What do you think of the economic, social and political situation in your area/country?</i>	
<input type="checkbox"/> Quality of work and protection of workers <input type="checkbox"/> Social security (social services, health insurance) <input type="checkbox"/> General political situation	How easy is it to find a good job? What happens if someone is sick and can no longer work? Who can help if people are sick or need money to go for treatment (the government, social service, family, neighbors)? Do you know about non-for-profit community-based insurance companies? What is the political situation (elections, corruption...) in the area/region/country? Is there insecurity or delinquency?
Utilization and access to health services – <i>What do you do when you have a serious health problem? What would you do if you had a serious health problem related to CHB?</i>	
<input type="checkbox"/> Symptoms of CHB-related diseases <input type="checkbox"/> Symptoms of other diseases <input type="checkbox"/> Willingness to seek medical attention for a health problem <input type="checkbox"/> Availability of CHB health services <input type="checkbox"/> Barriers and obstacles to accessing care	Do you have any signs of a CHB-related illness (e.g., yellow eyes, stomach pain, swollen belly)? Do you have any signs of other health problems? Tell me about the last time you went to see someone for your health (which problem, traditional practitioner or doctor...) Do you know if it is possible to be vaccinated, screened or followed for CHB in your area? Do you have any problems going to the health center or hospital (finding money, getting around, long waits...)?
Enabling public health and health care systems – <i>What is your perception on the work the healthcare facilities and health authorities (ministry representatives, physicians, dispensaries, health center, regional hospital and hospitals in Dakar) are doing in helping you taking care of your health, including when it comes to CHB?</i>	
<input type="checkbox"/> Information and advice on CHB <input type="checkbox"/> Protection against CHB (screening, vaccine) <input type="checkbox"/> Efficiency and quality of care (including accountability)	In health centers or hospitals, what information/advice have you been given about CHB? Have you ever been offered CHB screening or vaccine? Are you being monitored for CHB? Have you ever had a problem with a doctor, health center or hospital for yourself or your family? Tell me about your last experience at a health center (if none, ask about the family).

C. Interviews with local CHB stakeholders

Discussion guide for focus groups or one-on-one interviews depending on participants' availability.

Social norms – What do people <i>in the Niakhar area</i> think of CHB, and what do they do about it?	
<input type="checkbox"/> Social norms on hepatitis B, vaccine, blood sampling <input type="checkbox"/> Social norms on chronic carriers, alcohol, tobacco <input type="checkbox"/> Quantification of people who engage in these behaviors <input type="checkbox"/> Discrimination and stigmatization of CHB patients and others in health facilities <input type="checkbox"/> Social norms on health and CHB decision-making in the family <input type="checkbox"/> Changes in social norms related to CHB	What do people think about CHB in the area? of hepatitis B vaccines? of people doing blood sampling? What do they think of people with big bellies? of people who drink alcohol? of people who smoke? Does it concern many people (see behaviors listed in 1. and 2.) or specific people? Which ones? Are some people or groups of people unable to get vaccinated or tested? Are some people not well received at the health center (e.g., if they have CHB, if they drink alcohol)? In a household, how does someone decide to go to the hospital if they are sick? Do they decide alone, or with the head of the household, or with someone else? Have people changed their minds about vaccination or alcohol or CHB? Do you think this is a good thing?
Social networks and social capital for achieving positive health outcomes – Do people have help for their health and CHB?	
<input type="checkbox"/> Help available to do things <input type="checkbox"/> Help available to talk about hepatitis B <input type="checkbox"/> Health information sharing processes <input type="checkbox"/> Poor health information related to hepatitis B	Do people get help if they need to go to the clinic for a health problem? Do people have support to talk about their health problems, for example, about CHB? How do people share information about health and CHB (radio, marketplace, social networks)? Are there people who share rumors about CHB or about certain behaviors, such as drinking a lot of alcohol...?
Group membership influences – What do people <i>in groups</i> think of, and do about CHB?	
<input type="checkbox"/> Membership in groups/associations <input type="checkbox"/> Social norms of these groups on CHB	What are the main group, associations, political party, sports team active in the Niakhar area? What do people in these groups think about CHB?
Material circumstances – What are people's living conditions?	
<input type="checkbox"/> Economic situation: work (quantity, quality) and monetary resources <input type="checkbox"/> Neighborhood: noise, cleanliness, facilities <input type="checkbox"/> Water (cleanliness, access), hygiene, waste <input type="checkbox"/> Housing: comfort, heat protection <input type="checkbox"/> Food (quantity, diversity, quality) <input type="checkbox"/> Environment: pollution, disease	Do most people have a job (temporary, permanent)? Do they earn enough money to live comfortably? What are most people's neighborhoods like (cleanliness, noise, facilities and access to the road/Fatick)? Where do people get water to drink? To go to the bathroom? To wash themselves? Is the water clean? What do they do with the garbage? Are people's homes comfortable (heat protection, number of inhabitants)? Do they eat well? Who is in charge of choosing and cooking the food? What happens if there is not enough to eat? Are there any pollution problems around (e.g. air pollution or pesticides)? Are there many diseases (including CHB)?
Economic, political and social security – What is the economic, social and political situation in the area/country?	
<input type="checkbox"/> Quality of work and protection of workers <input type="checkbox"/> Social security (social services, health insurance)	How easy is it to find a good job? What happens if someone is sick and can no longer work? Who can help if people are sick or need money to go for treatment (the government, social service, family, neighbors)? Do they know about non-for-profit community-based health insurance companies?

<input type="checkbox"/> General political situation	What is the political situation (elections, corruption...) in the area, region or country? Is there insecurity or delinquency?
Utilization and access to health services – <i>What do people do when they have a serious health problem, including related to CHB?</i>	
<input type="checkbox"/> Symptoms of CHB-related diseases <input type="checkbox"/> Symptoms of other diseases <input type="checkbox"/> Willingness to seek medical attention for a health problem <input type="checkbox"/> Availability of CHB health services <input type="checkbox"/> Barriers and obstacles to accessing care	What do people do when they have any signs of a CHB-related illness (e.g., yellow eyes, stomach pain, swollen belly)? When they have signs of other health problems? Do you know if it is possible to be vaccinated, screened or followed for CHB in the Niakhar area? Do people have any problems going to the health center or hospital (finding money, getting around, long waits...)?
Enabling public health and health care systems <i>What is your perception on the work the healthcare facilities and health authorities (ministry representatives, physicians, dispensaries, health center, regional hospital and hospitals in Dakar) are doing in helping people taking care of their health, including when it comes to CHB? What are the strengths and weaknesses, and how could it be improved?</i>	
<input type="checkbox"/> Information and advice on CHB <input type="checkbox"/> Protection against CHB (screening, vaccine) <input type="checkbox"/> Efficiency and quality of care (including accountability)	In health centers or hospitals, what information/advice are given about CHB? Are people systematically offered CHB screening or vaccine? Are they being monitored for CHB? Do people often encounter problems with a doctor, health center or hospital related to the efficiency or quality of care? What usually happens when it is the case?

D. Health facility survey

Date |__|__| / |__|__| / |__|__|

Investigator _____

Name of the facility _____

Type of health facility ☐₁ Public ☐₂ Private for-profit ☐₃ Private denominational

Town/city _____

MODULE 1: GENERAL RESOURCES

- Staff

	Full time	Part-time (> 1day/week)
a. Number of physicians	__ __	__ __
b. Number of nurses	__ __	__ __
c. Other staff (including cleaning, security, administration, etc.)	__ __ __	__ __ __

How many hospital beds does the health facility have? |__|__|__| (set up at the time of the survey)

Does the health facility have the following equipments?

a. Electrocardiography	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes → Was it working at the time of the survey <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
b. Ultrasound	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes → Was it working at the time of the survey <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
c. Radiology	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes → Was it working at the time of the survey <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
d. Scanner	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes → Was it working at the time of the survey <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
e. GenExpert	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes → Was it working at the time of the survey <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No

MODULE 2: RESOURCES FOR CHB VACCINATION, TESTING AND MANAGEMENT

Activity	Available	Workload over the past month (indicate 0 if none in the past month but activity available)
Birth dose	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	_ _ _ _ _ _ _
Pentavalent vaccine	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	_ _ _ _ _ _ _
CHB testing	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	_ _ _ _ _ _ _ ⇒ _ _ _ _ positive results
CHB follow-up exams/consultations	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	_ _ _ _ _ CHB patients
CHB treatment prescription/follow-up	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No	_ _ _ _ _ treated patients

- **Staff involved in hepatitis B activities** (including laboratory and administrative staff e.g., social services)

	Level of education/training	Job	Working here since (month/year)	Hepatitis B activities (vaccination, counseling, consultation, analysis, etc.)	Ever trained for CHB ? (yes/no, cumulative duration of training)
1					
2					
3					

- **Pharmacy**

Is there tenofovir in the health facility ? ☐₀ No ☐₁ Yes

|_|_|_|_| boxes available
☐₁ For VIH patients
☐₂ For CHB patients
(several answers possible)

Place of storage : _____

Rate of supply : |_|_|_| per week/month/year

- **Exams associated with CHB management**

	Available
Blood count	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
AST	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
ALT	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
Creatinine	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
Glycemia	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
Urea	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
Liver ultrasound	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
Fibroscan	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
HBsAg (testing)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
Viral load	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
HBeAb	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
HIV	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
HDV	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No
HCV	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No

MODULE 3: TESTING**If testing is NOT available in the health facility****Is hepatitis B testing offered to pregnant women during ANC visits?** ☐₁ Yes ☐₀ No

If yes, where are pregnant women are referred to? _____

Distance between the referral place and the health facility |__|__|__| km**Is hepatitis B testing grouped with other analyses included in the antenatal care exams?** ☐₁ Yes ☐₀ No**⇒ Go to the next module****For ANC visits, is hepatitis B testing grouped with other analyses included in the antenatal care exams?**☐₁ Yes ☐₀ No

Type(s) of test(s) available for CHB testing

Rapid test: ☐₁ Yes => _____ ☐₀ NoSerological test: ☐₁ Yes => _____ ☐₀ No**Resources employed during testing (to be filled through observation)**

Resources	Quantity
Counseling	
Staff involved in counseling (indicate average time for one patient)	Example: head nurse (20 minutes) 1. 2.
Testing	
Consumables (indicate quantity for one test)	Example : needles (1 needle) 1. 2.
Staff involved (indicate average time for one patient)	1. 2.
Analysis	
Consumables (indicate quantity for one test or quantity of tests analyzed at once if grouped in a bundle)	1. 2. 3.
Machines/devices (indicate the reference and date of purchase)	1. 2.
Staff involved (indicate average time for one test or bundle of tests)	1. 2.
Counseling post-test	
Time between the test and the results delivered to the patient	In the past month - Minimum time - Maximum time - Average time
Consumables (indicate quantity for result delivery to one patient)	1. 2.
Staff involved (indicate average time for one patient)	1. 2. 3.
Notes on the information delivered (content and quality)	

MODULE 4: CHB MANAGEMENT

Go to the next module if CHB management is NOT available in this health facility

Resources	Quantity
Consultation/medical examination	
Staff involved (<i>indicate average time for one patient</i>)	Example : Physician (20 minutes) 1. 2.
Blood sampling	
Consumables (<i>indicate quantity for one patient</i>)	Example: sampling tubes (5 tubes) 1. 2.
Staff involved (<i>indicate average time for one patient</i>)	1. 2.
Imagery	
Consumables (<i>indicate quantity for one patient</i>)	Example: echography gel (1/50 tube) 2. 3. 4.
Machines/devices (<i>indicate the reference and date of purchase</i>)	1. 2.
Staff involved (<i>average time for one patient</i>)	1. 2.
Result delivery/follow-up visit	
Time between the test and the results delivered to the patient	In the past month - Minimum time - Maximum time - Average time
Consumables (<i>quantity for one patient</i>)	1. 2.
Staff involved (<i>average time for one patient</i>)	1. 2.

Observation**First visit**

- General organization
- Clinical examination
- Exams prescribed
- Time until the next visit : jusqu'à prochaine visite :

Follow-up visits

Frequency: ☐ Quarterly ☐ Bi-annual ☐ Annual ☐ Other => _____

Key exams	Resources required	Challenges ¹
Echography		
Fibroscan		
Viral load		

¹ Is it working at the moment? Does it often breaks down? Ever running out of consumables/reagents? Any other issues?

MODULE 4: COSTS FOR THE HEALTH FACILITY**Consumables***(to be filled with information from module 3 and 4)*

Type of consumable and quantity (unit/bundle)	Cost	Date of the invoice used for the cost estimation
<i>Example: box of 10 needles</i>	<i>3,000 CFA</i>	<i>February 2022</i>

Equipments

Equipment <i>n</i>	
Type of equipment (brand)	
Price (date of purchase)	
Costs of revision (frequency)	
Staff training (duration in days)	

Staff (including support and administration)

Job/training	Monthly salary	Date of the reference salary
<i>Example: nurse</i>	<i>300,000 CFA</i>	<i>January 2022</i>

Fixed costs (buildings, invoices, cars, etc.)

Type of costs	Cost (monthly or yearly)	Reference month/year
<i>Example : electricity</i>	<i>1,000,000 CFA (monthly)</i>	<i>January 2020</i>

MODULE 5: COSTS FOR THE PATIENTS

Type of intervention	Amount paid (0 if free)	Co-payment (insurance, free care for children/elderly/indigents)?
Testing		
Counseling/consultation before CHB testing	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Testing	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Result/post-test counseling	_ , _ _ _ , _ _ _ CFA	Details: _____
CHB management		
Consultation	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Blood count	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
AST/ALT	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Creatinin	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Glycemia	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Urea	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Liver echography	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Fibroscan	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Viral load	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
HBeAb	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
HIV	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
HDV	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
HCV	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Hospitalization (per day)	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Treatment		
Medication _____	_ , _ _ _ , _ _ _ CFA Duration : _____ (monthly/yearly)	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
Other (e.g., transport, administrative costs, etc.)		
	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____
	_ , _ _ _ , _ _ _ CFA	<input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No Details: _____