

Subject ID: \_\_\_\_\_

## HIGH RISK GROUP QUESTIONNAIRE: ANIMAL MARKET WORKER/ACTOR

Instructions to the administrators should be provided here.

### A. GENERAL INFORMATION

A1. Country where study is being conducted: \_\_\_\_\_

A2. Subject ID: \_\_\_\_\_

A3. Interviewee Name: First name \_\_\_\_\_ Surname \_\_\_\_\_

A4. Interviewer Name: First name \_\_\_\_\_ Surname \_\_\_\_\_

A5 Date of interview (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

A6. Primary Residence (options to be finalized by country) (Region, City, Province, Country):  
\_\_\_\_\_

A7. Secondary Residence (options to be finalized by country) (Region, City, Province, Country):  
\_\_\_\_\_

A8. Language used for interview (options to be finalized by country):

English  Arabic  Local dialect  Persian  Other, please specify \_\_\_\_\_

A9. Gender (tick one):  Male  Female

A10. Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (dd/mm/yyyy)

A11. What is your current marital status?  Single  Married  Divorced  Widowed

A112. How many people live in your household with you (one household is defined as sharing a single kitchen)?

A12.1 Children aged less than 18 years old: \_\_\_\_\_

A12.2 Adults aged 18 years and older: \_\_\_\_\_

### B. OCCUPATIONAL EXPOSURES

B1. How long have you worked at this or being involved in activities at this market?

\_\_\_\_ Years      \_\_\_\_ Months

B2. What is/are your job/jobs at this market? (tick all that apply)

Job titles need to be finalized after field visits and could include (loading, offloading animals, vehicle transport, trekking animals on hoof, broker, trader, cleaning, records keeping, animal health services including permits issuance and inspection of animals, collecting revenues, petty traders for support services- feeds, ropes, drugs, etc.)

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- Selling/buying of animals       Animal care       Slaughtering of animals       Admin staff
- Other \_\_\_\_\_

Of the listed options, which you selected, which is your primary job? \_\_\_\_\_

**B3. How many days per week do you work at this camel farm/barn/ranch?**

- Once a week       At least three times a week       Daily

**B4. Are there certain weeks/periods of the year when you work more or less at this market (e.g., for example around holiday or festivals)?**

- Yes     No

B5.2 If yes, please describe: \_\_\_\_\_

**B5. Is working at the market your main occupation?**

- Yes     No

B5.1 If no, what is your main occupation? \_\_\_\_\_

**B6. Which animals are sold at this market?**

Tick all that apply:

- Dromedary camels       Goats       Sheep       Cattle  
 Horses       Donkey       Other(1) \_\_\_\_\_  
 Other (2) \_\_\_\_\_

**B6.1 If dromedary camels are sold at the market, where do they come from?**

- Within the same region as the market       Other regions of the country  
 Other country: \_\_\_\_\_

**B6.2 If dromedary camels are sold at the market, who sells them?**

- Camel owner       Camel trader  
 Other: \_\_\_\_\_

**B7. Have you seen other animals, rodents or pests at the market?**

- Yes     No

B7.1 If yes, which other animals have you seen at the market?

- Cats       Dogs       Rats       Mice       Bats  
 Other \_\_\_\_\_

## C. PERSONAL PROTECTIVE EQUIPMENT AND HYGIENE PRACTICES

The questions below should be modified after piloting/field testing of the questionnaire.

**C1. Do you ever wear personal protective equipment while working at the market?**

- Yes       No

**C2. What personal protective equipment do you usually (daily) wear when working at the market?**

- Gloves                       Coveralls                       Dust masks                       Boots or boot covers  
 Respirators                       Eye protection (goggles, safety glasses)  
 Other: \_\_\_\_\_

**C3. How often do you usually wash your hands while working at the market?**

(Note to interviewers: Observe if there are handwashing facilities at the market and if there is soap or other cleaning materials are available.)

- At mealtimes                       Before and after each animal related task  
 At bathroom times                       The beginning and end of the day                       Rarely

**D. ANIMAL EXPOSURES IN/AROUND THE HOME (where you live)**

**D1. Have you had any livestock kept in or around your home in the last six months?**

- Yes                       No                       Unknown

D1.1 Name the species, the number of animals and what they are used for

Animal species	Number of animals	What are they used for (if known)?	Did you have direct contact (i.e., touch) with these animals?	Any illness affecting animals in the last six months?
Camels	<input type="checkbox"/> None <input type="checkbox"/> < 10 animals <input type="checkbox"/> ≥ 10 animals	<input type="checkbox"/> income <input type="checkbox"/> food <input type="checkbox"/> work <input type="checkbox"/> racing <input type="checkbox"/> pets <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sheep	<input type="checkbox"/> None <input type="checkbox"/> < 10 animals <input type="checkbox"/> ≥ 10 animals	<input type="checkbox"/> income <input type="checkbox"/> food <input type="checkbox"/> work <input type="checkbox"/> racing <input type="checkbox"/> pets <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Goats	<input type="checkbox"/> None <input type="checkbox"/> < 10 animals <input type="checkbox"/> ≥ 10 animals	<input type="checkbox"/> income <input type="checkbox"/> food <input type="checkbox"/> work <input type="checkbox"/> racing <input type="checkbox"/> pets <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cattle	<input type="checkbox"/> None <input type="checkbox"/> < 10 animals <input type="checkbox"/> ≥ 10 animals	<input type="checkbox"/> income <input type="checkbox"/> food <input type="checkbox"/> work <input type="checkbox"/> racing <input type="checkbox"/> pets <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Horses	<input type="checkbox"/> None <input type="checkbox"/> < 10 animals	<input type="checkbox"/> income <input type="checkbox"/> food	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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	<input type="checkbox"/> ≥ 10 animals	<input type="checkbox"/> work <input type="checkbox"/> racing <input type="checkbox"/> pets <input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
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**D2. In the last six months, did you have any contact with any carcasses, body fluids, secretions, urine or excrement of camels in or around your home?**

Yes       No       Unknown

**D3. In the last six months, did you have any contact with any camel bedding, stray of feed in or around your home?**

Yes       No       Unknown

**D4. At your home, in the last six months did you do any of the following activities:**

- |                                       |                              |                             |                                  |
|---------------------------------------|------------------------------|-----------------------------|----------------------------------|
| D4a. Feed camels?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4b. Clean camel housing?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4c. Slaughter camels?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4d. Assist with the birth of camels? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4e. Milk camels?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4f. Kiss/hug camels?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4g. Other tasks related to camels?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| D4g1. If yes, please specify: _____   |                              |                             |                                  |

**D5. Do others living in your household (e.g., domestic help or relative) frequently visit or work on a farm or market where camels are kept or sold?**

Yes       No       Unknown

D5a. Have others living in your household (e.g., domestic help or relative) had visited or worked in the in the past 2 weeks at a farm or market where camels are kept or sold?

Yes     No       Unknown

D5b. Have others living in your household (e.g., domestic help or relative) had direct contact with camels in the past 2 weeks?     Yes       No       Unknown

## E. FOOD/MEDICINAL EXPOSURES

*The following series of questions are focused on food exposures in the last six months and questions related to your use of camel or camel products for medicinal or therapeutic reasons.*

**E1. Do you regularly eat camel meat or consume other camel products (e.g., milk, urine)?**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <b>E1.1 Do you regularly drink raw camel milk?</b>    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>E1.2 Do you regularly drink boiled camel milk?</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>E1.3 Do you regularly drink camel urine?</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>E1.4 Do you regularly eat raw camel meat?</b>      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>E1.5 Do you regularly eat cooked camel meat?</b>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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**E2. Do you believe that camels or camel products have medicinal or therapeutic properties?**

Yes     No     Not sure

**E3. Do you use camel products for medicinal purposes?**                       Yes     No

If yes,

E3.1 Do you drink camel milk for medicinal or therapeutic purposes?

E3.2 Do you drink camel urine for medicinal purposes?

E3.3 Do you receive or use any traditional medications that contain camel products?

E3.4 What illnesses or medical conditions are you treating with camel or camel related products?

## F. TRAVEL HISTORY AND EXPOSURES

**F1. During the last six months have you travelled outside [study site]?**

Yes     No

F1.1 If yes, what countries/regions have you visited?

Country	Region/City	Approximate Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**F2. Have you attended any recent mass gatherings (e.g., weddings, festivals or religious pilgrimages) outside of your regions country where there were large numbers of people together?**

Yes     No     Unknown

F2.1 If yes, specify event(s) and location:

**F3. When you travelled, did you do any of the following?**

Tick all that apply:		Location of the farm (town, country)	Animals present at venue (circle all that apply)	Did you have direct contact with any of these animals?	Did you have any direct contact with any animal carcasses, body fluids, secretions, urine or excrement while at this venue?
Visit a farm with animals	<input type="checkbox"/>		<input type="checkbox"/> Camel <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Horse <input type="checkbox"/> Cattle	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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Visit an animal market	<input type="checkbox"/>		<input type="checkbox"/> Camel <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Horse <input type="checkbox"/> Cattle	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Visit a slaughter house	<input type="checkbox"/>		<input type="checkbox"/> Camel <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Horse <input type="checkbox"/> Cattle	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Visit a race track	Yes <input type="checkbox"/>		<input type="checkbox"/> Camel <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Horse <input type="checkbox"/> Cattle	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

### G. SIGNS AND SYMPTOMS

**G1. Are you sick today with fever and/or cough?**

Yes       No

(If yes, ask to take respiratory specimens)

**G2. Did you experience any respiratory signs or symptoms during the last six months?**

Yes       No       Unknown

**G3. If you answered yes to either G1 or G2, please indicate which symptoms:**

<b>Symptom</b>	<b>Today</b>	<b>Last 6 months</b>
G3.1 Dry Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.2 Productive Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.3 Phlegm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.4 Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.5 Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.6 Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.7 Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.8 Muscle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.9 Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.10 Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.11 Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
G3.12 Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**G4. Did you seek medical care?**

Yes    No    Unknown

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G4.1 If yes, where did you seek medical care (name and address of medical facility)?  
\_\_\_\_\_

**G5. Where you hospitalized during the course of your illness?**     YES     NO     UNKNOWN

G5.1 If yes, when were you hospitalized (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

G5.2 If yes, which hospital did you receive treatment(s)? (Name and address)  
\_\_\_\_\_

## H. MEDICAL HISTORY AND RELATED EXPOSURES

**H1. Do you currently smoke tobacco (ex. cigarettes, cigars, shisha)?**

Daily     A few days a week     Not at all     Unknown

**H2. Do you share your tobacco (e.g., shisha)?**

Yes     No     Unknown

**H3. Have you smoked tobacco daily in the past?**

Yes     No     Unknown

**H4. Is there any hereditary disease running in your family?**

Yes     No     Unknown

H4.1 If yes, please specify the disease(s): \_\_\_\_\_

**H5. Do you currently have any chronic illness (ex. asthma, cancer, diabetes)?**

Yes     No     Unknown

H5.1. If yes, please specify the disease(s): \_\_\_\_\_

**H6. Have you taken medications regularly in the last six months?**

Yes     No     Unknown

H6.1 If yes, what medications do you regularly take? List all: \_\_\_\_\_

**H7. Have you taken any traditional medications in the last six months?**

Yes     No     Unknown

H7.1 If yes, which traditional medications ? List all: \_\_\_\_\_

**H8. If female, were you pregnant in the last six months?**

Yes     No     Unknown

**H9. Have you visited anyone in the hospital in the last 6 months?**

Yes     No     Unknown

H9.1. If yes, was the person sick with respiratory (cough, breathing problems)?

Yes     No     Unknown

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H9.2 If yes, at what hospital (regions, city, district) \_\_\_\_\_

H9.3 If yes, what was your relationship to the person in the hospital?

Close family  Extended family  Friend  Other \_\_\_\_\_

## I. Contact

I1. May we contact you again with follow up questions or clarifications?

Yes  No  Unknown

I1.1 If yes, telephone number of subject: \_\_\_\_\_