

**Supplementary File 1****Close-ended structured questionnaire****A. Close ended structured questionnaire– Administered directly in English with oral translations into Fulbe, Kotoko, Mosgum, and Arab**

Name of Community: \_\_\_\_\_

Age (years): \_\_\_\_\_

Education: Informal education ( ) Formal education ( ) (specify) \_\_\_\_\_

Marital Status: Single ( ) Married ( ) Separated ( ) Widowed ( )

No of years having lived in community \_\_\_\_\_

Previous community \_\_\_\_\_

Economic activity-----

Residence ----- (collect coordinates)

**Questions on symptoms of urinary tract schistosomiasis; FGS; OR STI**

1. Do you see your menses? Yes ( ) No ( )
2. Did you observe/experience your menses within the last two weeks? Yes ( ) No ( ) Does your menses come every month? Regular?
3. Is your menses painful? \_\_\_\_\_(pain during menstruation – always very painful, sometimes painful, normal) Irregular? \_\_\_\_\_(every month?, not every month, stopped)
4. Do you have pain in your lower abdomen? When? For how long?
5. Do you have pain when urinating? Yes ( ) No ( )
6. Do you have difficulty in urinating (urine not coming out fluently)? Yes ( ) No ( )
7. Do you have sudden uncontrollable and unexpected urge to urinate and mostly cannot hold it? Even when you cough it comes out? Yes ( ) No ( )
8. Do you see blood in your urine? Yes ( ) No ( )
9. (If yes) When did you lastly see blood in your urine? \_\_\_\_\_Always, sometimes, Once in a while
10. Do you sometimes have itching in your private part? Yes ( ) No ( )
11. How often do you experience this? Once a while ( ) frequently ( )/ When was the last time?
12. Do you have a feeling of burning within your private part? Yes ( ) No ( )

13. How often do you experience this? Once a while ( ) Frequently ( )
14. Do you sense a swelling/lumps within your private part? Yes ( ) No ( ) No response ( )
15. Do you have any discharge that comes from your vagina? Yes ( ) No ( ) Does it have an odour? \_\_\_\_\_ Do you see the colour? Yes ( ) No ( ) What Color is it? White; grey; green/yellow; brown
16. Do you think this is normal? Yes ( ) No ( ) Do not know ( ). When did you start observing the discharge? Date \_\_\_\_\_
17. After sexual intercourse do you have a discharge? Yes ( ) No ( ) Is it smelly? Yes ( ) No ( ) Do not know ( )
18. After or during sexual intercourse do you have pain? Yes ( ) No ( ) I do not know ( ) ; Do you have a bloody discharge? Yes ( ) No ( ) I do not know ( )
19. Have you had any miscarriages /pregnancies that passed? Yes ( ) No ( )
20. How many? ( )
21. Do you have children? Yes ( ) No ( )
22. What age is your last child? ( )
23. Have you visited the clinic to complain about these issues? Yes ( ) No ( )
24. What you used/taken/done to treat any of these problems? \_\_\_\_\_ (Underline) Hospital or drug store/ local midwife/ traditional medicine/ prayers/ none of the above (what other? Specify)/nothing

**Water contact History**

1. Where do you fetch your household water? Lake; other source (name) \_\_\_\_\_
2. Do you fish in the lake? Yes ( ), No ( )
3. Do you bathe in the lake? Yes ( ), No ( )
4. What do you use the lake for? ( ) \_\_\_\_\_