

## VERBAL AUTOPSY QUESTIONNAIRE 3

### DEATH OF A PERSON AGED 15 YEARS AND ABOVE

#### CONSENT STATEMENT

Good Morning/Good Afternoon/ Good Evening.

My name is \_\_\_\_\_ and I am working with \_\_\_\_\_ University.

We are collecting information on the causes of death in the community. We would very much appreciate your participation in this effort. We want to ask you about the circumstances leading to the death of the deceased. Whatever information you provide will be kept strictly confidential. No information identifying you or the deceased will ever be released to anyone outside of this information-collection activity. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You may also stop the interview completely at any time without any consequences at all. However, we hope that you will participate in this survey since the results will help the government improve services for people.

At this time, do you want to ask me anything about the purpose or content of this interview?

May I begin the interview now?

Signature of interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

RESPONDENT AGREES TO BE INTERVIEWED ..... 1    Respondent does not agree to be interviewed ..... 2 → END



Personal data of the deceased: Name of the deceased _____ Kebele name and code _____ Name of village/genda _____	I.D of the deceased Family code House number
---------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------

Section 1: VA Interviewer Contact Result			
Name of interviewer: _____	Kebele name _____	Family ID _____	
Interviewer signature : _____			
Name of supervisors: _____			
Supervisors signature : _____	House number: _____		
Outcome of first visit	1.Completed 2. Not around home 3. Interrupted 4. Refused		Date of appointment for other time visit _____
Outcome of second visit	1.Completed 2. Not around home 3. Interrupted 4. Refused		Date of appointment for other time visit _____
Outcome of third Visit	1.Completed 2. Not around home 3. Interrupted 4. Refused		Date of appointment for other time visit _____
Name of interviewee:	Age of interviewee:		Sex of interviewee: 1. Male 2. female
Date of interview (ETC): Day/Month/Year		_____/_____/_____	

SECTION 2. BASIC INFORMATION ABOUT RESPONDENT										
201	RECORD THE TIME AT START OF INTERVIEW	HOUR ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MINUTES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>								
202	What is your relationship to the deceased?	FATHER .....1 MOTHER.....2 SIBLING .....4 OTHER RELATIVE .....6 (SPECIFY) NO RELATION .....8								
203	Did you live with the deceased in the period leading to her/his death	Yes .....1 No .....2								

SECTION 3. INFORMATION ON THE DECEASED AND DATE/PLACE OF DEATH														
301	Was the deceased female or male?	FEMALE .....1 MALE .....2												
302	When was the deceased born?  RECORD '9 8' IF DON'T KNOW DAY OR MONTH RECORD '9 9 9 8' IF DON'T KNOW YEAR	DAY ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTH ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> YEAR ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>												
303	How old was the deceased when s/he died?	AGE IN DAYS..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td></tr></table>												
304	What was her/his occupation, that is what kind of work did s/he mainly do?	_____ _____ _____ <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table>												
305	What was the highest level of formal education the deceased attended?	None .....1 Primary .....2 Secondary .....3 Don't know .....8												
306	What was her/his marital status?	Never married .....1 Married/living with a partner .....2 Widowed .....3 Divorced .....4 Separated .....5 Don't know .....8												
307	When did s/he die?  RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	Day ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Month ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Year ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>												

309	Where did s/he die?	Hospital .....1 Other health faculty.....2 Home.....3 Other .....6 (specify) Don't know.....8
-----	---------------------	--------------------------------------------------------------------------------------------------------------



s/he was ill. Some of these questions may not appear to be directly related to his/her death. Please bear with me and answer all the questions. They will help us to get a clear picture of all possible symptoms that the deceased had.

Please tell me if the deceased suffer from any of the following illnesses:

501	High blood pressure	Yes .....1 No .....2 Don't know .....8	
502	Diabetes?	Yes .....1 No .....2 Don't know .....8	
503	Asthma	Yes .....1 No .....2 Don't know .....8	
504	Epilepsy?	Yes .....1 No .....2 Don't know .....8	
505	Malnutrition?	Yes .....1 No .....2 Don't know .....8	
506	Cancer?	Yes .....1 No .....2 Don't know .....8	—▶ 508 —▶ 508
507	Can you specify the type or site of cancer?	Type/site _____ _____	
508	Tuberculosis?	Yes .....1 No .....2 Don't know .....8	
509	HIV/AIDS?	Yes .....1 No .....2 Don't know .....8	
510	Did s/he suffer from any other medically diagnosed illness?	Yes .....1 No .....2 Don't know .....8	—▶ 601 —▶ 601
511	Can you specify the illness?	Illness _____ _____	

**SECTION 6. HISOTRY OF INJURIES/ACCIDENTS**

601	Did s/he suffer from any injury or accident that led to her/his death?	Yes .....1 No .....2 Don't know .....8  —▶ 604 —▶ 604 602 What kind of injury or accident did the deceased suffer? Road traffic accident ..... 01 Fall ..... 02 Drowning ..... 03 Poisoning ..... 04 Burns ..... 05 Violence/assault ..... 06 Other .....96 (specify)	
603	Was the injury or accident intentionally inflicted by someone else?	Yes .....1 No ..... 2 Don't know ..... 8	
604	Do you think that s/he committed suicide?	Yes .....1 No ..... 2 Don't know ..... 8	
605	Did s/he suffer from any animal/insect bite that led to her/his death?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 608 —▶ 608
606	What type of animal/insect?	Dog .....1 Snake .....2 Insect .....3 Other ..... 6 (Specify) Don't know .....8	
607	CHECK QUESTION 302 FOR SEX AT DEATH:  FEMALE <input type="checkbox"/> 701  MALE <input type="checkbox"/> →		801

**SECTION 7. SYMPTOMOS AND SIGNS ASSOCIATED WITH ILLNESS OF WOMEN**

701	Did she have an ulcer or swelling in the breast?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 703 —▶ 703
702	For how long did she have an ulcer or swelling in the breast?	Days ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....9 9 8	
703	Did she have excessive vaginal bleeding during menstrual periods?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 705 —▶ 705

704	For how long did s/he have the excessive vaginal bleeding during menstrual periods?	Days ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....9 9 8	
705	Did she have vaginal bleeding in between menstrual periods?	Yes .....1 No ..... 2 Don't know ..... 8	→ 707 → 707
706	For how long did she have vaginal bleeding in between menstrual periods?	Days ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998	
707	Did she have abnormal vaginal discharge?	Yes .....1 No ..... 2 Don't know ..... 8	
708	For how long did she have abnormal vaginal discharge?	DAYS ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....9 9 8	

**SECTION 8. SYMPTOMS AND SIGNS ASSOCIATED WITH PREGNANCY**

801	Was she pregnant at the time of death	Yes .....1 No ..... 2 Don't know ..... 8	→ 806 → 806																																																
802	How long was she pregnant?	DAYS ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998																																																	
803	How many pregnancies had she had, including this one?	Days ..... <input type="text"/> <input type="text"/> Don't know ..... 9 8																																																	
804	During the last 3 months of pregnancy, did she suffer from any of the following illnesses: 1 Vaginal bleeding? 2 Smelly vaginal discharge? 3 Puffy face? 4 Headache? 5 Blurred vision? 6 Convulsion? 7 Febrile illness? 8 Severe abdominal pain that was not labor pain? 9 Pallor and shortness of breath (both present)? 10 Did she suffer from any other illness?	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>Vaginal bleeding.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Smelly vaginal discharge</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Puffy face .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Headache .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Blurred vision .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Convulsion .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Febrile illness .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>severe abdominal pain (not labor pain) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Pallor/shortness of breath (both).....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>other illness .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>specify _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	Vaginal bleeding.....	1	2	8	Smelly vaginal discharge	1	2	8	Puffy face .....	1	2	8	Headache .....	1	2	8	Blurred vision .....	1	2	8	Convulsion .....	1	2	8	Febrile illness .....	1	2	8	severe abdominal pain (not labor pain) .....	1	2	8	Pallor/shortness of breath (both).....	1	2	8	other illness .....	1	2	8	specify _____				
	YES	NO	DK																																																
Vaginal bleeding.....	1	2	8																																																
Smelly vaginal discharge	1	2	8																																																
Puffy face .....	1	2	8																																																
Headache .....	1	2	8																																																
Blurred vision .....	1	2	8																																																
Convulsion .....	1	2	8																																																
Febrile illness .....	1	2	8																																																
severe abdominal pain (not labor pain) .....	1	2	8																																																
Pallor/shortness of breath (both).....	1	2	8																																																
other illness .....	1	2	8																																																
specify _____																																																			
805	Did she die during labor, but undelivered?	Yes .....1 No ..... 2 Don't know ..... 8																																																	
806	Did she give birth recently?	Yes .....1 No ..... 2 Don't know ..... 8	→ 818 → 818																																																

807	How many days after giving birth did she die?	Days ..... <input type="text"/> <input type="text"/> Don't know ..... 98	
808	Was there excessive bleeding on the day labor started?	Yes .....1 No ..... 2 Don't know ..... 8	
809	Was there excessive bleeding during labor before delivering the baby?	Yes .....1 No ..... 2 Don't know ..... 8	
810	Was there excessive bleeding after delivering the baby?	Yes .....1 No ..... 2 Don't know ..... 8	
811	Did she have difficulty in delivering the placenta?	Yes .....1 No ..... 2 Don't know ..... 8	
812	Was she in labor for unusually long (more than 24 hours)?	Yes .....1 No ..... 2 Don't know ..... 8	
813	Was it a normal vaginal delivery?	Yes .....1 No ..... 2 Don't know ..... 8	—► 815 —► 815
814	What type of delivery was it?	Forceps/Vacuum.....1 Caesarean section .....2 Other _____ 6 (Specify) Don't know .....8	
815	Did she have foul smelling vaginal discharge?	Yes .....1 No ..... 2 Don't know ..... 8	
816	Where did she give birth?	Hospital .....1 Other health faculty.....2 Home.....3 Other _____ 6 (specify) Don't know.....8	
817	Who conducted the delivery?	Doctor .....1 Nurse/Midwife.....2 Traditional birth attendant .....3 Relative .....4 Mother by herself ..... 5 Other _____ (Specify) Don't know .....8	
818	Did she experience an abortion recently?	Yes .....1 No ..... 2 Don't know ..... 8	—► 901 —► 901
819	Did she die during the abortion?	Yes .....1 No ..... 2 Don't know ..... 8	—► 821 —► 821
820	How many days before death did she have the abortion?	Days ..... <input type="text"/> <input type="text"/> Don't know ..... 98	
821	How many months pregnant was she when she had the abortion?	Months ..... <input type="text"/> <input type="text"/> Don't know ..... 98	

822	Did she have heavy bleeding after the abortion?	Yes .....1 No ..... 2 Don't know ..... 8	
823	Did the abortion occur by itself, spontaneously?	Yes .....1 No ..... 2 Don't know ..... 8	—► 901 —► 901
824	Did she take medicine or treatment to induce?	Yes .....1 No ..... 2 Don't know ..... 8	

**SECTION 9. SIGNS AND SYMPTOMS NOTED DURING THE FINAL ILLNESS**

901	For how long was s/he ill before s/he died?	DAYS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
902	Did s/he have a fever?	Yes .....1 No ..... 2 Don't know ..... 8	—► 907 —► 907								
903	For how long did s/he have a fever?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
904	Was the fever continuous or on and off?	Continuous .....1 On and Off .....2 Don't know .....8									
905	Did s/he have fever only at night?	Yes .....1 No ..... 2 Don't know ..... 8									
906	Did s/he have chills/rigor?	Yes .....1 No ..... 2 Don't know ..... 8									
907	Did s/he have a cough?	Yes .....1 No ..... 2 Don't know ..... 8	—► 913 —► 913								
908	For how long did s/he have a cough?	DAYS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
909	Was the cough severe?	Yes .....1 No ..... 2 Don't know ..... 8									
910	Was the cough productive with sputum?	Yes .....1 No ..... 2 Don't know ..... 8									
911	Did s/he cough out blood?	Yes .....1 No ..... 2 Don't know ..... 8									
912	Did s/he have night sweats?	Yes .....1 No ..... 2 Don't know ..... 8									
913	Did s/he have breathlessness?	Yes .....1 No ..... 2 Don't know ..... 8	—► 918 —► 918								



914	For how long did s/he have breathlessness?	DAYS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
915	Was s/he unable to carry out daily routines due to breathlessness?	Yes .....1 No ..... 2 Don't know ..... 8									
916	Was s/he breathless while lying flat?	Yes .....1 No ..... 2 Don't know ..... 8									
917	Did s/he have wheezing?	Yes .....1 No ..... 2 Don't know ..... 8									
918	Did s/he have chest pain?	Yes .....1 No ..... 2 Don't know ..... 8	→ 928 → 928								
919	For how long did s/he have chest pain?	DAYS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
920	Did chest pain start suddenly or gradually?	Suddenly..... 1 Gradually .....2 Don't know ..... 8									
921	When s/he had severe chest pain, how long did it last?	Less than half an hour .....1 Half an hour to 24 hours .....2 Longer than 24 hours .....3 Don't know .....8									
922	Was the chest pain located below the breastbone (sternum)?	Yes .....1 No ..... 2 Don't know ..... 8									
923	Was the chest pain located over the heart and did it spread to the left arm?	Yes .....1 No ..... 2 Don't know ..... 8									
924	Was the chest pain located over the ribs (sides)?	Yes .....1 No ..... 2 Don't know ..... 8									
925	Was the chest pain continuous or on and off?	Continuous .....1 On and Off .....2 Don't know ..... 8									
926	Did the chest pain get worse while coughing?	Yes .....1 No ..... 2 Don't know ..... 8									
927	Did s/he have palpitations?	Yes .....1 No ..... 2 Don't know ..... 8									
928	Did s/he have diarrhea?	Yes .....1 No ..... 2 Don't know ..... 8	→ 933 → 933								
929	For how long did s/he have diarrhea?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
930	Was the diarrhea continuous or on and off?	Continuous .....1 On and Off .....2 Don't know ..... 8									

931	At any time during the final illness was there blood in the stool?	Yes .....1 No ..... 2 Don't know ..... 8	
932	When the diarrhea was most severe, how many times did s/he pass stools in a day?	Number..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	
933	Did s/he vomit?	Yes .....1 No ..... 2 Don't know ..... 8	→ 937 → 937
934	For how long did s/he vomit?	Days..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....9 9 8	
935	Did the vomit look like a coffee-colored fluid or bright red/blood red or some other?	Coffee-colored fluid .....1 Bright red/blood red .....2 Other ..... 6 (Specify) Don't know .....8	
936	When the vomiting was most severe, how many times did s/he vomit in a day?	Number..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	
937	CHECK QUESTION 302 SEX OF THE DECEASED:  FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>		→ 939
938	CHECK QUESTION 801, 805, 819, TO SEE IF SHE DIED DURING PREGNANCY, LABOR, ABORTION OR POSTPARTUM:  NO <input type="checkbox"/> YES <input type="checkbox"/>		→ 948
939	Did s/he have abdominal pain?	Yes .....1 No ..... 2 Don't know ..... 8	→ 941 → 941
940	For how long did s/he have abdominal pain?	Days..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....9 9 8	
941	Did s/he have abdominal distension?	Yes .....1 No ..... 2 Don't know ..... 8	→ 945 → 945
942	For how long did s/he have abdominal distension?	Days..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998	
943	Did the distension develop rapidly within days or gradually over months?	Rapidly within days .....1 Gradually over months .....2 Don't know .....8	
944	Was there a period of a day or longer during which s/he did not pass any stool?	Yes .....1 No ..... 2 Don't know ..... 8	

945	Did s/he have any mass in the abdomen?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 948 —▶ 948								
946	For how long did s/he have the mass in the abdomen?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
947	Where in the abdomen was the mass located?	Right upper abdomen .....1 Left upper abdomen .....2 Lower abdomen .....3 All over abdomen .....4 Don't know .....8									
948	Did s/he have difficulty or pain while swallowing solids?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 950 —▶ 950								
949	For how long did s/he have difficulty or pain while swallowing solids?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
950	Did s/he have difficulty or pain while swallowing liquids?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 952 —▶ 952								
951	For how long did s/he have difficulty or pain while swallowing liquids?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
952	Did s/he have headache?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 955 —▶ 955								
953	For how long did s/he the have headache?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
954	Was the headache severe?	Yes .....1 No ..... 2 Don't know ..... 8									
955	Did s/he have a stiff or painful neck?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 967 —▶ 967								
956	For how long did s/he have a stiff or painful neck?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> Don't know ..... 98									
957	Did s/he have mental confusion?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 960 —▶ 960								
958	For how long did s/he have mental confusion?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									

959	Did the mental confusion start suddenly, quickly within a single day, or slowly over many days?	Suddenly..... 1 Within a day (Fast).....2 Slowly (Many days).....3 Don't know ..... 8									
960	Did s/he become unconscious?	Yes .....1 No ..... 2 Don't know ..... 8	→ 963 → 963								
961	For how long was s/he unconscious?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
962	Did the unconsciousness start suddenly, quickly within a single day, or slowly over many days?	Suddenly..... 1 Within a day (Fast).....2 Slowly (Many days).....3 Don't know ..... 8									
963	Did s/he have convulsions?	Yes .....1 No ..... 2 Don't know ..... 8	→ 965 → 965								
964	For how long did s/he have convulsions?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
965	Was s/he unable to open the mouth?	Yes .....1 No ..... 2 Don't know ..... 8	→ 967 → 967								
966	For how long was s/he unable to open the mouth?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> Don't know ..... 98									
967	Did s/he have stiffness of the whole body?	Yes .....1 No ..... 2 Don't know ..... 8	→ 969 → 969								
968	For how long did s/he have stiffness of the whole body?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> Don't know ..... 98									
969	Did s/he have paralysis of one side of the body?	Yes .....1 No ..... 2 Don't know ..... 8	→ 972 → 972								
970	For how long did s/he have paralysis of one side of the body?	Days..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know .....998									
971	Did the paralysis of one side of the body start suddenly, quickly within a single day, or slowly over many days?	Suddenly..... 1 Within a day (Fast).....2 Slowly (Many days).....3 Don't know ..... 8	→ 1001 → 1001								
972	Did s/he have paralysis of the lower limbs?	Yes .....1 No ..... 2 Don't know ..... 8	→ 975 → 975								

973	How long did s/he have paralysis of the lower limbs?	Days..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998																									
974	Did the paralysis of the lower limbs start suddenly, quickly within a single day, or slowly over many days?	Suddenly..... 1 Within a day (Fast).....2 Slowly (Many days).....3 Don't know ..... 8																									
975	Was there any change in color of urine?	Yes .....1 No ..... 2 Don't know ..... 8	→ 977 → 977																								
976	For how long did s/he have the change in color of urine?	Days ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998																									
977	During the final illness did s/he ever pass blood in the urine?	Yes .....1 No ..... 2 Don't know ..... 8																									
978	For how long did s/he pass blood in the urine?	Days ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998																									
979	Was there any change in the amount of urine s/he passed daily?	Yes .....1 No ..... 2 Don't know ..... 8	→ 982 → 982																								
980	For how long did s/he have the change in the amount of urine passed daily?	Days ..... <input type="text"/> <input type="text"/> Months ..... <input type="text"/> <input type="text"/> Don't know .....998																									
981	Did s/he pass too much urine, too little urine, or no urine at all?	Too much .....1 Too little .....2 No urine at all .....3 Don't know .....8																									
982	During the illness that led to death, did s/he have any skin rash?	Yes .....1 No ..... 2 Don't know ..... 8	→ 986 → 986																								
983	For how long did s/he have the skin rash?	Days ..... <input type="text"/> <input type="text"/> Don't know ..... 98																									
984	Was the rash on: 1 The face? 2 The trunk? 3 The arms and legs? 4 Any other place?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Face.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Trunk.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Arms and Legs .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Other place .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Specify _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	Face.....	1	2	8	Trunk.....	1	2	8	Arms and Legs .....	1	2	8	Other place .....	1	2	8	Specify _____				→ 972 → 972
	YES	NO	DK																								
Face.....	1	2	8																								
Trunk.....	1	2	8																								
Arms and Legs .....	1	2	8																								
Other place .....	1	2	8																								
Specify _____																											
985	What did the rash look like?	Measles rash .....1 Rash with clear fluid .....2 Rash with pus .....3 Don't know .....8																									
986	Did s/he have red eyes?	Yes .....1 No ..... 2 Don't know ..... 8																									

987	Did s/he have bleeding from the nose, mouth, or anus?	Yes ..... 1 No ..... 2 Don't know ..... 8																													
988	Did s/he ever have shingles/herpes zoster?	Yes ..... 1 No ..... 2 Don't know ..... 8																													
989	Did s/he have weight loss?	Yes ..... 1 No ..... 2 Don't know ..... 8	—► 990 —► 990																												
989.1	For how long did s/he have weight loss?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know ..... 9 9 8																													
989.2	Did s/he look very thin and wasted?	Yes ..... 1 No ..... 2 Don't know ..... 8																													
990	Did s/he have mouth sores or white patches in the mouth or on the tongue?	Yes ..... 1 No ..... 2 Don't know ..... 8	—► 991 —► 991																												
990.1	For how long did s/he have mouth sores or white patches in the mouth or on the tongue?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> Don't know ..... 9 8																													
991	Did s/he have any swelling?	Yes ..... 1 No ..... 2 Don't know ..... 8	—► 992 —► 992																												
991.1	For how long did s/he have the swelling?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know ..... 998																													
991.2	Was the swelling on: 1 The face? 2 The joints? 3 The ankles? 4 The whole body? 5 Any other place?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 30%; text-align: center;">YES</th> <th style="width: 30%; text-align: center;">NO</th> <th style="width: 35%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Face.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Joints.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Ankles.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Whole body.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Other place .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Specify _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	Face.....	1	2	8	Joints.....	1	2	8	Ankles.....	1	2	8	Whole body.....	1	2	8	Other place .....	1	2	8	Specify _____				
	YES	NO	DK																												
Face.....	1	2	8																												
Joints.....	1	2	8																												
Ankles.....	1	2	8																												
Whole body.....	1	2	8																												
Other place .....	1	2	8																												
Specify _____																															
992	Did s/he have any lumps?	Yes ..... 1 No ..... 2 Don't know ..... 8	—► 993 —► 993																												
992.1	For how long did s/he have the lumps?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know ..... 998																													
992.2	Were the lumps on: 1 The neck? 2 The armpit? 3 The groin? 4 Any other place?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 30%; text-align: center;">YES</th> <th style="width: 30%; text-align: center;">NO</th> <th style="width: 35%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Neck.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Armpit.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Groin.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Other place .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Specify _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	Neck.....	1	2	8	Armpit.....	1	2	8	Groin.....	1	2	8	Other place .....	1	2	8	Specify _____								
	YES	NO	DK																												
Neck.....	1	2	8																												
Armpit.....	1	2	8																												
Groin.....	1	2	8																												
Other place .....	1	2	8																												
Specify _____																															
993	Did s/he have yellow discoloration of the eyes?	Yes ..... 1 No ..... 2 Don't know ..... 8	—► 994 —► 994																												

993.1	For how long did s/he have yellow discoloration of the eyes?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know ..... 9 9 8									
994	Did s/he look pale (thinning/lack of blood) or have pale palms, eyes or nail beds?	Yes ..... 1 No ..... 2 Don't know ..... 8	—▶ 995 —▶ 995								
994.1	For how long did s/he look pale or have pale palms, eyes or nail beds?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Months ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Don't know ..... 9 9 8									
995	Did s/he have an ulcer, abscess, or sore anywhere on the body?	Yes ..... 1 No ..... 2 Don't know ..... 8	—▶ 1001 —▶ 1001								
995.1	For how long did s/he have the ulcer, abscess, or sore?	Days ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> Don't know ..... 9 8									
995.2	What was the location of the ulcer, abscess, or sore?	_____ _____ _____ (Specify)									

**SECTION 10. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS**

1001	Did s/he receive any treatment for the illness that led to death?	Yes ..... 1 No ..... 2 Don't know ..... 8	—▶ 1008 —▶ 1008																																												
1002	Can you please list the drugs s/he was given for the illness that led to death?  COPY FROM PRESCRIPTION/DISCHARGE NOTES IF AVAILABLE	_____ _____ _____																																													
1003	What type of treatment did s/he receive: 1 Oral rehydration salts and/or intravenous fluids (drip) treatment? 2 Blood transfusion? 3 Treatment/food through a tube passed through the nose? 4 Any other treatment?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Ors/drip treatment.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Blood transfusion.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Through the nose.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Other place .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Specify _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	Ors/drip treatment.....	1	2	8	Blood transfusion.....	1	2	8	Through the nose.....	1	2	8	Other place .....	1	2	8	Specify _____																								
	YES	NO	DK																																												
Ors/drip treatment.....	1	2	8																																												
Blood transfusion.....	1	2	8																																												
Through the nose.....	1	2	8																																												
Other place .....	1	2	8																																												
Specify _____																																															
1004	Please tell me at which of the following places/facilities s/he received treatment during the illness that led to death: 1 Home? 2 Traditional healer? 3 Government clinic? 4 Government hospital? 5 Private clinic? 6 Private hospital? 7 Pharmacy, drug seller, store? 8 Any other placer or facility?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Home .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Traditional healer.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Government clinic.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Government hospital....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Private clinic .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Private hospital.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Pharmacy/drug seller</td> <td></td> <td></td> <td></td> </tr> <tr> <td>  /store .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Other place _____</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td style="text-align: center;">Specify</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	DK	Home .....	1	2	8	Traditional healer.....	1	2	8	Government clinic.....	1	2	8	Government hospital....	1	2	8	Private clinic .....	1	2	8	Private hospital.....	1	2	8	Pharmacy/drug seller				/store .....	1	2	8	Other place _____	1	2	8	Specify				
	Yes	No	DK																																												
Home .....	1	2	8																																												
Traditional healer.....	1	2	8																																												
Government clinic.....	1	2	8																																												
Government hospital....	1	2	8																																												
Private clinic .....	1	2	8																																												
Private hospital.....	1	2	8																																												
Pharmacy/drug seller																																															
/store .....	1	2	8																																												
Other place _____	1	2	8																																												
Specify																																															

1005	In the month before death, how many contacts with formal health services did s/he have?	Number of contacts..... <input type="text"/> <input type="text"/> Don't know ..... 98	
1006	Did a health care worker tell you the cause of death?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 1008 —▶ 1008
1007	What did the health care worker say?	_____ _____ _____	
1008	Did s/he have any operation for the illness?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 1101 —▶ 1101
1009	How long before death did s/he have the operation?	Days ..... <input type="text"/> <input type="text"/> Don't know ..... 98	
1010	On what part of the body was the operation?	Abdomen .....1 Chest .....2 Head .....3 Other ..... 6 (Specify) Don't know .....8	

**SECTION 11. RISK FACTORS**

1101	Did s/he drink alcohol?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 1106 —▶ 1106
1102	How long had s/he been drinking? RECORD 'Off IF LESS THAN ONE YEAR	Days ..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	
1103	How often did s/he drink alcohol?	Daily .....1 Frequently (Weekly) .....2 Once in a while ..... 3 Don't know .....8	
1104	Did she stop drinking?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 1106 —▶ 1106
1105	How long before death did s/he stop drinking? RECORD 'Off IF LESS THAN ONE MONTH	Months ..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	
1106	Did s/he smoke tobacco (cigarette, cigar, pipe etc.)?	Yes .....1 No ..... 2 Don't know ..... 8	—▶ 1201 —▶ 1201
1107	How long had s/he been smoking? RECORD 'Off IF LESS THAN ONE YEAR	Years ..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	
1108	How often did s/he smoke?	Daily .....1 Frequently (Weekly) .....2 Once in a while ..... 3 Don't know .....8	
1109	How many cigarettes did s/he smoke daily?	Number of cigarettes..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	



1110	Did s/he stop smoking before death?	Yes ..... 1 No ..... 2 Don't know ..... 8	—▶ 1201 —▶ 1201
1111	How long before death did s/he stop smoking? RECORD 'Off IF LESS THAN ONE MONTH	Months ..... <input type="text"/> <input type="text"/> Don't know ..... 9 8	

**SECTION 12. DATA ABSTRACTED FROM DEATH CERTIFICATE**

1201	Do you have a death certificate for the baby	Yes ..... 1 No ..... 2 Don't know ..... 8	—▶ 1301 —▶ 1301
1202	Can I see the death certificate? COPY DAY, MONTH AND YEAR OF DEATH FROM THE DEATH CERTIFICAT	Day      Month      Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
1203	COPY DAY, MONTH AND YEAR OF ISSUE OF DEATH CERTIFICATE.	Day      Month      Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
1204	Record the cause of death from the first (top) line of the death certificate _____		
1205	Record the cause of death from the second line of the death certificate (If Any) _____		
1206	Record the cause of death from the third line of the death certificate (If Any) _____		
1207	Record the cause of death from the fourth line of the death certificate (If Any) _____		

**INTERVIEWER'S OBSERVATIONS**

**TO BE FILLED IN AFTER COMPLETING INTERVIEW**

---

---

---

---

---

---

COMMENT ON SPECIFIC QUESTIONS:

---

---

---

---

---

ANY OTHER COMMENTS:

---

---

---

---

---

**SUPERVISOR'S OBSERVATIONS**

---

---

---

---

---

---

---

---

NAME OF THE SUPERVISOR: \_\_\_\_\_ DATE \_\_\_\_\_