

**VERBAL AUTOPSY QUESTIONNAIRE 2:
DEATH OF A CHILD AGED 28 DAYS TO 14 YEARS**

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
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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	Relationship of respondent to the deceased?	FATHER1 MOTHER..... 2 SIBLING4 OTHER RELATIVE 6 (SPECIFY) NO RELATION 8					
203	Did you live with the deceased in the period leading to her/his death	Yes1 No2					

SECTION 3. INFORMATION ON THE DECEASED AND DATE/PLACE OF DEATH							
301	Was the deceased female or male?	FEMALE1 MALE2					
302	When was the deceased born? 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>				
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></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 married1 Married/living with a partner 2 Widowed3 Divorced4 Separated5 Don't know8					
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?	Hospital1 Other health faculty.....2 Home.....3 Other 6 (specify) Don't know.....8	
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310	For deaths at hospital or health facility, record facility name and address: <hr/> <hr/>
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SECTION 4. RESPONDENT'S ACCOUNT OF ILLNESS/EVENTS LEADING TO DEATH

401	Could You Tell Me About the Illness/Events that Led To Her/His Death? <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	
402	CAUSE OF DEATH 1 ACCORDING TO RESPONDENT <hr/>	
403	CAUSE OF DEATH 2 ACCORDING TO RESPONDENT <hr/>	

SECTION 5. HISTORY OF PREVIOUSLY KNOWN MEDICAL CONDITIONS

I would like to ask you some questions concerning previously known medical conditions the deceased had; injuries and accidents that the deceased suffered; and signs and symptoms that the deceased had/showed when 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	Yes1 No2 Don't know8	
502	Diabetes?	Yes1 No2 Don't know8	
503	Asthma	Yes1 No2 Don't know8	
504	Epilepsy?	Yes1 No2 Don't know8	
505	Malnutrition?	Yes1 No2 Don't know8	
506	Cancer?	Yes1 No2 Don't know8	—▶ 508 —▶ 508
507	Can you specify the type or site of cancer?	Type/site _____ _____	
508	Tuberculosis?	Yes1 No2 Don't know8	
509	HIV/AIDS?	Yes1 No2 Don't know8	
510	Did s/he suffer from any other medically diagnosed illness?	Yes1 No2 Don't know8	—▶ 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?	Yes1 No2 Don't know8	—▶ 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 (specify) 96	
603	Was the injury or accident intentionally inflicted by someone else?	Yes 1 No 2 Don't know 8	
604	CHECK QUESTION 304 FOR AGE AT DEATH: 10 YEARS OR OLDER <input type="checkbox"/> UNDER 10 YEARS <input type="checkbox"/>		606
605	Do you think that s/he committed suicide?	Yes 1 No 2 Don't know 8	
606	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
607	What type of animal/insect?	Dog 1 Snake 2 Insect 3 Other (Specify) 6 Don't know 8	
608	CHECK QUESTION 304 FOR AGE AT DEATH: UNDER ONE YEAR <input type="checkbox"/> ONE YEAR OR OLDER <input type="checkbox"/>		801

SECTION 7. SYMPTOMOS AND SIGNS NOTED DURING THE FINAL ILLNESS OF INFANTS

701	Was the child small at birth?	Yes 1 No 2 Don't know 8	
702	Was the child born premature?	Yes 1 No 2 Don't know 8	→ 704 → 704
			703 How many months or weeks premature? INDICATE PERIOD OF PREGNANCY Weeks Months Don't know998 704 Was the child growing normally Yes 1 No 2 Don't know 8

705	Did the child have bulging of the fontanel?	Yes1 No 2 Don't know 8	→ 801 → 801
706	For how many days before death did s/he have the bulging?	Days <input type="text"/> <input type="text"/> Don't know 9 8	

SECTION 8. STATUS OF MOTHER AND SYMPTOMS NOTED DURING THE FINAL ILLNESS FOR ALL CHILDREN

801	How is the mother's health now?	Health1 Ill.....2 Not alive3 Don't know8	
802	For how long was the child ill before s/he died?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know9 9 8	
803	Did s/he have a fever?	Yes1 No 2 Don't know 8	→ 808 → 808
804	For how long did s/he have a fever	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know9 9 8	
805	Was the fever severe?	Yes1 No 2 Don't know 8	
806	Was the fever continuous or on and off?	Continuous1 On and Off2 Don't know8	
807	Did s/she have chills/rigor?	Yes1 No 2 Don't know 8	
808	Did s/he have cough?	Yes1 No 2 Don't know 8	→ 812 → 812
809	For how long did s/he have a cough?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know9 9 8	
810	Was the cough severe?	Yes1 No 2 Don't know 8	
811	Did the child vomit after s/he coughed?	Yes1 No 2 Don't know 8	
		Yes1	

812	Did s/he have fast breathing?	No 2 Don't know 8	→ 818 → 818
813	For who long did s/he have fast breathing?	Days <input type="text"/> <input type="text"/> Don't know 9 8	
814	Did s/he have difficulty in breathing?	Yes 1 No 2 Don't know 8	→ 820 → 820
815	For how long did s/he have difficulty in breathing?	Days <input type="text"/> <input type="text"/> Don't know 98	
816	Did s/he have chest indrawing?	Yes 1 No 2 Don't know 8	→ 818 → 818
817	For how long did s/he have chest indrawing	Days <input type="text"/> <input type="text"/> Don't know 98	
818	Did s/he have noisy breathing (grunting or wheezing)? DEMONSTRATE	Yes 1 No 2 Don't know 8	
819	Did s/he have flaring of the nostrils?	Yes 1 No 2 Don't know 8	
820	Did s/he have diarrhea?	Yes 1 No 2 Don't know 8	→ 824 → 824
821	For how long did s/he have diarrhoea?	Days <input type="text"/> <input type="text"/> Don't know 9 8	
822	When the diarrhoea was most severe, how many times did s/he pass stool in a day?	Days <input type="text"/> <input type="text"/> Don't know 9 8	
823	At any time during the final illness was there blood in the stool?	Yes 1 No 2 Don't know 8	
824	Did s/he vomit?	Yes 1 No 2 Don't know 8	→ 827 → 827
825	For how long did s/he vomit?	Days <input type="text"/> <input type="text"/> Don't know 9 8	
826	When the vomiting was most severe, how many times did s/he vomit in a day?	Days <input type="text"/> <input type="text"/> Don't know 9 8	
827	Did s/he have abdominal pain?	Yes 1 No 2 Don't know 8	→ 830 → 830
828	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 998	

829	Was the abdominal pain severe?	Yes1 No 2 Don't know 8									
830	Did s/he have abdominal distension?	Yes1 No 2 Don't know 8	→ 834 → 834								
831	For how long did s/he have abdominal distension?	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 know998									
832	Did the distension develop rapidly within days or gradually over months?	Rapidly within days1 Gradually over months..... 2 Don't know 8									
833	Was there a period of a day or longer during which s/he did not pass any stool?	Yes1 No 2 Don't know 8									
834	Did s/he have any mass in the abdomen?	Yes1 No 2 Don't know 8	→ 836 → 836								
835	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 know9 9 8									
836	Did s/he have headache?	Yes1 No 2 Don't know 8	→ 839 → 839								
837	For how long did s/he 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 know9 9 8									
838	Was the headache severe?	Yes1 No 2 Don't know 8									
839	Did s/he have a stiff or painful neck?	Yes1 No 2 Don't know 8	→ 841 → 841								
840	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 9 8									
841	Did s/he become unconscious	Yes1 No 2 Don't know 8	→ 844 → 844								
842	For how long was s/he unconscious?	Days <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> Don't know 9 8									
843	Did the unconsciousness start suddenly, quickly within a single day, or slowly over many days?	Suddenly..... 1 Fast (in a day)2 Slowly (many days)3 Don't know 8									
844	Did s/he have convulsions?	Yes1 No 2 Don't know 8	→ 846 → 846								

845	For how long did s/he have convulsions?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know9 9 8																	
846	Did s/he have paralysis of the lower limbs?	Yes1 No 2 Don't know 8	→ 849 → 849																
847	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 know9 9 8																	
848	Did the paralysis of the lower limbs start suddenly, quickly within a single day, or slowly over many days?	Suddenly..... 1 Fast (in a day)2 Slowly (many days)3 Don't know 8																	
849	Was there any change in the amount of urine s/he passed daily?	Yes1 No 2 Don't know 8	→ 852 → 852																
850	For how long did s/he have the change in the amount of urine s/he passed daily?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know9 9 8																	
851	How much urine did s/he pass?	Too much 1 Too little 2 No urine at all3 Don't know8																	
852	During the illness that led to death, did s/he have any skin rash?	Yes1 No 2 Don't know 8	→ 856 → 856																
853	For how long did s/he have the skin rash?	Days <input type="text"/> <input type="text"/> Don't know 9 8																	
854	Was the rash located on: 1. The face? 2. The trunk? 3. On the arms and legs?	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> <td>DK</td> </tr> <tr> <td>Face</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Trunk</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Arms and Legs</td> <td>1</td> <td>2</td> <td>8</td> </tr> </table>		Yes	No	DK	Face	1	2	8	Trunk	1	2	8	Arms and Legs	1	2	8	
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855	What did the rash look like	Measles rash1 Rash with clear fluid.....2 Rash with pus3 Don't know8																	
856	Did s/he have red eyes?	Yes1 No 2 Don't know 8																	
857	Did s/he have bleeding form the nose, mouth, or anus?	Yes1 No 2 Don't know 8																	
858	Did s/he have weight loss?	Yes1 No 2 Don't know 8	→ 861 → 861																
859	For how long before death did s/he have the weight loss?	DAYS <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																	

		Months																																	
		Don't know9 9 8																																	
860	Did s/he look very thin and wasted	Yes1 No 2 Don't know 8																																	
861	Did s/he have mouth sores or white patches in the mouth or on the tongue?	Yes1 No 2 Don't know 8	→ 863 → 863																																
862	For how long did s/he have mouth sores or white patches in the mouth or on the tongue?	Days <input type="text"/> <input type="text"/> Don't know 9 8																																	
863	Did s/he have any swelling?	Yes1 No 2 Don't know 8	→ 866 → 866																																
864	For how long did s/he have the swelling?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know998																																	
865	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></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>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>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>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	Arms and Legs	1	2	8	Whole body	1	2	8	Other place	1	2	8	Specify				
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Other place	1	2	8																																
Specify																																			
866	Did s/he have any lumps?	Yes1 No 2 Don't know 8	→ 869 → 869																																
867	For how long did s/he have the lumps?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know998																																	
868	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></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>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												
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869	Did s/he have yellow discoloration of the eyes?	Yes1 No 2 Don't know 8	→ 871 → 871																																
870	For how long did s/he have the yellow discoloration of the eyes?	DAYS <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/> Don't know998																																	
871	Did her/his hair color change to reddish or yellowish?	Yes1 No 2 Don't know 8	→ 873 → 873																																
872	For how long did s/he have reddish/yellowish hair?	DAYS <input type="text"/> <input type="text"/>																																	

		Months Don't know998	
873	Did s/he look pale (thinning/lack of blood) or have pale palms, eyes or nail beds	Yes1 No 2 Don't know 8	→ 875 → 875
874	For how long did s/he look pale (thinning/lack of blood) or have pale palms, eyes, or nail beds	Days <input type="text"/> <input type="text"/> Don't know 98	
875	Did s/he have sunken eyes?	Yes1 No 2 Don't know 8	→ 901 → 901
876	For how long did s/he have sunken eyes?	Days <input type="text"/> <input type="text"/> Don't know 98	

SECTION 9. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS

901	Was s/he vaccinated for measles?	Yes1 No 2 Don't know 8																																					
902	Did s/he receive any treatment for the illness that led to death?	Yes1 No 2 Don't know 8	→ 909 → 909																																				
903	Can you please list the drugs s/he was given for the illness that led to death? COPY FROM PRESCRIPTION/DISCHARGE NOTES IF AVAILABLE	_____ _____ _____																																					
904	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 border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>Ors/drip treatment</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Blood transfusion</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Through the nose.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Other</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table> <p style="text-align: center;">Specify</p>		Yes	No	DK	Ors/drip treatment	1	2	8	Blood transfusion	1	2	8	Through the nose.....	1	2	8	Other	1	2	8																	
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Other	1	2	8																																				
905	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 place or facility?	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>Home</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Traditional healer.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Government clinic.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Government hospital.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Private clinic</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Private hospital.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Pharmacy/drug seller /store</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Other place</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table> <p style="text-align: center;">Specify</p>		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	
	Yes	No	DK																																				
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Private hospital.....	1	2	8																																				
Pharmacy/drug seller /store	1	2	8																																				
Other place	1	2	8																																				
906	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 9 8																																					
907	Did a health care worker tell you the cause of death?	Yes1 No 2 Don't know 8	→ 909 → 909																																				
908	What did the health care worker say?	_____ _____																																					

		<hr/>	
909	Did s/he have any operation for the illness?	Yes 1 No 2 Don't know 8	→ 1001 → 1001
910	How long before death did s/he have the operation?	Days <input type="text"/> <input type="text"/> Don't know 9 8	
911	On what part of the body was the operation?	Abdomen 1 Chest 2 Head 3 Other 6 (Specify) Don't know 8	

SECTION 10. DATA ABSTRACTED FROM DEATH CERTIFICATE			
1001	Do you have a death certificate for the baby	Yes 1 No 2 Don't know 8	→ 1201 → 1201
1002	Can I see the death certificate for the baby 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"/>	
1003	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"/>	
1004	Record the cause of death from the first (top) line of the death certificate _____		
1005	Record the cause of death from the second line of the death certificate _____		
1006	Record the cause of death from the third line of the death certificate _____		
1007	Record the cause of death from the fourth line of the death certificate _____		

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 _____