

VERBAL AUTOPSY QUESTIONNAIRE 1: DEATH OF A CHILD AGED UNDER 4 WEEKS

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 <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	
202	What is your relationship 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 '9 8' IF DON'T KNOW DAY OR MONTH RECORD '9 9 8' IF DON'T KNOW YEAR	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
303	How old was the deceased when s/he died?	AGE IN DAYS..... <input type="text"/> <input type="text"/>	
304	When did s/he die? RECORD '9 8' IF DON'T KNOW DAY OR MONTH RECORD '9 9 8' IF DON'T KNOW YEAR	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
305	Where did s/he die?	HOSPITAL1 OTHER HEALTH FACULTY.....2 HOME.....3 OTHER6 (SPECIFY) DON'T KNOW.....8	
306	For deaths at hospital or health facility, record facility name and address: _____ _____		

SECTION 4. RESPONDENT'S ACCOUNT OF ILLNESS/EVENTS LEADING TO DEATH

401		
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SECTION 5. PREGNANCY HISTORY: I would like to ask you some questions concerning the mother and symptoms that the deceased had/showed at birth and shortly after. Some of these questions may not appear to be directly related to the baby's 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.

501	How many births, including stillbirths, did the mother have before this baby?	Number of births/stillbirths <input type="text"/> <input type="text"/> Don't know 98																																																	
502	How many months was the pregnancy when the baby was born?	Months <input type="text"/> <input type="text"/> Don't know 98																																																	
503	Did the pregnancy end earlier than expected?	Yes1 No2 Don't know8	—▶ 505 —▶ 505																																																
504	How many weeks before the expected date of delivery?	Weeks <input type="text"/> <input type="text"/> Don't know 98																																																	
505	During the pregnancy did the mother suffer from any of the following known illnesses: 1 High blood pressure? 2 Heart disease? 3 Diabetes? 4 Epilepsy/convulsion? 5 Did she suffer from any other medically diagnosed illness?	<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>High blood pressure?.....</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>Heart disease?</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>Diabetes?</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>Epilepsy/convulsion?.....</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</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table> <p style="text-align: center;">_____</p> <p style="text-align: center;">(specify)</p>		YES	NO	DK	High blood pressure?.....	1	2	8	Heart disease?	1	2	8	Diabetes?	1	2	8	Epilepsy/convulsion?.....	1	2	8	Other	1	2	8																									
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506	During the last 3 months of pregnancy did the mother suffer from any of the following illnesses 1. Vaginal bleeding? 2. Smelly vaginal discharge? 3. Puffy face? 4. Headache? 5. Burred 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 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>Vaginal bleeding?</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>Smelly vaginal discharge?..</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>Puffy 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>Headache?</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>Burred vision.....</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>Convulsion?</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>Febrile illness?.....</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>Severe abdominal pain (not labor pain)</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>Pallor/shortness</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>Of breath (both)</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 illness</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table> <p style="text-align: center;">_____</p> <p style="text-align: center;">(SPECIFY)</p>		YES	NO	DK	Vaginal bleeding?	1	2	8	Smelly vaginal discharge?..	1	2	8	Puffy face?.....	1	2	8	Headache?	1	2	8	Burred vision.....	1	2	8	Convulsion?	1	2	8	Febrile illness?.....	1	2	8	Severe abdominal pain (not labor pain)	1	2	8	Pallor/shortness	1	2	8	Of breath (both)	1	2	8	Other illness	1	2	8	
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507	Was the child a single or multiple birth?	Singleton.....1 Twin2 Triplet of more3 Don't know8	—▶ 601 —▶ 601																																																
508	What was the birth order of the child that died?	First1 Second2 Third or higher 3 Don't know8																																																	

SECTION 6. DELIVERY HISOTRY

601	Where was the child born?	Hospital.....1 Other health facility2 Home.....3 other.....6 (SPECIFY) Don't know8	
602	Who assisted with the delivery?	Doctor1 Nurse/midwife.....2 Traditional birth attendant.....3 Relative.....4 Mother by herself5 Other.....6 Don't know8	
603	When did the water break?	Before labor started1 During labor2 Don't know8	
604	How many hours after the water broke was the baby born?	Less than 24 hours1 24 hours or more2 Don't know8	
605	Was the water foul smelling?	Yes1 No2 Don't know8	
606	Did the baby stop moving in the womb?	Yes1 No2 Don't know8	→ 608 → 608
607	When did the baby stop moving in the womb?	Before labor started1 During labor2 Don't know8	

608	Did a birth attendant listen for fetal heart sounds during labor?	Yes1 No2 Don't know8	→ 610 → 610
609	Were fetal heart sounds present?	Yes1 No2 Don't know8	
610	Was there excess bleeding on the day labor started?	Yes1 No2 Don't know8	
611	Did the mother have a fever on the day labor started?	Yes1 No2	

		Don't know 8	
612	How long did the labor pains last? Less than 24 hours1 12-23 hours2 24 hours or more3 Don't know8	—▶ 615 —▶ 615	613 Was it a normal vaginal delivery? Yes 1 No 2 Don't know 8 614 What type of delivery was it? Forceps/Vacuum1 Caesarean section2 Other 6 _____ (Specify) Don't know8
615	Which part of the baby came first?	Head1 Bottom2 Feet3 Arm/Hand4 Other 6 _____ (Specify) Don't know8	
616	Did the umbilical cord come out before the baby was born?	Yes1 No2 Don't know8	

SECTION 7. CONDITION OF THE BABY SOON AFTER BIRTH			
701	At birth what was the size of the baby?	Smaller than normal 1 Normal2 Larger than normal3 Don't know8	
702	Was the baby premature?	Yes1 No2	—▶ 704

		Don't know8	—▶704								
703	How many months or weeks along was the pregnancy? INDICATE PERIOD OF PREGNANCY	Months <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> Weeks..... <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									
704	What was the birth weight of the baby?	Kilograms _____ Don't know 98									
705	Was anything applied to the umbilical cord stump after birth?	Yes 1 No 2 Don't know 8	—▶707 —▶707								
706	What was it?	_____ _____ (specify)									
707	Were there any signs of injury or broken bones?	Yes1 No2 Don't know8	—▶709 —▶709								
708	Where were marks or signs of injury?	_____ _____ (specify)									
709	Was there any sign of paralysis	Yes1 No2 Don't know8									
710	Did the baby have any malformation?	Yes 1 No 2 Don't know 8	—▶712 —▶712								
711	What kind of malformation did the baby have?	Swelling/defect on the back.....1 Very large head2 Very small head3 Defect of lip and/or palate4 Other malformation_____ 8 (Specify) Don't know8									
712	What was the color of the baby at birth?	Normal1 Pale2 Blue3 Don't know8									
713	Did the baby breathe after birth, even a little?	Yes1 No2 Don't know8									
714	Was the baby given assistance to breathe?	Yes1 No2 Don't know8									
715	Did the baby ever cry after birth, even a little?	Yes1 No2 Don't know8									
716	Did the baby ever move, even a little?	Yes1 No2 Don't know8									
717	Check 713, 715, AND 716 for codes NO:										

	All three codes 'No' The baby didn't breath <input type="checkbox"/> The baby didn't cry <input type="checkbox"/> The baby didn't move	OTHER <input type="checkbox"/>	801
718	If the baby did not cry, breathe or move; was it born dead?	Yes 1 No 2 Don't know 8	—▶ 801 —▶ 801
719	Was the baby macerated, that is, showed signs of decay?	Yes 1 No 2 Don't know 8	—▶ 1001 —▶ 1001 —▶ 1001

SECTION 8. HISTORY OF INJURIES/ACCIDENTS			
801	Did the baby suffer from any injury or accident that led to her/his death?	Yes 1 No 2 Don't know 8	—▶ 804 —▶ 804
802	What kind of injury or accident did the baby suffer?	Road traffic accident..... 01 Fall.....02 Drowning03 Poisoning04 Burns.....05 violence/assault..... 06 Other _____ 96 (Specify) Don't know98	
803	Was the injury or accident intentionally inflicted by someone else?	Yes1 No2 Don't know8	
804	Did the baby suffer from any animal/insect bite that led to her/his death?	Yes1 No2 Don't know8	—▶ 901 —▶ 901
805	What type of animal/insect?	Dog.....1 Snake2 Insect.....3 Other _____ 6 (Specify) Don't know8	

SECTION 9. NEONATAL ILLNESS HISTORY							
901	Was the baby ever able to suckle or bottle-feed?	Yes1 No2 Don't know8	—▶ 905 —▶ 905				
902	How soon after birth did the baby suckle or bottle-feed?	Months <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>					

		Weeks.....	
		Don't know998	
903	Did the baby stop suckling or bottle-feeding?	Yes1 No2 Don't know8	—▶905 —▶905
904	How many days after birth did the baby stop suckling or bottle-feeding?	Days <input type="text"/> <input type="text"/> Don't know 98	
905	Was the breastfeeding exclusive?	Yes1 No2 Don't know8	
906	Did the baby have convulsions?	Yes1 No2 Don't know8	—▶908 —▶908
907	How soon after birth did the convulsions start?	Days <input type="text"/> <input type="text"/> Don't know 98	
908	Did the baby become stiff and arched backwards?	Yes1 No2 Don't know8	
909	Did the child have bulging of the fontanel?	Yes1 No2 Don't know8	—▶911 —▶911
910	How many days after birth did the baby have the bulging?	Days <input type="text"/> <input type="text"/> Don't know 98	
911	Did the baby become unresponsive or unconscious?	Yes1 No2 Don't know8	—▶913 —▶913
912	How many days after birth did the baby become unresponsive or unconscious?'	Days <input type="text"/> <input type="text"/> Don't know 98	
913	Did the baby have a fever?	Yes1 No2 Don't know8	—▶915 —▶915
914	How many days after birth did the baby have a fever?	Days <input type="text"/> <input type="text"/> Don't know 98	
915	Did the baby become cold to the touch?	Yes1 No2 Don't know8	—▶917 —▶917
916	How many days after birth did the baby become cold to the touch?	Days <input type="text"/> <input type="text"/> Don't know98	
917	Did the baby have a cough?	Yes1 No2 Don't know8	—▶919 —▶919
918	How many days after birth did the baby start to cough?	Days <input type="text"/> <input type="text"/> Don't know 98	
919	Did the baby have fast breathing?	Yes 1 No 2	—▶921

		Don't know 8	—▶921
920	How many days after birth did the baby start breathing fast?	Days <input type="text"/> <input type="text"/> Don't know 98	
921	Did the baby have difficulty breathing?	Yes 1 No 2 Don't know 8	—▶926 —▶926
922	How many days after birth did the baby start having difficulty in breathing?	Days <input type="text"/> <input type="text"/> Don't know 98	
923	Did the baby have chest indrawing?	Yes 1 No 2 Don't know 8	
924	Did the baby have grunting? DEMONSTRATE	Yes 1 No 2 Don't know 8	
925	Did the baby have flaring of the nostrils?	Yes 1 No 2 Don't know 8	
926	Did the baby have diarrhea?	Yes 1 No 2 Don't know 8	—▶930 —▶930
927	How many days after birth did the baby have diarrhea?	Days <input type="text"/> <input type="text"/> Don't know 98	
928	When the diarrhea was most severe, how many times did the baby pass stools in a day?	Number <input type="text"/> <input type="text"/> Don't know 98	
929	Was there blood in the stools?	Yes 1 No 2 Don't know 8	
930	Did the baby have vomiting?	Yes 1 No 2 Don't know 8	—▶933 —▶933
931	How many days after birth did vomiting start?	Days <input type="text"/> <input type="text"/> Don't know 98	
932	When the vomiting was most severe, how many times did the baby vomit in a day?	Number <input type="text"/> <input type="text"/> Don't know 98	
933	Did the baby have abdominal distension?	Yes 1 No 2 Don't know 8	—▶935 —▶935
934	How many days after birth did the baby have abdominal distension?	Days <input type="text"/> <input type="text"/> Don't know 98	
935	Did the baby have redness or discharge from the umbilical cord stump?	Yes 1 No 2 Don't know 8	
936	Did the baby have a pustular skin rash?	Yes 1 No 2 Don't know 8	
		Yes 1	

937	Did the baby have yellow palms or soles?	No 2 Don't know 8	→ 1001 → 1001
938	How many days after birth did the yellow palms or soles begin?	Days <input type="text"/> Don't know 98	
939	For how many days did the baby have yellow palms or soles?	Days <input type="text"/> Don't know 98	

SECTION 10. MOTHER'S HEALTH AND CONTEXTUAL FACTORS

1001	What was the age of the mother at the time the baby died?	Years <input type="text"/> Don't know 98	
1002	Did the mother receive antenatal care?	Yes1 No2 Don't know8	
1003	Did the mother receive tetanus toxoid (TT) vaccine?	Yes1 No2 Don't know8	
1004	How many doses of TT?	Number of doses <input type="text"/> Don't know 98	
1005	How is the mother's health now?	Healthy1 Ill2 Not alive3 Don't know8	

SECTION 11. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS

1101	Did the baby receive any treatment for the illness that led to death?	Yes1 No2 Don't know8	→ 1201 → 1201																																				
1102	Can you please list the treatments the baby was given for the illness that led to death? COPY FROM PRESCRIPTION/DISCHARGE NOTES IF AVAILABLE	_____ _____ _____																																					
1103	Please tell me at which of the following places or facilities the baby 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</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table> <p>(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	1	2	8	
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1104	In the month before death, how many contacts with formal health services did the baby have?	Number of contacts <input type="text"/> Don't know 98																																					
1105	Did a health care worker tell you the cause of death?	Yes 1 No 2	→ 1201																																				

		Don't know 8	—▶1201
1106	What did the health care worker say?	_____	

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	—▶1201 —▶1201
1202	Can I see the death certificate for the baby COPY DAY, MONTH AND YEAR OF DEATH FROM THE DEATH CERTIFICAT	Day Month Year □□ □□ □□□□	
1203	COPY DAY, MONTH AND YEAR OF ISSUE OF DEATH CERTIFICATE.	Day Month Year □□ □□ □□□□	
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	_____	

1206	Record the cause of death from the third line of the death certificate	_____
1207	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 _____