

2012 WHO VERBAL AUTOPSY
SAMPLE QUESTIONNAIRE 1

Death of a child
Under 4 weeks (0-28 days)



DEATH OF A CHILD AGED UNDER 4 WEEKS (28 DAYS)		
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 1. BASIC INFORMATION ABOUT THE INTERVIEW AND THE RESPONDENT		
2A120	Name of verbal autopsy interviewer: Surname _____ Name _____	
2A140	RECORD THE DATE OF INTERVIEW	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"/>
2A130	RECORD THE TIME AT START OF INTERVIEW MORNING =1 EVENING=2	MORNING/EVENING <input type="text"/> HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>
2A100	Name of verbal autopsy respondent: Surname _____ Name _____	
2A110	What is your relationship to the deceased?	FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> SIBLING <input type="checkbox"/> OTHER RELATIVE _____ (SPECIFY) <input type="checkbox"/> NO RELATION <input type="checkbox"/>
2A115	Did you live with the deceased in the period leading to her/his death?	YES <input type="checkbox"/> NO <input type="checkbox"/>
SECTION 2. INFORMATION ON THE DECEASED AND DATE/PLACE OF DEATH		
1A100	What was the name of the deceased? Surname _____ Name _____	
1A110	Was the deceased female or male?	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
1A200	Is date of birth known?	YES <input type="checkbox"/> NO <input type="checkbox"/>
1A210	+ When was the deceased born?	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"/>
1A220	Is date of death known?	YES <input type="checkbox"/> NO <input type="checkbox"/>
1A230	+ When did s/he die?	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"/>
1A260	How old was the deceased when s/he died?	DAYS <input type="text"/> <input type="text"/> HOURS <input type="text"/> <input type="text"/>
1A500	What was her/his citizenship/nationality?	CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED CITIZ. <input type="checkbox"/> ALIEN <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES															
1A510	What was her/his ethnicity?	ETHNICITY A ETHNICITY B ETHNICITY C OTHER (specify) _____ <table border="1" style="float: right; margin-left: 20px;"> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> </table>															
1A520	What was her/his place of birth? 1 Larger admin area (e.g., province) _____ 2 Smaller admin area (e.g., county) _____ 3 Locality (e.g., city, village) _____ 4 Urban/Rural 5 Other country	LARGER ADMIN AREA SMALLER ADMIN AREA LOCALITY DON'T KNOW URBAN RURAL OTHER COUNTRY (specify) _____ <table border="1" style="float: right; margin-left: 20px;"> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>															
1A530	What was her/his place of usual residence? 1 Larger admin area (e.g., province) _____ 2 Smaller admin area (e.g., county) _____ 3 Locality (e.g., city, village) _____ 4 Urban/Rural 5 Other country	LARGER ADMIN AREA SMALLER ADMIN AREA LOCALITY DON'T KNOW URBAN RURAL OTHER COUNTRY (specify) _____ <table border="1" style="float: right; margin-left: 20px;"> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>															
1A550	Where did death occur? 1 Larger admin area (e.g., province) _____ 2 Smaller admin area (e.g., county) _____ 3 Locality (e.g., city, village) _____ 4 Urban/Rural 5 Other country	LARGER ADMIN AREA SMALLER ADMIN AREA LOCALITY DON'T KNOW URBAN RURAL OTHER COUNTRY (specify) _____ <table border="1" style="float: right; margin-left: 20px;"> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>															
1A560	What was the site of death?	HOSPITAL OTHER HEALTH FACILITY HOME OTHER (specify) _____ DON'T KNOW <table border="1" style="float: right; margin-left: 20px;"> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> </table>															
1A630	What was the name of the mother? Surname _____ Name _____																
1A620	What was the name of the father? Surname _____ Name _____																
SECTION 3. DEATH REGISTRATION AND CERTIFICATION																	
1A700	Death registration number	<table border="1" style="float: right; margin-left: 20px;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>															
1A710	Date of registration RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	DAY MONTH YEAR <table border="1" style="float: right; margin-left: 20px;"> <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> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>															

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES												
1A720	Place where the death is registered: 1 Larger admin area (e.g., province) _____ 2 Smaller admin area (e.g., county) _____ 3 Locality (e.g., city, village) _____ 4 Urban/Rural 5 Name of local registrar Surname _____ Name _____	LARGER ADMIN AREA SMALLER ADMIN AREA LOCALITY URBAN RURAL DON'T KNOW <div style="display: flex; justify-content: flex-end; align-items: center; margin-top: 10px;"> <table border="1" style="border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"></td><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><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table> <table border="1" style="border-collapse: collapse; text-align: center; margin-left: 10px;"> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> </table> <table border="1" style="border-collapse: collapse; text-align: center; margin-left: 10px;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table> </div>												
1A730	National identification number of deceased	<table border="1" style="border-collapse: collapse; text-align: center; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>												

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 4. RESPONDENT'S ACCOUNT OF ILLNESS/EVENTS LEADING TO DEATH		
	<p data-bbox="310 128 824 149">Could you tell me about the illness/events that led to her his/death?</p> <hr data-bbox="310 184 1263 191"/> <hr data-bbox="310 226 1263 233"/> <hr data-bbox="310 268 1263 275"/> <hr data-bbox="310 331 1263 338"/> <hr data-bbox="310 394 1263 401"/>	
	<p data-bbox="310 432 699 453">CAUSE OF DEATH 1 ACCORDING TO RESPONDENT</p> <hr data-bbox="310 485 1263 491"/>	
	<p data-bbox="310 522 699 543">CAUSE OF DEATH 2 ACCORDING TO RESPONDENT</p> <hr data-bbox="310 575 1263 581"/>	

DEATH OF A CHILD AGED UNDER 4 WEEKS (28 DAYS)		
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 4. 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. Kindly be patient and answer all the questions. They will help us to get a clear picture of all possible symptoms that [NAME] had.	
3D500	How many births, including stillbirths, did the baby's mother have before this baby?	NUMBER OF BIRTHS/ STILLBIRTHS DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D210	How many weeks was the pregnancy when the baby was born?	NUMBER OF WEEKS DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D510	During the pregnancy did the baby's mother suffer from high blood pressure?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D550	Did the baby's mother have vaginal bleeding during the last 3 months of pregnancy but before labour started?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D520	Did the baby's mother have foul smelling vaginal discharge during pregnancy and/or after delivery?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D540	During the last 3 months of pregnancy did the baby's mother suffer from blurred vision?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D530	During the last 3 months of pregnancy did the baby's mother suffer from convulsions?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D100	Was the child part of a multiple birth?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D110	Was the child born in a complicated delivery?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
SECTION 5. DELIVERY HISTORY		
3D560	Was the child born in a health facility?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D570	Was the child born at home?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D580	Was the child born somewhere else (e.g. on the way to a health facility)?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D590	Did the mother receive professional assistance during the delivery?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D120	Was the baby born 24 hours or more after the water broke?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D130	Did the baby stop moving in the womb before labour started?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D140	Was baby born in a normal vaginal delivery?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D150	Was baby born with forceps/vacuum?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D160	Was baby delivered by caesarean section?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D170	Did the baby's bottom, feet, arm or hand come into the vagina before its head?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
SECTION 6. CONDITION OF THE BABY SOON AFTER BIRTH		
3D180	Was the baby of abnormal size?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>
3D190	+ Was the baby smaller than normal, weighing under + 2.5 kg?	YES NO DON'T KNOW <input type="text"/> <input type="text"/> <input type="text"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3D200	+ Was the baby larger than normal, weighing over 4.5 kg?	YES NO DON'T KNOW
3D220	Was the umbilical cord wrapped several times (more than once) around the neck of the child at birth?	YES NO DON'T KNOW
3D230	Did the baby have any noticeable malformation?	YES NO DON'T KNOW
3D240	+ Did the baby have a swelling/defect on the back?	YES NO DON'T KNOW
3D250	+ Did the baby have a very large head?	YES NO DON'T KNOW
3D260	+ Did the baby have a very small head?	YES NO DON'T KNOW
3D280	Was the baby blue in colour at birth?	YES NO DON'T KNOW
3D300	Did the baby breathe after birth, even a little?	YES NO DON'T KNOW
3D310	Was the baby given assistance to breathe at birth?	YES NO DON'T KNOW
3D290	Did the baby ever cry after birth, even if only a little bit?	YES NO DON'T KNOW
3D320	If the baby did not cry or breathe, was it born dead?	YES NO DON'T KNOW
3D330	+ Was the dead baby macerated, that is, showed signs of decay?	YES NO DON'T KNOW
SECTION 7. HISTORY OF INJURIES/ACCIDENTS		
3E100	Did the baby suffer from any injury or accident that led to her/his death?	YES NO DON'T KNOW
3E110	+ Did the baby suffer from a road traffic accident?	YES NO DON'T KNOW
3E120	+ + Was the baby injured as a pedestrian?	YES NO DON'T KNOW
3E130	+ + + Was the baby injured as an occupant of a car vehicle?	YES NO DON'T KNOW
3E140	+ + + Was the baby injured as an occupant of a bus/heavy transport vehicle?	YES NO DON'T KNOW
3E150	+ + Was the baby injured as a passenger of a motorcycle?	YES NO DON'T KNOW
3E170	+ + Do you know anything about the counter-part that was hit + + during the road traffic accident?	YES NO
3E200	+ + + Was it a pedestrian?	YES NO DON'T KNOW
3E210	+ + + Was it a stationary object?	YES NO DON'T KNOW
3E220	+ + + Was it a car vehicle?	YES NO DON'T KNOW
3E230	+ + + Was it a bus or heavy transport vehicle?	YES NO DON'T KNOW

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3E240	+++ Was it a motor cycle?	YES NO DON'T KNOW
3E250	+++ Was it a pedal cycle?	YES NO DON'T KNOW
3E260	+++ Was it something else?	YES (specify) _____ NO DON'T KNOW
3E300	+ Was the baby injured in a non-road transport accident?	YES NO DON'T KNOW
3E310	++ Was the baby injured in a fall?	YES NO DON'T KNOW
3E320	++ Did the baby die of drowning?	YES NO DON'T KNOW
3E330	++ Did the baby suffer from burns?	YES NO DON'T KNOW
3E340	++ Did (s)he suffer from any plant/animal/insect bite or sting that led to her/his death?	YES NO DON'T KNOW
3E400	+++ Was it a dog?	YES NO DON'T KNOW
3E410	+++ Was it a snake?	YES NO DON'T KNOW
3E420	+++ Was it an insect?	YES NO DON'T KNOW
3E500	++ Was the baby injured by a force of nature?	YES NO DON'T KNOW
3E510	++ Was there any poisoning?	YES NO DON'T KNOW
3E520	+ Was the baby subject to violence or assault?	YES NO DON'T KNOW
3E530	+ Was the injury or accident intentionally inflicted by someone else?	YES NO DON'T KNOW
3E600	++ Was the baby injured by a fire arm?	YES NO DON'T KNOW
3E610	++ Was the baby injured from a stab, cut or pierce?	YES NO DON'T KNOW
3E620	++ Was the baby injured by machinery?	YES NO DON'T KNOW
3E630	++ Was the baby struck by an animal or object?	YES NO DON'T KNOW
SECTION 8. NEONATAL ILLNESS HISTORY		
3A280	Did the baby die during the wet season?	YES NO DON'T KNOW
3A290	Did the baby die during the dry season?	YES NO DON'T KNOW
3A300	For how long was the baby ill before s/he died?	NUMBER OF HOURS NUMBER OF DAYS DON'T KNOW

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3A310	Did the baby die suddenly?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D340	Was the baby able to suckle or bottle-feed within first 24 hours after birth?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D350	+ Did the baby stop suckling of bottle feeding 3 days after birth?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B460	Did the baby have convulsions?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D360	+ Did the baby have convulsions starting within the first day of life?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3S370	+ Did the baby have convulsions starting on the second day or + later after birth?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D380	Did the baby's body become stiff, with the back arched backwards?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D390	Did the child have bulging or raised fontanelle?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D400	Did the child have a sunken fontanelle?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D410	+ Did the baby become unresponsive or unconscious soon + after birth (within less than 24 hours)?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D420	+ Did the baby become unresponsive or unconscious more + than 1 day after birth?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B100	Did the baby have a fever?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D430	Did the baby become cold to the touch before it died?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B130	Did the baby have a cough?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B170	+ Did the baby make a whooping sound when coughing? DEMONSTRATE	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B180	Did the baby have any breathing problem?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B190	+ Did the baby have fast breathing?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B210	+ Did the baby have breathlessness?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B250	+ Did you see the lower chest wall/ribs being pulled in as the child + breathed?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B260	+ Did the baby have noisy breathing (grunting or wheezing)? + DEMONSTRATE	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B280	Did the baby have diarrhoea?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B300	+ At any time during the final illness was there blood in the stools?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B310	Did the baby vomit?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B320	+ Did the baby vomit "coffee grounds" or bright red/blood?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3B360	+ Did the baby have a more than usual protruding abdomen?	YES NO DON'T KNOW <input type="checkbox"/>
3D440	Did the baby have redness or discharge from the umbilical cord stump?	YES NO DON'T KNOW <input type="checkbox"/>
3B530	Did the baby have any skin problems?	YES NO DON'T KNOW <input type="checkbox"/>
3B540	+ Did the baby have any ulcers, abscess or sores + anywhere except the feet?	YES NO DON'T KNOW <input type="checkbox"/>
3B550	+ Did the baby have any ulcers, abscess or sores on the feet?	YES NO DON'T KNOW <input type="checkbox"/>
3B560	+ During the illness that led to death, did the baby have + any skin rash?	YES NO DON'T KNOW <input type="checkbox"/>
3B580	+ + Did the baby have measles rash?	YES NO DON'T KNOW <input type="checkbox"/>
3D450	Did the baby have yellow palms or soles?	YES NO DON'T KNOW <input type="checkbox"/>
3D460	Did the mother receive tetanus toxoid (TT) vaccine?	YES NO DON'T KNOW <input type="checkbox"/>

DEATH OF A CHILD AGED UNDER 4 WEEKS (28 DAYS)		
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 9. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS		
3G100	Was s/he adequately vaccinated?	YES NO DON'T KNOW
3G110	Did s/he receive any treatment for the illness that led to death?	YES NO DON'T KNOW
3G120	+ Did s/he receive oral rehydration salts?	YES NO DON'T KNOW
3G130	+ Did s/he receive (or needed) intravenous fluids (drip) treatment?	YES NO DON'T KNOW
3G140	+ Did s/he receive (or needed) a blood transfusion?	YES NO DON'T KNOW
3G150	+ Did s/he receive (or needed) treatment/food through a tube passed through the nose?	YES NO DON'T KNOW
3G160	+ Did s/he receive (or needed) injectable (IV or IM) antibiotics?	YES NO DON'T KNOW
3G170	+ Did s/he have (or needed) an operation for the illness?	YES NO DON'T KNOW
3G190	+ Was s/he discharged from the hospital very ill?	YES NO DON'T KNOW
SECTION 10. BACKGROUND		
4A100	In the final days, did the baby travel to a hospital or health facility?	YES NO DON'T KNOW
4A110	+ Did s/he use motorised transport to get to the hospital or health facility?	YES NO DON'T KNOW
4A120	+ Were there any problems during admission to the hospital or health facility?	YES NO DON'T KNOW
4A130	+ Were there any problems with the way (s)he was treated (medical treatment, procedures, inter-personal attitudes, respect, dignity) in the hospital or health facility?	YES NO DON'T KNOW
4A140	+ Were there any problems getting medications, or diagnostic tests in the hospital or health facility?	YES NO DON'T KNOW
4A150	Does it take more than 2 hours to get to the nearest hospital or health facility from the deceased's household?	YES NO DON'T KNOW
4A160	In the final days before death, were there any doubts about whether medical care was needed?	YES NO DON'T KNOW
4A170	In the final days before death, was traditional medicine used?	YES NO DON'T KNOW
4A180	In the final days before death, did anyone use a telephone or cell phone to call for help?	YES NO DON'T KNOW
4A190	Over the course of illness, did the total costs of care and treatment prohibit other household payments?	YES NO DON'T KNOW

5A100

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR: _____ DATE: _____