

2012 WHO VERBAL AUTOPSY
SAMPLE QUESTIONNAIRE 2

Death of a child aged 4
weeks to 14 years



2012 WHO VERBAL AUTOPSY [FORM 2]
DEATH OF A CHILD AGED 4 WEEKS (29 DAYS) TO 14 YEARS

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 style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
2A130	RECORD THE TIME AT START OF INTERVIEW MORNING =1 EVENING=2	MORNING/EVENING <input style="width: 20px; height: 20px;" type="text"/> HOUR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MINUTES <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
2A100	Name of verbal autopsy respondent Surname _____ Name _____	
2A110	What is your relationship to the deceased?	FATHER <input style="width: 20px; height: 20px;" type="checkbox"/> MOTHER <input style="width: 20px; height: 20px;" type="checkbox"/> SPOUSE <input style="width: 20px; height: 20px;" type="checkbox"/> SIBLING <input style="width: 20px; height: 20px;" type="checkbox"/> OTHER RELATIVE _____ <input style="width: 20px; height: 20px;" type="checkbox"/> (SPECIFY) NO RELATION <input style="width: 20px; height: 20px;" type="checkbox"/>
2A115	Did you live with the deceased in the period leading to her/his death?	YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO <input style="width: 20px; height: 20px;" 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?	FEMALE <input style="width: 20px; height: 20px;" type="checkbox"/> MALE <input style="width: 20px; height: 20px;" type="checkbox"/>
1A200	Is date of birth known?	YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO <input style="width: 20px; height: 20px;" type="checkbox"/>
1A210	+ When was the deceased born?	DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
1A220	Is date of death known?	YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO <input style="width: 20px; height: 20px;" type="checkbox"/>
1A230	+ When did s/he die?	DAY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> MONTH <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> YEAR <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
1A240 1A250	How old was the deceased when s/he died? IF AGE IS LESS THAN 1 YEAR RECORD IN MONTHS	AGE IN YEARS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> AGE IN MONTHS <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
1A400	Was this a woman who died more than 42 days but less than 1 year after being pregnant or delivering a baby?	YES <input style="width: 20px; height: 20px;" type="checkbox"/> NO <input style="width: 20px; height: 20px;" type="checkbox"/> DON'T KNOW <input style="width: 20px; height: 20px;" type="checkbox"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
1A500	What was her/his citizenship/nationality?	CITIZEN BY BIRTH NATURALIZED CITIZ. ALIEN DON'T KNOW
1A510	What was her/his ethnicity?	ETHNICITY A ETHNICITY B ETHNICITY C OTHER (specify) _____
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) _____
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) _____
1A540	What was her/his place of normal residence 1 to 5 years before death? 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) _____
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) _____
1A560	What was the site of death?	HOSPITAL OTHER HEALTH FACILITY HOME OTHER (specify) _____ DON'T KNOW
1A600	What was her/his marital status?	NEVER MARRIED MARRIED/LIVING WITH A PARTNER WIDOWED DIVORCED SEPARATED DON'T KNOW
1A610	What was the date of marriage? RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	DAY MONTH YEAR

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
1A630	What was the name of the mother? Surname _____ Name _____	
1A620	What was the name of the father? Surname _____ Name _____	
1A640	What was her/his highest level of schooling?	NO FORMAL EDUCATION <input type="checkbox"/> PRIMARY <input type="checkbox"/> SECONDARY <input type="checkbox"/> HIGHER <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
1A650	Was s/he able to read and write?	YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
1A660	What was her/his economical activity status in year prior to death?	USUALLY ECONOMICALLY ACTIVE MAINLY EMPLOYED <input type="checkbox"/> MAINLY UNEMPLOYED <input type="checkbox"/> NOT ECONOMICALLY ACTIVE HOME-MAKER <input type="checkbox"/> STUDENT <input type="checkbox"/> PENSION <input type="checkbox"/> OTHER (specify) _____ <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
1A670	What was her/his occupation, that is, what kind of work did s/he mainly do?	_____ _____ _____
SECTION 3. DEATH REGISTRATION AND CERTIFICATION		
1A700	Death registration number	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1A710	Date of registration RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	DAY <input type="checkbox"/> <input type="checkbox"/> MONTH <input type="checkbox"/> <input type="checkbox"/> YEAR <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SMALLER ADMIN AREA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LOCALITY <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> URBAN <input type="checkbox"/> RURAL <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
1A730	National identification number of deceased	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
OF A CHILD AGED 4 WEEKS TO 14 YEARS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 4. RESPONDENT'S ACCOUNT OF ILLNESS/EVENTS LEADING TO DEATH		
	<p>Could you tell me about the illness/events that led to her his/death?</p> <hr/> <hr/> <hr/> <hr/>	
	<p>CAUSE OF DEATH 1 ACCORDING TO RESPONDENT</p> <hr/>	
	<p>CAUSE OF DEATH 2 ACCORDING TO RESPONDENT</p> <hr/>	
SECTION 5. CONTEXT AND HISTORY OF PREVIOUSLY KNOWN MEDICAL CONDITIONS		
	<p>I would like to ask you some questions concerning the contexts and 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.</p>	
3A100	Was there any diagnosis of Tuberculosis?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A110	Was there any diagnosis of HIV/AIDS?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A120	Did s/he have a recent positive test for Malaria?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A130	Did s/he have a recent negative test for Malaria?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A140	Was there any diagnosis of Measles?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A150	Was there any diagnosis of High Blood Pressure?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A160	Was there any diagnosis of Heart Disease?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A170	Was there any diagnosis of Diabetes?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A180	Was there any diagnosis of Asthma?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A190	Was there any diagnosis of Epilepsy?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>
3A200	Was there any diagnosis of Cancer?	<p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>DON'T KNOW <input type="checkbox"/></p>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3A210	Was there any diagnosis of Chronic Obstructive Pulmonary Disease (COPD)?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A220	Was there any diagnosis of Dementia?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A230	Was there any diagnosis of Depression?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A240	Was there any diagnosis of Stroke?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A250	Was there any diagnosis of Sickle Cell disease?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A260	Was there any diagnosis of Kidney disease?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A270	Was there any diagnosis of Liver disease?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A280	Did s/he die during the wet season?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A290	Did s/he die during the dry season?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A300	For how long was s/he ill before s/he died?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3A310	Did s/he die suddenly?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
OF A CHILD AGED 4 WEEKS TO 14 YEARS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 6. HISTORY OF INJURIES/ACCIDENTS		
3E100	Did s/he suffer from any injury or accident that led to her/his death?	YES NO DON'T KNOW <input type="checkbox"/>
3E110	+ Did s/he suffer from a road traffic accident?	YES NO DON'T KNOW <input type="checkbox"/>
3E120	++ Was s/he injured as a pedestrian/walking?	YES NO DON'T KNOW <input type="checkbox"/>
3E130	++ Was s/he injured as an occupant of a car vehicle?	YES NO DON'T KNOW <input type="checkbox"/>
3E140	++ Was s/he injured as an occupant of a bus/heavy transport vehicle?	YES NO DON'T KNOW <input type="checkbox"/>
3E150	++ Was s/he injured as a driver or passenger of a motorcycle?	YES NO DON'T KNOW <input type="checkbox"/>
3E160	++ Was s/he injured as a pedal cyclist?	YES NO DON'T KNOW <input type="checkbox"/>
3E170	++ Do you know anything about the counter-part that was hit during the road traffic accident?	YES NO <input type="checkbox"/>
3E200	+++ Was it a pedestrian?	YES NO DON'T KNOW <input type="checkbox"/>
3E210	+++ Was it a stationary object?	YES NO DON'T KNOW <input type="checkbox"/>
3E220	+++ Was it a car vehicle?	YES NO DON'T KNOW <input type="checkbox"/>
3E230	+++ Was it a bus or heavy transport vehicle?	YES NO DON'T KNOW <input type="checkbox"/>
3E240	+++ Was it a motor cycle?	YES NO DON'T KNOW <input type="checkbox"/>
3E250	+++ Was it a pedal cycle?	YES NO DON'T KNOW <input type="checkbox"/>
3E260	+++ Was it something else?	YES (specify) _____ <input type="checkbox"/> NO DON'T KNOW <input type="checkbox"/>
3E300	+ Was s/he injured in a non-road transport accident?	YES NO DON'T KNOW <input type="checkbox"/>
3E310	++ Was s/he injured in a fall?	YES NO DON'T KNOW <input type="checkbox"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3E320	++ Did s/he die of drowning?	YES NO DON'T KNOW <input type="checkbox"/>
3E330	++ Did s/he suffer from burns?	YES NO DON'T KNOW <input type="checkbox"/>
3E340	++ Did (s)he suffer from any plant/animal/insect bite or sting that led to ++ her/his death?	YES NO DON'T KNOW <input type="checkbox"/>
3E400	+++ Was it a dog?	YES NO DON'T KNOW <input type="checkbox"/>
3E410	+++ Was it a snake?	YES NO DON'T KNOW <input type="checkbox"/>
3E420	+++ Was it an insect?	YES NO DON'T KNOW <input type="checkbox"/>
3E500	++ Was s/he injured by a force of nature?	YES NO DON'T KNOW <input type="checkbox"/>
3E510	++ Was there any poisoning?	YES NO DON'T KNOW <input type="checkbox"/>
3E520	+ Was s/he subject to violence or assault?	YES NO DON'T KNOW <input type="checkbox"/>
3E530	+ Was the injury or accident intentionally inflicted by someone else?	YES NO DON'T KNOW <input type="checkbox"/>
3E600	++ Was s/he injured by a fire arm?	YES NO DON'T KNOW <input type="checkbox"/>
3E610	++ Was s/he injured from a stab, cut or pierce?	YES NO DON'T KNOW <input type="checkbox"/>
3E620	++ Was s/he injured by machinery?	YES NO DON'T KNOW <input type="checkbox"/>
3E630	++ Was s/he struck by an animal or object?	YES NO DON'T KNOW <input type="checkbox"/>
3E700	+ Do you think that s/he committed suicide?	YES NO DON'T KNOW <input type="checkbox"/>
<p data-bbox="310 1650 779 1661">CHECK QUESTIONS 1A240 AND 1A250 FOR AGE AT DEATH:</p> <p data-bbox="406 1669 552 1751">IF UNDER ONE YEAR <input type="checkbox"/> ↓</p> <p data-bbox="682 1669 1071 1751">IF ONE YEAR OR OLDER <input type="checkbox"/> → JUMP TO SECTION 8</p>		

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 7. SYMPTOMS AND SIGNS NOTED DURING THE FINAL ILLNESS OF INFANTS		
3D190	Was the child born smaller than normal, weighing under 2.5 kg?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D210	How many weeks was the pregnancy when the baby was born?	NUMBER OF WEEKS DON'T KNOW <input type="text"/> <input type="checkbox"/>
3D390	Did the child have bulging of the 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"/>

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
OF A CHILD AGED 4 WEEKS TO 14 YEARS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 8. SYMPTOMS NOTED DURING THE FINAL ILLNESS FOR ALL CHILDREN		
3D220	Did the child have any noticeable malformation?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D240	+ Did the child have a swelling or defect on the back?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D250	+ Did the child have a very large head?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D260	+ Did the child have a very small head?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B100	Did s/he have a fever?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B110	+ For how long did s/he have a fever?	NUMBER OF DAYS NUMBER OF WEEKS <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
3B120	+ Did s/he have night sweats?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B130	Did s/he have a cough?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B140	+ For how long did s/he have a cough?	NUMBER OF DAYS NUMBER OF WEEKS <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
3B170	+ Did s/he make a whooping sound when coughing?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B150	+ Was the cough productive with sputum?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B160	+ Did s/he cough out blood?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B180	Did s/he have any breathing problem?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B190	+ Did s/he have fast breathing?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B200	++ For how long did s/he have fast breathing?	NUMBER OF DAYS NUMBER OF WEEKS <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
3B210	+ Did s/he have breathlessness?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B220	++ For how long did s/he have breathlessness?	NUMBER OF DAYS NUMBER OF WEEKS <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>
3B230	++ Was s/he unable to carry out daily routine activities due to ++ breathlessness?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3B240	++ Was s/he breathless while lying flat?	YES NO DON'T KNOW <input type="checkbox"/>
3B250	+ Did you see the lower chest wall/ribs be pulled in as the child + breathed?	YES NO DON'T KNOW <input type="checkbox"/>
3B260	+ Did s/he have noisy breathing (grunting or wheezing)? + DEMONSTRATE	YES NO DON'T KNOW <input type="checkbox"/>
3B270	Did s/he have severe chest pain?	YES NO DON'T KNOW <input type="checkbox"/>
3B280	Did s/he have diarrhoea?	YES NO DON'T KNOW <input type="checkbox"/>
3B290	+ For how long did s/he have diarrhoea?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW <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"/>
3B310	Did s/he vomit?	YES NO DON'T KNOW <input type="checkbox"/>
3B320	+ Did s/he vomit "coffee grounds" or bright red/blood?	YES NO DON'T KNOW <input type="checkbox"/>
3B330	Did s/he have any abdominal problem?	YES NO DON'T KNOW <input type="checkbox"/>
3B340	+ Did s/he have severe abdominal pain?	YES NO DON'T KNOW <input type="checkbox"/>
3B350	++ For how long before death did s/he have severe abdominal ++ pain?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW <input type="checkbox"/>
3B360	+ Did s/he have a more than usual protruding abdomen?	YES NO DON'T KNOW <input type="checkbox"/>
3B370	++ For how long did s/he have a more than usual protruding ++ abdomen?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW <input type="checkbox"/>
3B380	+ Did s/he have any lump inside the abdomen?	YES NO DON'T KNOW <input type="checkbox"/>
3B390	++ For how long did s/he have the lump inside the abdomen?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW <input type="checkbox"/>
3B400	Did s/he have a severe headache?	YES NO DON'T KNOW <input type="checkbox"/>
3B405	Did s/he have a stiff or painful neck?	YES NO DON'T KNOW <input type="checkbox"/>
3B410	+ For how long did s/he have a stiff or painful neck?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW <input type="checkbox"/>
3B420	Did s/he have mental confusion?	YES NO DON'T KNOW <input type="checkbox"/>

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3B430	+ For how long did s/he have mental confusion?	NUMBER OF DAYS NUMBER OF MONTHS DON'T KNOW
3B440	Was s/he unconscious for more than 24 hours?	YES NO DON'T KNOW
3B450	+ Did the unconsciousness start suddenly, quickly (at least within + a single day)?	YES NO DON'T KNOW
3B460	Did s/he have convulsions?	YES NO DON'T KNOW
3B470	+ For how long did s/he have convulsions?	NUMBER OF MINUTES DON'T KNOW
3B480	+ Did s/he become unconscious immediately after the convulsion?	YES NO DON'T KNOW
3B490	Did s/he have any urine problems?	YES NO DON'T KNOW
3B500	+ Did s/he pass no urine at all?	YES NO DON'T KNOW
3B510	+ Did s/he go to urinate more often than usual?	YES NO DON'T KNOW
3B520	+ During the final illness did s/he ever pass blood in the urine?	YES NO DON'T KNOW
3B530	Did s/he have any skin problems?	YES NO DON'T KNOW
3B540	+ Did s/he have any ulcers, abscess or sores + anywhere except on the feet?	YES NO DON'T KNOW
3B550	+ Did (s)he have any ulcers, abscess or sores on the feet + that were not also on other parts of the body?	YES NO DON'T KNOW
3B560	+ During the illness that led to death, did s/he have any skin rash?	YES NO DON'T KNOW
3B570	+ + For how long did s/he have the skin rash?	NUMBER OF DAYS NUMBER OF WEEKS DON'T KNOW
3B580	+ + Did s/he have measles rash?	YES NO DON'T KNOW
3B590	+ + Did s/he ever have shingles/herpes zoster?	YES NO DON'T KNOW
3B600	Did s/he have bleeding from the nose, mouth, or anus?	YES NO DON'T KNOW
3B610	Did s/he have noticeable weight loss?	YES NO DON'T KNOW
3B620	+ Was s/he severely thin or wasted?	YES NO DON'T KNOW

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	
3B630	Did s/he have mouth sores or white patches in the mouth or on the tongue?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B640	Did s/he have stiffness of the whole body or was unable to open the mouth?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B650	Did s/he have swelling (puffiness) of the face?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B660	Did s/he have both feet swollen?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B670	Did s/he have any lumps?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B680	+ Did s/he have a lumps or lesions in the mouth?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B690	+ Did s/he have any lumps on the neck?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B700	+ Did s/he have any lumps on the armpit?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B710	+ Did s/he have any lumps on the groin?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B730	Did s/he have paralysis of one side of the body?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B740	Did s/he have difficulty or pain while swallowing liquids?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B750	Did s/he have yellow discoloration of the eyes?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B760	Did her/his hair colour change to reddish or yellowish?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B770	Did s/he look pale (thinning/lack of blood) or have pale palms, eyes or nail beds?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B780	Did s/he have sunken eyes?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3D270	Was the child not growing normally?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3B790	Did (s)he drink a lot more water than usual?	YES NO DON'T KNOW	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>CHECK QUESTIONS 1A110, 1A240 AND 1A250 FOR SEX AND AGE AT DEATH:</p> <p>IF FEMALE BETWEEN 12 - 14 YEARS <input type="checkbox"/> ↓</p> <p>IF MALE OR FEMALE UNDER 12 YEARS <input type="checkbox"/> → JUMP TO SECTION 10</p>			

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
OF A CHILD AGED 4 WEEKS TO 14 YEARS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 9. SYMPTOMS AND SIGNS ASSOCIATED WITH PREGNANCY		
3C100	Was she neither pregnant, nor delivered, within 6 weeks of her death? OR	YES skip pregnancy section if YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C110	Was she pregnant at the time of death? OR	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C120	Did she die within 6 weeks of giving birth? OR	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C130	Did she die within 6 weeks of a pregnancy that lasted less than 6 months?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C200	+ Did she die within 24 hours after delivery?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C210	+ Did she die during labour, but undelivered?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C220	+ Was she breastfeeding at death?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C230	+ How many births, including stillbirths, did she have + before this baby?	NUMBER OF BIRTHS/STILLBIRTHS <input type="text"/> DON'T KNOW <input type="checkbox"/>
3C240	+ Did she have any previous C-section?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C250	+ Did she die during or after a multiple pregnancy?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C260	+ During pregnancy, did she suffer from high blood pressure?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C270	+ Did she have foul smelling vaginal discharge during pregnancy + or after delivery?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C280	+ During the last 3 months of pregnancy, did she suffer from + convulsions?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C290	+ During the last 3 months of pregnancy, did she suffer from + blurred vision?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C300	+ Did she give birth to a live, healthy baby within 6 weeks of death?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C310	+ Was there any vaginal bleeding during pregnancy or + after delivery?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C320	++ Was there vaginal bleeding during the first 6 months + of pregnancy?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3C330	++ Was there vaginal bleeding during the last 3 months of + pregnancy but before labour started?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
3C340	+ + Was there excessive vaginal bleeding during labour?	YES NO DON'T KNOW <input type="checkbox"/>
3C350	+ + Was there excessive vaginal bleeding after delivering the baby?	YES NO DON'T KNOW <input type="checkbox"/>
3C360	+ Was the placenta not completely delivered?	YES NO DON'T KNOW <input type="checkbox"/>
3C365	+ Did she deliver or try to deliver an abnormally positioned baby?	YES NO DON'T KNOW <input type="checkbox"/>
3C370	+ Was she in labour for unusually long (more than 24 hours)?	YES NO DON'T KNOW <input type="checkbox"/>
3C380	Did she attempt to terminate the pregnancy?	YES NO DON'T KNOW <input type="checkbox"/>
3C390	+ Did she recently have a pregnancy that ended in + an abortion (spontaneous or induced)?	YES NO DON'T KNOW <input type="checkbox"/>
3C400	+ Did she give birth in a health facility?	YES NO DON'T KNOW <input type="checkbox"/>
3C410	+ Did she give birth at home?	YES NO DON'T KNOW <input type="checkbox"/>
3C420	Did she give birth elsewhere, e.g. on the way to a facility?	YES NO DON'T KNOW <input type="checkbox"/>
3C430	+ Did she receive professional assistance for the delivery?	YES NO DON'T KNOW <input type="checkbox"/>
3C440	+ Did she have an operation to remove her uterus shortly + before death?	YES NO DON'T KNOW <input type="checkbox"/>
3C450	+ Did she have a normal vaginal delivery?	YES NO DON'T KNOW <input type="checkbox"/>
3C460	+ Did she have an assisted delivery, with forceps/vacuum?	YES NO DON'T KNOW <input type="checkbox"/>
3C470	+ Was it a delivery with caesarean section?	YES NO DON'T KNOW <input type="checkbox"/>
3C480	+ Was the baby born more than one month early?	YES NO DON'T KNOW <input type="checkbox"/>

2012 WHO VERBAL AUTOPSY [FORM 2] DEATH
OF A CHILD AGED 4 WEEKS TO 14 YEARS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
SECTION 10. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS		
3G100	Was s/he adequately vaccinated?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G110	Did s/he receive any treatment for the illness that led to death?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G120	+ Did s/he receive oral rehydration salts?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G130	+ Did s/he receive (or needed) intravenous fluids (drip) treatment?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G140	+ Did s/he receive (or needed) a blood transfusion?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G150	+ Did s/he receive (or needed) treatment/food through a tube passed + through the nose?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G160	+ Did s/he receive (or needed) injectable (IV or IM) antibiotics?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G170	+ Did s/he have (or needed) an operation for the illness?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G180	+ + Did s/he have the operation within 1 month before death?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3G190	+ Was s/he discharged from the hospital very ill?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
SECTION 11. BACKGROUND		
4A100	In the final days before death, did s/he travel to a hospital or health facility?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4A110	+ Did s/he use motorised transport to get to the hospital or health facility?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4A120	+ Were there any problems during admission to the hospital or health facility?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4A140	+ Were there any problems getting medications, or diagnostic tests in the hospital or health facility?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4A160	In the final days before death, were there any doubts about whether medical care was needed?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
4A170	In the final days before death, was traditional medicine used?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4A180	In the final days before death, did anyone use a telephone or cell phone to call for help?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4A190	Over the course of illness, did the total costs of care and treatment prohibit other household payments?	YES NO DON'T KNOW <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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: _____

