VERBAL AUTOPSY QUESTIONNAIRE 3
DEATH OF A PERSON AGED 15 YEARS AND ABOVE

CONSENT STATEMENT

Good Morning/Good Afternoon/ Good Evening.

My name is ____________________________and I am working with ________________________University.

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

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

May I begin the interview now?

Signature of interviewer: _______________________________ Date: _________________________

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

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

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 ……………………… [ ][ ] MINUTES ………………….. [ ][ ]	
202	What is your relationship to the deceased?	FATHER ……………………………1 MOTHER………………………. …. 2 SIBLING ……………………………4 OTHER RELATIVE ____________ 6 (SPECIFY) NO RELATION ……………………… 8	
203	Did you live with the deceased in the period leading to her/his death	Yes ……………………………………1 No ……………………………………..2	

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

309	Where did s/he die?	Hospital …………………………………1 Other health faculty……….................2 Home……………………………………..3 Other ______________________6 (specify) Don't know………………………………8	

310	For deaths at hospital or health facility, record facility name and address: ____ ____

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? **Note: When possible, use local term for the symptom.** ____	
402	CAUSE OF DEATH 1 ACCORDING TO RESPONDENT ______________________________	
403	CAUSE OF DEATH 2 ACCORDING TO RESPONDENT ______________________________	

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

SECTION 6. HISOTRY OF INJURIES/ACCIDENTS

601	Did s/he suffer from any injury or accident that led to her/his death?	Yes ……………………………………1 No ……………………………………..2 Don't know ……………………………8	
		—► 604 —► 604	
602	What kind of injury or accident did the deceased suffer?	Road traffic accident ……………… 01 Fall ………………………………… 02 Drowning ………………………… 03 Poisoning ……………………….. … 04 Burns ……………………………… 05 Violence/assault ………………..... 06 Other ________________________96 (specify)	
603	Was the injury or accident intentionally inflicted by someone else?	Yes ……………………………………..1 No …………………………………….. 2 Don't know …………………………… 8	
604	Do you think that s/he committed suicide?	Yes ……………………………………..1 No …………………………………….. 2 Don't know …………………………… 8	
605	Did s/he suffer from any animal/insect bite that led to her/his death?	Yes ……………………………………..1 No …………………………………….. 2 Don't know …………………………… 8	—► 608 —► 608
606	What type of animal/insect?	Dog ……………………………………1 Snake …………………………………2 Insect …………………………………..3 Other ________________________ 6 (Specify) Don't know ……………………………8	
607	CHECK QUESTION 302 FOR SEX AT DEATH: FEMALE ☐ ↓ 701 MALE ☐ ——————►		801

SECTION 7. SYMPTOMOS AND SIGNS ASSOCIATED WITH ILLNESS OF WOMEN			
701	Did she have an ulcer or swelling in the breast?	Yes ……………………………………..1 No …………………………………….. 2 Don't know …………………………… 8	—► 703 —► 703
702	For how long did she have an ulcer or swelling in the breast?	Days ……………………… ☐☐ Months ……………………….. ☐☐ Don't know ………….............9 9 8	
703	Did she have excessive vaginal bleeding during menstrual periods?	Yes ……………………………………..1 No …………………………………….. 2 Don't know …………………………… 8	—► 705 —► 705

704	For how long did s/he have the excessive vaginal bleeding during menstrual periods?	Days .... [ ][ ] Months .... [ ][ ] Don't know 9 9 8	
705	Did she have vaginal bleeding in between menstrual periods?	Yes ....1 No .... 2 Don't know 8	 —▶ **707** —▶ **707**
706	For how long did she have vaginal bleeding in between menstrual periods?	Days .... [ ][ ] Months .... [ ][ ] Don't know 998	
707	Did she have abnormal vaginal discharge?	Yes ....1 No .... 2 Don't know 8	
708	For how long did she have abnormal vaginal discharge?	DAYS .... [ ][ ] Months .... [ ][ ] Don't know 9 9 8	

SECTION 8. SYMPTOMS AND SIGNS ASSOCIATED WITH PREGNANCY			
801	Was she pregnant at the time of death	Yes ....1 No .... 2 Don't know 8	 —▶ **806** —▶ **806**
802	How long was she pregnant?	DAYS .... [ ][ ] Months .... [ ][ ] Don't know 998	
803	How many pregnancies had she had, including this one?	Days .... [ ][ ] Don't know 9 8	
804	During the last 3 months of pregnancy, did she suffer from any of the following illnesses: 1 Vaginal bleeding? 2 Smelly vaginal discharge? 3 Puffy face? 4 Headache? 5 Blurred vision? 6 Convulsion? 7 Febrile illness? 8 Severe abdominal pain that was not labor pain? 9 Pallor and shortness of breath (both present)? 10 Did she suffer from any other illness?	YES NO DK Vaginal bleeding........ 1 2 8 Smelly vaginal discharge 1 2 8 Puffy face .... 1 2 8 Headache .... 1 2 8 Blurred vision .... 1 2 8 Convulsion .... 1 2 8 Febrile illness .... 1 2 8 severe abdominal pain (not labor pain) .... 1 2 8 Pallor/shortness of breath (both)............1 2 8 other illness ....1 2 8 specify___________________________	
805	Did she die during labor, but undelivered?	Yes ....1 No .... 2 Don't know 8	
806	Did she give birth recently?	Yes ....1 No .... 2 Don't know 8	 —▶ **818** —▶ **818**

807	How many days after giving birth did she die?	Days .... [ ][ ] Don't know 98	
808	Was there excessive bleeding on the day labor started?	Yes ....1 No .... 2 Don't know 8	
809	Was there excessive bleeding during labor before delivering the baby?	Yes ....1 No .... 2 Don't know 8	
810	Was there excessive bleeding after delivering the baby?	Yes ....1 No .... 2 Don't know 8	
811	Did she have difficulty in delivering the placenta?	Yes ....1 No .... 2 Don't know 8	
812	Was she in labor for unusually long (more than 24 hours)?	Yes ....1 No .... 2 Don't know 8	
813	Was it a normal vaginal delivery?	Yes ....1 No .... 2 Don't know 8	—► 815 —► 815
814	What type of delivery was it?	Forceps/Vacuum...........................1 Caesarean section ....2 Other ___________________________6 (Specify) Don't know 8	
815	Did she have foul smelling vaginal discharge?	Yes ....1 No .... 2 Don't know 8	
816	Where did she give birth?	Hospital ....1 Other health faculty............................2 Home...3 Other __________________________ 6 (specify) Don't know.................................8	
817	Who conducted the delivery?	Doctor ....1 Nurse/Midwife...............................2 Traditional birth attendant ....3 Relative ....4 Mother by herself .... 5 Other ____________________________ (Specify) Don't know 8	
818	Did she experience an abortion recently?	Yes ....1 No .... 2 Don't know 8	—► 901 —► 901
819	Did she die during the abortion?	Yes ....1 No .... 2 Don't know 8	—► 821 —► 821
820	How many days before death did she have the abortion?	Days .... [ ][ ] Don't know 98	
821	How many months pregnant was she when she had the abortion?	Months .... [ ][ ] Don't know 98	

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

SECTION 9. SIGNS AND SYMPTOMS NOTED DURING THE FINAL ILLNESS			
901	For how long was s/he ill before s/he died?	DAYS .... Months .... Don't know 998	
902	Did s/he have a fever?	Yes ....1 No .... 2 Don't know 8	—▶907 —▶907
903	For how long did s/he have a fever?	Days.............................. Months .... Don't know 998	
904	Was the fever continuous or on and off?	Continuous ....1 On and Off ....2 Don't know 8	
905	Did s/he have fever only at night?	Yes ....1 No .... 2 Don't know 8	
906	Did s/he have chills/rigor?	Yes ....1 No .... 2 Don't know 8	
907	Did s/he have a cough?	Yes ....1 No .... 2 Don't know 8	—▶913 —▶913
908	For how long did s/he have a cough?	DAYS .... Months .... Don't know 998	
909	Was the cough severe?	Yes ....1 No .... 2 Don't know 8	
910	Was the cough productive with sputum?	Yes ....1 No .... 2 Don't know 8	
911	Did s/he cough out blood?	Yes ....1 No .... 2 Don't know 8	
912	Did s/he have night sweats?	Yes ....1 No .... 2 Don't know 8	
913	Did s/he have breathlessness?	Yes ....1 No .... 2 Don't know 8	—▶918 —▶918

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

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

945	Did s/he have any mass in the abdomen?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 →948 →948
946	For how long did s/he have the mass in the abdomen?	Days…………………… Months ………………………. Don't know ………………….......998	
947	Where in the abdomen was the mass located?	Right upper abdomen ………………1 Left upper abdomen …………………2 Lower abdomen ……………………..3 All over abdomen ……………………4 Don't know ……………………………8	
948	Did s/he have difficulty or pain while swallowing solids?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 →950 →950
949	For how long did s/he have difficulty or pain while swallowing solids?	Days…………………………… Months ………………………. Don't know ………………….......998	
950	Did s/he have difficulty or pain while swallowing liquids?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 →952 →952
951	For how long did s/he have difficulty or pain while swallowing liquids?	Days…………………… Months ………………………. Don't know ………………….......998	
952	Did s/he have headache?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 →955 →955
953	For how long did s/he the have headache?	Days…………………… Months ………………………. Don't know ………………….......998	
954	Was the headache severe?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	
955	Did s/he have a stiff or painful neck?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 →967 →967
956	For how long did s/he have a stiff or painful neck?	Days ………………………… Don't know …………………… 98	
957	Did s/he have mental confusion?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 →960 →960
958	For how long did s/he have mental confusion?	Days…………………… Months ………………………. Don't know ………………….......998	

959	Did the mental confusion start suddenly, quickly within a single day, or slowly over many days?	Suddenly……………. ………………… 1 Within a day (Fast)……………………2 Slowly (Many days)…………………...3 Don't know …………………………… 8	
960	Did s/he become unconscious?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶963 —▶963
961	For how long was s/he unconscious?	Days…………………… Months ……………………….. ☐☐ Don't know …………............998	
962	Did the unconsciousness start suddenly, quickly within a single day, or slowly over many days?	Suddenly……………. ………………… 1 Within a day (Fast)……………………2 Slowly (Many days)…………………...3 Don't know …………………………… 8	
963	Did s/he have convulsions?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶965 —▶965
964	For how long did s/he have convulsions?	Days…………………… Months ……………………….. ☐☐ Don't know …………............998	
965	Was s/he unable to open the mouth?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶967 —▶967
966	For how long was s/he unable to open the mouth?	Days …………………………. ☐☐ Don't know …………………… 98	
967	Did s/he have stiffness of the whole body?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶969 —▶969
968	For how long did s/he have stiffness of the whole body?	Days …………………………. ☐☐ Don't know …………………… 98	
969	Did s/he have paralysis of one side of the body?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶972 —▶972
970	For how long did s/he have paralysis of one side of the body?	Days…………………… Months ……………………….. ☐☐ Don't know …………............998	
971	Did the paralysis of one side of the body start suddenly, quickly within a single day, or slowly over many days?	Suddenly……………. ………………… 1 Within a day (Fast)……………………2 Slowly (Many days)…………………...3 Don't know …………………………… 8	 —▶1001 —▶1001
972	Did s/he have paralysis of the lower limbs?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶975 —▶975

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

987	Did s/he have bleeding from the nose, mouth, or anus?	Yes ....1 No .... 2 Don't know 8	
988	Did s/he ever have shingles/herpes zoster?	Yes ....1 No .... 2 Don't know 8	
989	Did s/he have weight loss?	Yes ....1 No .... 2 Don't know 8	 —► 990 —► 990
989.1	For how long did s/he have weight loss?	Days .... [ ][ ] Months .... [ ][ ] Don't know 9 9 8	
989.2	Did s/he look very thin and wasted?	Yes ....1 No .... 2 Don't know 8	
990	Did s/he have mouth sores or white patches in the mouth or on the tongue?	Yes ....1 No .... 2 Don't know 8	 —► 991 —► 991
990.1	For how long did s/he have mouth sores or white patches in the mouth or on the tongue?	Days .... [ ][ ] Don't know 9 8	
991	Did s/he have any swelling?	Yes ....1 No .... 2 Don't know 8	 —► 992 —► 992
991.1	For how long did s/he have the swelling?	Days .... [ ][ ] Months .... [ ][ ] Don't know 998	
991.2	Was the swelling on: 1 The face? 2 The joints? 3 The ankles? 4 The whole body? 5 Any other place?	YES NO DK Face....1 2 8 Joints....1 2 8 Ankles.... 1 2 8 Whole body.... 1 2 8 Other place .... 1 2 8 Specify ________	
992	Did s/he have any lumps?	Yes ....1 No .... 2 Don't know 8	 —► 993 —► 993
992.1	For how long did s/he have the lumps?	Days .... [ ][ ] Months .... [ ][ ] Don't know 998	
992.2	Were the lumps on: 1 The neck? 2 The armpit? 3 The groin? 4 Any other place?	YES NO DK Neck....1 2 8 Armpit.... 1 2 8 Groin.... 1 2 8 Other place .... 1 2 8 Specify ________	
993	Did s/he have yellow discoloration of the eyes?	Yes ....1 No .... 2 Don't know 8	 —► 994 —► 994

993.1	For how long did s/he have yellow discoloration of the eyes?	Days ……………………………. [ ][ ] Months ………………………..[ ][ ] Don't know …………….........9 9 8	
994	Did s/he look pale (thinning/lack of blood) or have pale palms, eyes or nail beds?	Yes ……………………………….…1 No …………………………………….. 2 Don't know …………………………. 8	 —▶995 —▶995
994.1	For how long did s/he look pale or have pale palms, eyes or nail beds?	Days ……………………………. [ ][ ] Months ………………………..[ ][ ] Don't know …………….........9 9 8	
995	Did s/he have an ulcer, abscess, or sore anywhere on the body?	Yes ……………………………….…1 No …………………………………….. 2 Don't know …………………………. 8	 —▶1001 —▶1001
995.1	For how long did s/he have the ulcer, abscess, or sore?	Days ………………………….. [ ][ ] Don't know …………………… 9 8	
995.2	What was the location of the ulcer, abscess, or sore?	____________________ ____________________ (Specify)	

SECTION 10. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS			
1001	Did s/he receive any treatment for the illness that led to death?	Yes ……………………………….…1 No …………………………………….. 2 Don't know …………………………. 8	 —▶1008 —▶1008
1002	Can you please list the drugs s/he was given for the illness that led to death? COPY FROM PRESCRIPTION/DISCHARGE NOTES IF AVAILABLE	____________________ ____________________ ____________________	
1003	What type of treatment did s/he receive: 1 Oral rehydration salts and/or intravenous fluids (drip) treatment? 2 Blood transfusion? 3 Treatment/food through a tube passed through the nose? 4 Any other treatment?	YES NO DK Ors/drip treatment………1 2 8 Blood transfusion……… 1 2 8 Through the nose……… 1 2 8 Other place ……………. 1 2 8 Specify ____________	
1004	Please tell me at which of the following places/facilities s/he received treatment during the illness that led to death: 1 Home? 2 Traditional healer? 3 Government clinic? 4 Government hospital? 5 Private clinic? 6 Private hospital? 7 Pharmacy, drug seller, store? 8 Any other placer or facility?	**Yes No DK** Home ………………… 1 2 8 Traditional healer…… 1 2 8 Government clinic…... 1 2 8 Government hospital…. 1 2 8 Private clinic ……………1 2 8 Private hospital…………1 2 8 Pharmacy/drug seller /store ……………….. 1 2 8 Other place __________1 2 8 Specify	

1005	In the month before death, how many contacts with formal health services did s/he have?	Number of contacts………… [ ][ ] Don't know …………………… 98	
1006	Did a health care worker tell you the cause of death?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶ 1008 —▶ 1008
1007	What did the health care worker say?	__________ __________ __________	
1008	Did s/he have any operation for the illness?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶ 1101 —▶ 1101
1009	How long before death did s/he have the operation?	Days ………………………….. [ ][ ] Don't know …………………… 98	
1010	On what part of the body was the operation?	Abdomen ……………………………1 Chest ……………………………….....2 Head …………………………………3 Other ________________6 (Specify) Don't know …………………………….8	

SECTION 11. RISK FACTORS			
1101	Did s/he drink alcohol?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶ 1106 —▶ 1106
1102	How long had s/he been drinking? RECORD 'Off IF LESS THAN ONE YEAR	Days ………………………….. [ ][ ] Don't know …………………… 9 8	
1103	How often did s/he drink alcohol?	Daily …………………………………1 Frequently (Weekly) …………………..2 Once in a while ……………………… 3 Don't know ……………………………8	
1104	Did she stop drinking?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶ 1106 —▶ 1106
1105	How long before death did s/he stop drinking? RECORD 'Off IF LESS THAN ONE MONTH	Months ……………………….. [ ][ ] Don't know …………………… 9 8	
1106	Did s/he smoke tobacco (cigarette, cigar, pipe etc.)?	Yes ……………………………………1 No …………………………………… 2 Don't know …………………………… 8	 —▶ 1201 —▶ 1201
1107	How long had s/he been smoking? RECORD 'Off IF LESS THAN ONE YEAR	Years ………………………….[ ][ ] Don't know …………………… 9 8	
1108	How often did s/he smoke?	Daily …………………………………1 Frequently (Weekly) …………………..2 Once in a while ……………………… 3 Don't know ……………………………8	
1109	How many cigarettes did s/he smoke daily?	Number of cigarettes………. [ ][ ] Don't know …………………… 9 8	

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

SECTION 12. DATA ABSTRACTED FROM DEATH CERTIFICATE			
1201	Do you have a death certificate for the baby	Yes .... 1 No .... 2 Don't know 8	—▶ 1301 —▶ 1301
1202	Can I see the death certificate? COPY DAY, MONTH AND YEAR OF DEATH FROM THE DEATH CERTIFICAT	Day [ ][ ] Month [ ][ ] Year [ ][ ][ ][ ]	
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 (If Any) ____________________		
1206	Record the cause of death from the third line of the death certificate (If Any) ____________________		
1207	Record the cause of death from the fourth line of the death certificate (If Any) ____________________		

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

____
____
____
____
____
____

COMMENT ON SPECIFIC QUESTIONS:

____
____
____
____
____

ANY OTHER COMMENTS:

____
____
____
____
____

SUPERVISOR'S OBSERVATIONS

____
____
____
____
____
____
____
____

NAME OF THE SUPERVISOR: _______________________ DATE ___________________