

AFRICAN POPULATION AND HEALTH RESEARCH CENTER (APHRC)
 NAIROBI URBAN HEALTH AND DEMOGRAPHIC SURVEILLANCE SYSTEM (NUHDSS)
VERBAL AUTOPSY FORM FOR PEOPLE 5 YEARS AND OLDER

A. BACKGROUND

GET AND CONFIRM RESPONSES FOR A.4 TO A.10 FROM DEATH REGISTRATION FORM

- A.1. START TIME
- A.2. FIELD WORKER'S CODE
- A.3. DATE OF INTERVIEW
- A.4. NAME OF DECEASED PERSON
- A.5. ID OF THE DECEASED PERSON
- A.6. HOUSEHOLD ID
- A.7. DATE OF BIRTH OF THE DECEASED PERSON
- A.8. DATE OF DEATH
- A.9. SEX OF THE DECEASED PERSON (F=Female; M=Male)
- A.10. ID OF ROOM WHERE (NAME) USED TO SLEEP
- A.11. COMPUTE AGE IN YEARS (CHECK A.7 & A.8)

B. RESPONDENT PARTICULARS

- B.1. What is your **full** name?.....
- B.2. DOES RESPONDENT STAY IN THIS HOUSEHOLD? (1= YES; 2=NO) **[IF 2 SKIP TO B.4]**
- B.3. RESPONDENT'S LINE NUMBER IN HOUSEHOLD LISTING **[SKIP TO B.5]**
- B.4. RECORD ID OF ROOM WHERE RESPONDENT SLEEPS
- B.5. What is your relationship to (NAME OF DECEASED)? **(CODE SHEET A²)**
- B.6. Were you taking care of (NAME) at the time of his/her illness or death?
 (0=NO; 1=YES, THROUGHOUT ILLNESS DURATION;
 2=YES, FOR PART OF THE ILLNESS DURATION)
- C. RESULT OF INTERVIEW **(CODE SHEET A⁷)**

SECTION 1: OPEN HISTORY

- 1.1. Please tell me the area or town where (NAME) died.

P)..... D)..... L)..... /N/E).....

RECORD THE CODE FOR AREA/TOWN WHERE DEATH OCCURRED (CODE SHEET A⁵)

- 1.2. Did (NAME) die in a house, health facility, en route to health facility or elsewhere? (HS=HOUSE;
HF=HEALTH FACILITY; RT=EN ROUTE TO HEALTH FACILITY;
OT=ELSEWHERE, SPECIFY

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- 1.3. Please, tell me about the circumstances that surrounded the death of (NAME)

PROBE FOR MORE DETAILS: WAS THERE ANYTHING ELSE?

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1.4 FOR EACH OF THE SYMPTOMS/CONDITIONS LISTED BELOW, CIRCLE THE CORRESPONDING LETTERS ON THE RIGHT IF MENTIONED IN Q. 1.3, OTHERWISE LEAVE IT UNCIRCLED. DO NOT READ OUT WHAT IS CONTAINED IN THIS LIST.

- | | |
|----------------------------|-----|
| a. Accident | a. |
| b. HIV/AIDS | b. |
| c. Born Premature | c. |
| d. Cholera | d. |
| e. Coma | e. |
| f. Complicated Delivery | f. |
| g. Cough | g. |
| h. Diarrhoea | h. |
| i. Difficult Breathing | i. |
| j. Dysentery | j. |
| k. Fever | k. |
| l. Fit/Convulsion | l. |
| m. Injury | m. |
| n. Jaundice | n. |
| o. Kwashiorkor | o. |
| p. Malaria | p. |
| q. Malformation | q. |
| r. Marasmus | r. |
| s. Measles | s. |
| t. Meningitis | t. |
| u. Multiple Birth | u. |
| v. Pneumonia | v. |
| w. Rapid Breathing | w. |
| x. Rash | x. |
| y. Stiff Neck | y. |
| z. Tetanus | z. |
| aa. Tuberculosis (TB) | aa. |
| ab. Typhoid | ab. |
| ac. Very small at birth | ac. |
| ad. Very thin | ad. |
| ae. Vomiting | ae. |
| af. Others (specify) | af. |

1.5a Did (NAME) have an illness around the time he/she died?
(1=YES; 2=NO; 8=DON'T KNOW)

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1.5b Did (NAME) have an injury around the time he/she died?
(1=YES; 2=NO; 8=DON'T KNOW)

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1.6 For how long was (NAME) ill/injured before he/she died?
RECORD D=DAYS; M=MONTHS; Y=YEARS ; N= NO DURATION GIVEN
97=REFUSAL; 98=DON'T KNOW

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1.7. Was health care sought while (NAME) was sick/injured? (1=YES; 2=NO; 8=DON'T KNOW)

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[IF THE ANSWER IS 2 OR 8, SKIP AND READ INSTRUCTION JUST BEFORE Q. 1.10]

1.8. Where was care sought? (CIRCLE ONLY THOSE METIONED)

- a Government Hospital
- b Private not for profit Hospital (e.g. Missionary or muslim founded charity hospitals_)
- c Private for profit Hospital
- d Government health center/dispensary/clinic(including city council clinics)
- e Private health center/Clinic Not for Profit
- f Private health center/Clinic- For profit
- g Traditional healer
- h Religious healer
- i Pharmacy/Drug seller/Store/Market
- j Other (specify)

- a.
- b
- c
- d
- e
- f.
- g
- h.
- i
- j

1.9 If care was sought from more than one source, which of them was the first?

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(INDICATE SOURCE USING Q.1.8 AND LETTER ABOVE E.g 1.8f, 1.8d e.t.c)

[CHECK Q. 1.5a. IF ANSWER IS 2 OR 8, SKIP TO INSTRUCTION JUST BEFORE Q. 1.11]

1.10 What illness do you think (NAME) had/died of? **[CIRCLE THOSE MENTIONED AND PROBE i.e. "ANY OTHER"?]**

- a. HIV/AIDS
- b. Cholera
- c. Dysentery
- d. Diarrhoea
- e. Kwashiokor
- f. Malaria
- g. Marasmus
- h. Measles
- i. Pneumonia
- j. Tetanus
- k. Typhoid
- l. Tuberculosis (TB)
- m Other (specify)

- a.
- b.
- c.
- d.
- e.
- f.
- g.
- h.
- i.
- j.
- k.
- l.
- m

CHECK Q. 1.5b. [IF ANSWER IS 2 OR 8, SKIP TO Q. 1.12]

1.11. What caused the injury?

CIRCLE THOSE MENTIONED AND PROBE "ANY OTHER". DO NOT READ OUT

- a. Vehicle accident
- b. Fall
- c. Drowning
- d. Poisoning
- e. Alcohol/Drug overdose
- f. Shooting
- g. Bite or sting by venomous animals
- h. Burn (scald/flame)
- i. Strangulation
- j Cuts/stab
- k Assault by blunt object
- L Other (specify).....

- a.
- b.
- c.
- d.
- e.
- f.
- g.
- h.
- i.
- j
- k
- L

1.111 Was the cause of the injury accidental or intentional?

1=Accidental; 2=Intentional; 3=Don't know

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1.12. What was the most immediate cause of death (in Q.1.10 or Q1.11)?

RECORD THE QUESTION NUMBER AND LETTER FOR THE IMMEDIATE CAUSE

(e.g., 110g or 111g)

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1.13. How long did (NAME) survive the immediate cause above (Q1.11) before death?
(1=LESS THAN 24 HRS; 2=1 DAY OR MORE; 8=DON'T KNOW)

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[CHECK: IF THE ANSWER IN 1.5b IS 1 AND ANSWER IN 1.5a IS EITHER 2 OR 8, SKIP TO SECTION 4]

SECTION 2: ALL DEATHS

2.1. Did (NAME) have any of the following before he/she died? (1=YES; 2=NO; 8=DON'T KNOW)

- a. Hypertension
- b. Diabetes
- c. Epilepsy
- d. Tuberculosis (TB)
- e. HIV/AIDS
- f. Heart disease
- g. Kidney disease
- h. Other (specify).....

2.2. Did (NAME) have fever? (1=YES; 2=NO; 8=DON'T KNOW)

[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.3]

- a. How many days did the fever last? (21=21 AND MORE; 98=DON'T KNOW)
- b. Was the fever 1=Severe; 2=Mild; 8=Don't know?
- c. Was the fever 1=Continuous; 2=On & off; 8=Don't know?
- d. Did (NAME) experience backpain and myalgia (muscle pain)? (N/Y/D)

2.3. Did (NAME) have a rash? (1=YES; 2=NO; 8=DON'T KNOW)

[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.4]

- a. How many days did the rash last? (21=21 AND MORE; 98=DON'T KNOW)
- b. What did the rash look like? (1=MEASLES RASH; 2=RASH WITH CLEAR FLUID;
3=RASH WITH PUS; 4=OTHER (SPECIFY).....8=DON'T KNOW)
- c. Where was the rash located? (1=ON FACE; 2=ON BODY TRUNK; 3=ON THE MOUTH;
4=OTHER(specify): 8=DON'T KNOW)
- d. Was the rash painful? (1=YES; 2=NO; 8=DON'T KNOW)
- e. Did he/she have sore eyes? (1=YES; 2=NO; 8=DON'T KNOW)

2.4. Had (NAME) lost weight before death? (1=Y; 2=N; 8=D) **[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.6]**

2.5. Was the weight loss 1=Severe; 2=Moderate; 8=Don't know)?

2.6. Did (NAME) have swelling in any part of the body? (1=Y; 2=N; 8=D)

[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.7]

- a. Did he/she have swelling around ankle? (1=Y; 2=N; 8=D)
- b. Did he/she have puffiness of the face? (1=Y; 2=N; 8=D)
- c. Did he/she have swelling in the armpit? (1=Y; 2=N; 8=D)
- d. Did he/she have swelling in the groin ? (1=Y; 2=N; 8=D)
- e. Did he/she have other swelling? (1=Y; 2=N; 8=D), (Specify).....]

2.7.	Did (NAME) have dark colored urine (like coca-cola)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.8.	Did (NAME) look pale (anaemic)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.9.	Did (NAME) have yellow eyes? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.10.	Did (NAME) have cough? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.11]	
a.	How many days did the cough last? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
b.	Was the cough productive (sputum)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
c.	Did (NAME) cough blood? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.11.	Did (NAME) have shortness of breath? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.13]	
2.12.	How many days did the breathlessness last? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
2.13.	Did (NAME) have chest pain ? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.14]	
a.	Where was the pain? (1=UPPER LEFT; 2=LOWER LEFT; 3=UPPER RIGHT; 4=LOWER RIGHT; 5=CENTER; 6 =WHOLE CHEST; 8=DON'T KNOW)	<input type="checkbox"/>
b.	Was the pain 1=Continuous; 2=On and off; 8=Don't know?	<input type="checkbox"/>
2.14.	Did (NAME) have diarrhoea? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.15]	
a.	How many days did the diarrhoea last? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
b.	Was the diarrhoea 1=CONTINUOUS; 2=ON & OFF; 8=DON'T KNOW?	<input type="checkbox"/>
c.	On the average, how many times did he/she pass stool a day? (98=DON'T KNOW)	<input type="checkbox"/>
d.	Did (NAME) pass blood in the stool? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.15.	Did (NAME) have vomiting? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.16]	
a.	How many days did the vomiting last? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
b.	Was the vomiting 1=Continuous; 2=On & off; 8=Don't know?	<input type="checkbox"/>
c.	How many times did he/she vomit a day? (8=DON'T KNOW)	<input type="checkbox"/>
d.	What did the vomitus look like? (1=WATERLY FLUID; 2=YELLOW FLUID; 3=COFFEE COLORED FLUID; 4=BLOODY; 5=FOOD PARTICLES; 6=OTHER(specify).....8=DON'T KNOW)	<input type="checkbox"/>
2.16.	Did (NAME) have abdominal pain? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8", SKIP TO Q. 2.17]	
a.	What was the type of pain? (1=CRAMP; 2=DULL ACHE; 3=BURNING PAIN; 4=OTHER..... 8=DON'T KNOW)	<input type="checkbox"/>
b.	Was the pain 1=Continuous; 2=On & off; 8=Don't know?	<input type="checkbox"/>
c.	How many days did the pain last? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
d.	Where exactly was the pain? (1=LOWER ABDOMEN; 2=UPPER ABDOMEN; 3=ALL OVER ABDOMEN; 4=OTHER(specify):; 8=DON'T KNOW)	<input type="checkbox"/>
e.	Was the abdominal pain 1=Relieved by meal; 2=Increased by meal; 3=Did not change with meal; 8=No idea if related to meal intake)?	<input type="checkbox"/>

2.17. Did (NAME) have distension of abdomen? (N/Y/D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.18]	
a. Was the distension of the abdomen painful? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
b. What was the type of pain? (1=CRAMP; 2=DULL ACHE; 3=BURNING PAIN; 4=OTHER..... 8=DON'T KNOW)	
c. Did the distension develop 1=Rapidly; 2=Slowly over time; 8=Don't know?	<input type="checkbox"/>
d. How many days did the distension of the abdomen last? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
2.18. Did (NAME) have any hard swelling in the abdomen? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.20]	
2.19. Where exactly was the swelling? (1=RIGHT UPPER ABDOMEN; 2= LEFT UPPER ABDOMEN; 3=LOWER ABDOMEN; 4=OTHER (specify.....); 8=DON'T KNOW)	<input type="checkbox"/>
2.20. Did (NAME) have difficulty in swallowing? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.22]	
2.21. How many days did he/she have difficulty swallowing? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
2.22. Did (NAME) have headache? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.23. Did (NAME) have stiff neck?) (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.25]	
2.24. For how many days did (NAME) have stiff neck? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>
2.25. Did (NAME) experience uncounciousness? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.27]	
2.26. Did the uncounciousness start 1=Suddenly; 2=Slowly over a few days; 8=Don't know?	<input type="checkbox"/>
2.27. Did (NAME) have fits? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.28]	
a. How many days did he/she have fits? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>
b. When the fits were most frequent, how many fits per day did she/he have? (98=DON'T KNOW)	<input type="checkbox"/>
c. Between fits, was he/she 1=Awake; 2=Unconscious; 8=Don't know?	<input type="checkbox"/>
2.28. Did (NAME) have difficulty in opening the mouth? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.30]	
2.29. For how long did (NAME) have difficulty opening his/her mouth? (21=21 AND MORE; 98=DON'T KNOW)	<input type="checkbox"/>
2.30. Did (NAME) have stiffness in the whole body? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.31]	
a. How many days did the body stiffness last? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>
b. Did the stiffness develop 1=Rapidly; 2=Slowly over time; 8=Don't know?	<input type="checkbox"/>
2.31. Did (NAME) have paralysis? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.32]	
a. Where was the paralysis? (1=BOTH LEGS; 2=ONE LEG; 3=BOTH LEGS AND ARMS; 4=ONE LEG AND ONE ARM; 5=FAILED TO CONTROL URINE/FECES; 6= ONE ARM; 8=DON'T KNOW)	<input type="checkbox"/>
b. How long did the paralysis last? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>

2.32.	Was there a change in the amount of urine just before death? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 2, SKIP TO Q. 2.33]	
a.	How much urine did the deceased pass per day? (1=TOO MUCH; 2=TOO LITTLE; 3=NO URINE AT ALL; 8=DON'T KNOW) [IF ANSWER IS "3" SKIP TO Q. 2.32.C]	<input type="checkbox"/>
b.	Was (NAME) passing urine, 1=More Frequently; 2=About Normal Frequency; 3=Less than normal frequency; 8=Don't know)?	<input type="checkbox"/>
c.	How long (in days) did the change in urine amount last? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>
2.33.	Did (NAME) stop passing stool before death? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO Q. 2.35]	
2.34.	How many days did the person stop passing stool before he/she died? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>
2.35.	Did (NAME) have any surgery/operation (1=Y; 2=N; 8=D) [IF ANSWER IS 2 OR 8, SKIP TO Q. 2.36]	<input type="checkbox"/>
a.	How many days before (NAME'S) death did she/he have the surgery? (21=21 AND MORE 98=DON'T KNOW)	<input type="checkbox"/>
b.	Where did (NAME) have the surgery? (1=HOSPITAL; 2=HEALTH FACILITY WITHIN THE SLUM; 3=OTHER HEALTH CENTRE OUTSIDE THE SLUM; 4=HOME 6=OTHER.....; 8=DON'T KNOW)	<input type="checkbox"/>
2.36.	Did (NAME) ever complain of heart problem? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
a.	Did (NAME) complain of tiredness during physical activity? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
b.	Did (NAME) complain of tiredness while lying down? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
c.	Was (NAME) waking up during the night due to shortness of breath? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
d.	Did (NAME) ever complain of sudden rapid heart beats lasting for some minutes? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
2.37.	Did (NAME) have any abnormal growth in any part of the body excluding the abdomen? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 2 OR 8, SKIP TO SECTION 3]	
2.38.	Did the growth persist until the time of death? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
SECTION 3: PREGNANCY RELATED DEATHS		
CHECK QUESTIONS A.9 & A.11:		
IF DECEASED IS MALE, FEMALE (YOUNGER THAN 12 YEARS OR 50 YEARS AND ABOVE), PLEASE SKIP TO SECTION 4.		
3.1.	Was (NAME) pregnant at the time of her death? (1=Y; 2=N; 8=D) [IF ANSWER IS 1, SKIP TO Q. 3.3]	<input type="checkbox"/>
3.2.	Did she die within 6 weeks after end of the pregnancy ? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
	[IF ANSWER IS 1 SKIP TO INSTRUCTIONS BEFORE Q. 3.23; OTHERWISE SKIP TO SECTION 4]	
3.3.	How many months was she pregnant? PROBE TO MAKE AN ESTIMATE [IF PREGNANCY WAS MORE THAN 5 MONTHS (20 WEEKS), SKIP TO Q. 3.11]	
DEATH BEFORE 20 WEEKS (5 MONTHS) OF PREGNANCY		
3.4.	Was the pregnancy diagnosed or visible? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.5.	Was there any interference with the pregnancy (may be to terminate it)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.6.	Did she have vaginal bleeding? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.7.	a. Did (NAME) have a high-grade fever? (1=Y; 2=N; 8=D) [IF ANSWER IS "N" OR "D", SKIP TO Q. 3.8]	<input type="checkbox"/>

b. Was the fever, 1=Continuous; 2=On & off; 8=Don't know?	<input type="checkbox"/>
3.8 Did she have vaginal discharge with bad smell? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.9 Did she have lower abdominal pain? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.10 In your opinion, was this pregnancy a timely/wanted one? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[SKIP TO SECTION 4]	
DEATH AFTER 20 WEEKS (5 MONTHS) OF PREGNANCY	
3.11. Did (NAME) have increased blood pressure (if measured only)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.12. Did she complain of body swelling (legs, fingers, face, etc) which started during pregnancy? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.13. Did she complain of visual problems? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.14. Did she have any convulsions (non-epileptic fits not seen before pregnancy) within 1 week of her death? (1/2/8)	<input type="checkbox"/>
3.15. Was she diagnosed with malaria before her death? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.16. Was she diagnosed to have anemia? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.17. Did she have a recurrent painful vaginal bleeding while pregnant that continued until time of death? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.18. Was there a history of caesarian section during previous pregnancies? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.19. Did she have labor pains before she died? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[IF ANSWER IS 2 OR 8, SKIP TO Q. 3.21]	
3.20. Was the labor prolonged (>24 hours in women delivering for the first time and >8-10 hours in repeat pregnancies)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.21. Did she die before the baby was delivered? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.22. Did she have any previous complicated delivery? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
[SKIP TO SECTION 4]	
DEATH WITHIN 42 DAYS (6 WEEKS) AFTER DELIVERY/PREGNANCY ENDING	
3.23. What was the outcome of the pregnancy? (LBR=Livebirth; STB=Stillbirth; MIS=Miscarriage; ABT=Abortion)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.24. How many days/weeks before her death did the delivery occur/pregnancy end? RECORD D=DAYS, W=WEEKS IN 1st BOX AND DURATION IN LAST 2 BOXES	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.25. Where did the delivery occur/pregnancy end? (1=Hospital; 2=Health facility within the slum; 3=Other health facility outside slum; 4=Home; 5=Other.....; 8=Don't know)	<input type="checkbox"/>
CHECK Q. 3.23. [IF ANSWER IS "MIS" OR "ABT", SKIP TO SECTION 4]	
3.26. Was the labor prolonged (>24 hours in women delivering for the first time and >8-10 hours in repeat pregnancies)? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.27. What was the mode of delivery? (1=SPONTANEOUS NORMAL VAGINAL DELIVERY; 2=VACUUM/FORCEPS; 3=CEASAREAN SECTION; 8=DON'T KNOW)	<input type="checkbox"/>
3.28. Did she bleed heavily after birth? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
CHECK QUESTION 3.27. [IF ANSWER IS 3, SKIP TO Q. 3.30]	
3.29. Was the placenta delivered within 1 hr after childbirth? (1=Y; 2=N; 8=D)	<input type="checkbox"/>
3.30. Did she have high-grade fever after delivery? (1=Y; 2=N; 8=D)	<input type="checkbox"/>

- 3.31. Did the lochia change smell? (1=Y; 2=N; 8=D)
- 3.32. Did the deceased have increased blood pressure (if measured only) (1=Y; 2=N; 8=D)
- 3.33. Did she have any convulsions (body spasms that were not seen before pregnancy) within one week of her death? (1=Y; 2=N; 8=D)
- 3.34. Did she have any previous complicated delivery? (1=Y; 2=N; 8=D)

SECTION 4: TREATMENTS AND RECORDS

I would like to ask a few questions about any drugs that (NAME) may have received during the illness that led to his/her death

- 4.1. Did (NAME) receive any of the following drugs before his/her death:
- a. Antibiotics? (1=Y; 2=N; 8=D)
 - b. Antimalarials (e.g., Chloroquine, Fansidar, Quinine, Artemisinin, etc)? (1=Y; 2=N; 8=D)
 - c. Painkillers/Fever reliever (e.g., Aspirin, Paracetamol, Ibuprofen, etc)? (1=Y; 2=N; 8=D)
 - d. Others (specify)
- 4.2. Do you have any health records that belonged to (NAME)? (0=NO; 1=YES, SEEN; 2=YES, BUT NOT SEEN; 8=DON'T KNOW)

[IF ANSWER IS "0", "2" OR "8", SKIP TO Q. 4.3]

- | | Date | Weight (KG) | |
|--|---|---|--|
| a. Date and most recent Weight on health records | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | |
| b. Date and 2 nd most recent Weight on health records | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | |
| c. Date of last entry on the medical record | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | |
| d. Record what is written on the medical record | | | |

- 4.3. Was a death certificate issued? (0=NO; 1=YES, SEEN; 2=YES, BUT NOT SEEN; 8=DON'T KNOW)

[IF ANSWER IS "0", "2" OR "8", SKIP TO Q. 4.5]

- 4.4. Record the information below from the death certificate:
- a. Immediate cause of death
 - b. Underlying cause of death

- 4.5. RECORD ANY GENERAL COMMENTS.....

- 4.6. END TIME

9 OFFICE/FIELD CHECK DETAILS

- 9.1 FIELD SUPERVISOR/TEAM LEADER CODE

- 9.2 DATA ENTRY CLERK'S CODE