

Batch: Bundle:

Verbal Autopsy Narrative

VAN

Round	Weekblock	BSID	DSID
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Version 3, 2011-06-07
2014/06/11 9:02:16

BSID:	Weekblock:	Informant:
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Individual

DSID:	Name:	Sex:	Age:
Father:		DoB:	
Mother:		DoD:	

All household memberships

BSID	Resident
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Bounded Structure where Death was notified

BSID	Week block	HH	Household Head	Current
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Place of Death

Setting:	Care Provider:
Type: BSID:	Other Place:
Hospital/Clinic Attendance:	

Other Details

Circumstances:

Laymans Diagnosis:	Maternal Death: -
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Other Deaths at this Bounded Structure

BSID	DSID	Name	DoD	VA Visit
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Premature completion				Refused	<input type="checkbox"/>	Non Contact	<input type="checkbox"/>	Stillbirth	<input type="checkbox"/>	Still alive	<input type="checkbox"/>
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Date of Attempt 1:	<table border="1" style="display: inline-table; text-align: center;"> <tr><td>y</td><td>y</td><td>y</td><td>y</td></tr> <tr><td>m</td><td>m</td><td>d</td><td>d</td></tr> </table>	y	y	y	y	m	m	d	d	Interviewer:	<table border="1" style="display: inline-table; text-align: center;"> <tr><td></td><td></td><td></td></tr> </table>				Reason: _____
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m	m	d	d												
Date of Interview:	<table border="1" style="display: inline-table; text-align: center;"> <tr><td>y</td><td>y</td><td>y</td><td>y</td></tr> <tr><td>m</td><td>m</td><td>d</td><td>d</td></tr> </table>	y	y	y	y	m	m	d	d	Interviewer:	<table border="1" style="display: inline-table; text-align: center;"> <tr><td></td><td></td><td></td></tr> </table>				Reason: _____
y	y	y	y												
m	m	d	d												

Informant: _____	Relationship: _____
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Did you care for the deceased before death?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	
If no, were you present during the illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>	

Tick relationship of the informant to the deceased:	Places or persons for care in temporal order:
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<table border="1" style="width: 100%; text-align: center;"> <tr><td>Spouse</td><td><input type="checkbox"/></td></tr> <tr><td>Child</td><td><input type="checkbox"/></td></tr> <tr><td>Son-in-law</td><td><input type="checkbox"/></td></tr> <tr><td>Daughter-in-law</td><td><input type="checkbox"/></td></tr> </table>	Spouse	<input type="checkbox"/>	Child	<input type="checkbox"/>	Son-in-law	<input type="checkbox"/>	Daughter-in-law	<input type="checkbox"/>	<table border="1" style="width: 100%; text-align: center;"> <tr><td>Grandchild</td><td><input type="checkbox"/></td></tr> <tr><td>Parent</td><td><input type="checkbox"/></td></tr> <tr><td>Father-in-law</td><td><input type="checkbox"/></td></tr> <tr><td>Mother-in-law</td><td><input type="checkbox"/></td></tr> </table>	Grandchild	<input type="checkbox"/>	Parent	<input type="checkbox"/>	Father-in-law	<input type="checkbox"/>	Mother-in-law	<input type="checkbox"/>	<table border="1" style="width: 100%; text-align: center;"> <tr><td>Grandparent</td><td><input type="checkbox"/></td></tr> <tr><td>Sibling</td><td><input type="checkbox"/></td></tr> <tr><td>Other relative</td><td><input type="checkbox"/></td></tr> <tr><td>Other non relative</td><td><input type="checkbox"/></td></tr> </table>	Grandparent	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Other relative	<input type="checkbox"/>	Other non relative	<input type="checkbox"/>	<table border="1" style="width: 100%;"> <tr><td>1.</td></tr> <tr><td>2.</td></tr> <tr><td>3.</td></tr> <tr><td>4.</td></tr> <tr><td>5.</td></tr> <tr><td>6.</td></tr> <tr><td>7.</td></tr> </table>	1.	2.	3.	4.	5.	6.	7.
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Son-in-law	<input type="checkbox"/>																																	
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Parent	<input type="checkbox"/>																																	
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Grandparent	<input type="checkbox"/>																																	
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Other non relative	<input type="checkbox"/>																																	
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Stillbirth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
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Screening Questions	
Q1. Is the deceased a woman between the age of 12 and 49? If yes complete check list A. Go to Q2	Y/N
Q2. Is the deceased a woman who died pregnant or within 3 months after end of pregnancy? If yes complete the maternal questionnaire & check list A. If No go to Q3	Y/N
Q3. Is the deceased an infant aged below 29days? If Yes complete check list A and neonates questionnaire. If No go to Q4	Y/N
Q4. Is the deceased an infant aged above 29days and below 5 years old? If yes complete check list A and children questionnaire. If No go to Q5	Y/N
Q5. Is the presumed cause of death a traffic accident, injuries, burns, suicide assault or caused by an animal? If Yes complete check list A and the injury questionnaire. If No complete check list A and Chapter 3 of the questionnaire	Y/N

Bio-Medical part

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54287331

Round

Weekblock

BSID

DSID

Version 2, 2011-08-01

2014/06/10 15:22:23

Section 1: Identification and circumstances of death.

1. Surname of deceased

2. First Name(s)

3. Bounded structure ID

4. Date of Birth

5. Date of Death

6. Place of Death Home ☐ Hospital ☐ on the way to hospital or clinic ☐
Clinic ☐ Other ☐ waiting for care in OPD or GP surgery ☐

7. Age Hours ☐ Days ☐ Months ☐ Years ☐

8. Sex Female ☐ Male ☐

9. Occupation of deceased

10. Years of formal education

11. For how long was s/he ill before s/he died?
 Hours ☐ Days ☐ Months ☐ Years ☐

12. Do you know the cause of his/her death? Yes ☐
No ☐ → Go to Q.15

13. What was the cause of death according to you? NA ☐

14. Who gave you information about the cause of death?
Nobody ☐ Nurse ☐ Private GP ☐ NA ☐
Family members ☐ Doctor in hospital ☐ Media ☐
Neighbours ☐ Traditional Healer ☐ Deceased ☐

15. Was s/he in hospital or clinic in the last year before s/he died? Yes ☐
No ☐ → Go to Q.17

16. If s/he was in Hlabisa hospital is there any document from the hospital that you could show me?
16.a Date of admission
16.b OPD No. /
16.c Reg No.

17. Was s/he a resident or non-resident member? Resident ☐ Non-resident ☐
Yes ☐ → Go to Ch.4
No ☐

18. Did s/he die due to a direct maternal death? Yes ☐ → Go to Ch.2
No ☐

19. Did s/he die due an injury, accident, suicide or tetanus? Yes ☐ → Go to Ch.2
No ☐

Section 2: Personal and family disease history.

1. Did s/he ever have any of the following illnesses or habits?
Hypertension ☐ HIV/AIDS ☐ Alcohol abuse ☐ None ☐
Diabetes ☐ Epilepsy ☐ Smoker ☐
Tuberculosis (TB) ☐ Asthma ☐ Paralysis ☐

2. Did s/he take any medicine on a regular basis? Yes ☐
No ☐ → Go to Q.4
DK ☐

3. Which medicine? NA ☐
 NA ☐

4. Was s/he diagnosed in hospital with any of the following diseases prior to death?
Cancer ☐ Meningitis ☐ Liver disease ☐ Stroke ☐
Pleuritis ☐ Pneumonia ☐ Renal disease ☐ Malaria ☐
HIV ☐ Tuberculosis (TB) ☐ Cardiac disease ☐ None ☐
Other ☐

5. If yes, when was that? NA ☐

6. If other, specify NA ☐

7. Did s/he had any major operation while still alive? Yes ☐
No ☐ → Go to Q.10

8. If yes, in which year was that? NA ☐

9. If yes, specify location or type of surgery NA ☐

10. Is/was there anybody else in the family who is/was very ill or who died in the last 2 years?
was ver ill ☐ died ☐
is very ill ☐ No ☐ → Go to next Chapter

11. If so, what does/did this the family member suffer from? NA ☐
Tuberculosis (TB) ☐
HIV/AIDS ☐
Other ☐

12. If other, specify NA ☐

13. How is/was that person(s) related to the deceased? NA ☐

Section 3: Places or persons for care.

1. Where did the deceased go for care during the illness prior to death in temporal order

Section 4: Respondent.

1. Age of the respondent in years

 years

2. Sex of the respondent

Female ☐ Male ☐

3. What was the relationship between the informant and the deceased?

Spouse ☐

Grandchild ☐

Grandparent ☐

Uncle ☐

Child ☐

Parent ☐

Sibling ☐

Other relative ☐

Child-in-law ☐

Parent-in-law ☐

Aunt ☐

None relative ☐

4. How many years of education did the respondent complete?

 years

5. What was the highest level of education of the respondent?

Primary ☐

Tertiary ☐

Secondary ☐

None ☐

6. If the deceased was a child and the mother was not the informant, is the child's mother still alive?

Yes ☐

No ☐

DK ☐

NA ☐

Section 5: Death certificate.

1. Was a death certificate issued?

Yes ☐

No ☐

DK ☐

Go to next Chapter

2. Was the VA nurse able to see the death certificate?

Yes ☐

No ☐

DK ☐

3. Record immediate cause of death appearing in the death certificate?

 NA ☐

4. Record first underlying cause of death appearing in the death certificate?

5. Record second underlying cause of death appearing in the death certificate?

6. Record third cause of death appearing in the death certificate?

7. Record the contributing cause of death appearing in the death certificate?



54287332

Round

Weekblock

BSID

DSID

Version 2, 2011-08-01

2014/06/10 15:23:05

Section 1: Unintentional and intentional injuries and accidents.

1. Did s/he sustain any injury which lead to his/her death?

 Yes ☐
 No ☐ → Go to Q.16
 DK ☐

2. Was the injury intentional or accidental?

 Intentional ☐ NA ☐
 Accidental ☐ DK ☐

3. How long after the injury did s/he die?

 Hours ☐ Days ☐ Months ☐ NA ☐ DK ☐

4.a. Where did s/he die?

 Where the injury occurred ☐ In the hospital ☐ Elsewhere ☐
 In the ambulance ☐ At home ☐ NA ☐

4.b. Did s/he have any ongoing chronic illness or was s/he sick in the month before the accident or the injury?

Yes ☐ No ☐ DK ☐

5. Was the injury self inflicted?

 Yes ☐ NA ☐
 No ☐ → Go to Q.10 DK ☐

6. Do you think s/he committed suicide?

 Yes ☐ NA ☐
 No ☐ → Go to Q.10
 DK ☐

7. How did s/he commit suicide?

 Hanging ☐ Burns ☐ NA ☐
 Poisoning ☐ Gunshot ☐ Other ☐

8. If other, specify

 NA ☐

9. Do you know why s/he committed suicide?

 NA ☐

10. What kind of injury was it?

 Traffic accident ☐ → Go to Q.16 Drowning ☐ Animal bite ☐ → Go to Q.15
 Fire accident ☐ Fall ☐ Poisoning ☐ → Go to Q.12
 Assault ☐ → Go to Q.13 Burns ☐ → End
 Other ☐ NA ☐

11. If it was another type of injury, specify

 NA ☐

12. Do you know the substance that caused the poisoning?

 NA ☐

13. What type of assault was it?

 gunshot ☐ Hit ☐ NA ☐
 stabbed ☐ Strangulation ☐ Other ☐

14. Specify the instrument of the assault

 NA ☐

15. What animal inflicted the bite?

 NA ☐

If it was a dog or mammal bite → Go to Section 2

16. If traffic accident where was s/he at that time?

Driver in car ☐ On foot ☐Passenger in car ☐ On bike ☐

17. If one car was involved which car was that?

Taxi ☐ private car ☐ NA ☐Bus ☐ Other ☐ DK ☐

18. If other car was involved which car was that?

Taxi ☐ private car ☐ NA ☐Bus ☐ Other ☐ DK ☐

19. What type of accident was it?

car rolled ☐ collision of 2 cars ☐ NA ☐car went off cliff ☐ other ☐ DK ☐

20. Describe what happened

Section 2: Animal bite or stiffness of the body or problems swallowing or problems to open mouth.

1. Did s/he become unconscious?

 Yes ☐
 No ☐ → Go to Q.4
 DK ☐

2. How did the change in the level of consciousness start?

 Suddenly ☐ NA ☐
 Slowly over more than 1 day ☐ DK ☐

3. For how long was s/he unconscious?

 Hours ☐ Days ☐

4. Did s/he have any fear of drinking water?

Yes ☐ No ☐ DK ☐

5. Did s/he have any problems swallowing?

Yes ☐ No ☐ DK ☐

6. Did s/he have problems to open her/his mouth?

Yes ☐ No ☐ DK ☐

7. Was there any stiffness of the body before s/he died?

 Yes ☐
 No ☐ → Go to Q.9
 DK ☐

8. How long did the stiffness of the body last?

 Hours ☐ Days ☐ Months ☐ NA ☐ DK ☐

9. Did s/he have any problems breathing?

 Yes ☐
 No ☐ → Go to Q.11
 DK ☐

10. For how long did s/he have problems with breathing?

 Hours ☐ Days ☐ NA ☐

11. Was s/he diagnosed in the hospital as suffering from rabies or tetanus?

Yes, from rabies ☐ No ☐Yes, from tetanus ☐ DK ☐12. Did s/he have fever? Yes ☐ No ☐ DK ☐

Rabies: Dog bite or bite of wild animal (E) and (unconsciousness or difficulty in swallowing or stiffness of the body) (S)

Tetanus: Stiffness of body <14 days + difficulty breathing < 14 days + absence of sudden onset of unconsciousness (E) and (difficulty to open mouth or fever or recent injury)(S)

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54287333

Round

Weekblock

BSID

DSID

Version 2.1, 2012-08-15

2014/06/10 15:23:44

Section 1 : History and loss of weight.

1. Did s/he loose weight before s/he died? Yes ☐ No ☐ DK ☐ → Go to q.3
2. Was the weight loss severe? severe ☐ light ☐ moderate ☐ DK ☐ NA ☐
3. Did s/he suffer from repeated episodes of illnesses before death? Yes ☐ No ☐ DK ☐
4. Did her/his partner die recently? Yes ☐ No ☐ DK ☐

Section 2: Cough.

1. Did s/he have a cough before s/he died? Yes ☐ No ☐ DK ☐ → Go to q.6
2. For how long did s/he have a cough? Days ☐ Months ☐ Years ☐ NA ☐
3. Was the cough productive (sputum)? Yes ☐ NA ☐ No ☐ DK ☐ → Go to q.6
4. For how long did s/he have a cough with sputum? Days ☐ Months ☐ Years ☐ NA ☐
5. Did s/he cough blood? Yes ☐ No ☐ DK ☐ NA ☐
6. Was s/he ever treated for pulmonary tuberculosis? Yes ☐ No ☐ DK ☐
7. Did s/he have night sweats? Yes ☐ No ☐ DK ☐

Section 3: Skin, mouth and eye condition.

1. Did s/he have a skin condition before s/he died? Yes ☐ No ☐ DK ☐ → Go to q.7
2. For how long did s/he have that skin condition? Days ☐ Months ☐ Years ☐ NA ☐
3. How did the skin condition look like? Like a rash ☐ others ☐ Dark elevated growing spots with peeling skin ☐ DK ☐ → Go to q.7 like ulcers or sores ☐ NA ☐
4. Specify size, location and colour of skin condition.
Specify size(s) NA ☐
Specify location(s) NA ☐
Specify colour NA ☐
5. If it was a rash, how did the rash look like? Like measles ☐ others ☐ Rash with a clear fluid ☐ DK ☐ Rash with pus ☐ NA ☐
- 6.a. If other type of rash, specify type of rash and location.
Specify location(s) NA ☐
- 6.b. Did the skin crack/split or peel after the start of the rash? Yes ☐ No ☐ DK ☐ NA ☐
7. Did s/he have itching of the skin? Yes ☐ No ☐ DK ☐ NA ☐
8. Did s/he have sore eyes? Yes ☐ No ☐ DK ☐
9. Did s/he have mouth infections which lasted for more than 21 days? Yes, like white spots ☐ others ☐ Yes, small ulcers ☐ No ☐ → Go to S.4 Yes, hairy smelly sores ☐ DK ☐
10. Were these infections so severe that s/he had difficulty swallowing? Yes ☐ No ☐ DK ☐ NA ☐

Section 4: Diarrhoea.

1. Did s/he have diarrhoea or loose or liquid stool before s/he died? Yes ☐ No ☐ DK ☐ → Go to next section
2. When the loose or liquid stool or the diarrhoea was severe, how many times did s/he pass stool per day? times NA ☐
3. For how long did s/he have loose or liquid stool or diarrhoea? Days ☐ Weeks ☐ Months ☐ NA ☐
4. What did the stool look like? Watery ☐ With mucus ☐ Loose, not watery ☐ DK ☐ Bloody ☐ NA ☐
5. Was the loose or liquid stool or the diarrhoea continuous or on and off? Continuous ☐ DK ☐ On and off ☐ NA ☐
6. Did s/he have sunken eyes? Yes ☐ No ☐ DK ☐ NA ☐

Section 5: Swelling of neck, armpit or groin.

1. Did s/he have swelling in the neck? Yes ☐ No ☐ DK ☐ → Go to q.3
2. For how long did s/he have the swelling in the neck? Days ☐ Months ☐ Years ☐ NA ☐
3. Did s/he have swelling in the armpit or groin? Yes, armpit ☐ No ☐ NA ☐ Yes, groin ☐ DK ☐

Section 6: Change in the level of consciousness.

1. Did s/he have any change in the level of consciousness before s/he died?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	<input type="checkbox"/> → Go to next section	4. How did the change in the level of consciousness start?	Suddenly <input type="checkbox"/> Rapidly within 1 day <input type="checkbox"/>	Slowly over more than 2 days <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/>
2. What was the level of unconsciousness?	Confused <input type="checkbox"/> Others <input type="checkbox"/>	Unconscious <input type="checkbox"/> NA <input type="checkbox"/>	5. If confused or unconscious for how long was s/he confused or unconscious before she died?		
3. If others, specify	<div style="border: 1px solid black; height: 15px; width: 100%;"></div>		<div style="display: flex; align-items: center;"><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div>Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/></div></div>		
			NA <input type="checkbox"/>		

Section 7: fever.

1. Did s/he have fever before s/he died?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	<input type="checkbox"/> → Go to next section	3. Was the fever continuous or on and off?	Continuous <input type="checkbox"/> On and off <input type="checkbox"/>	DK <input type="checkbox"/> NA <input type="checkbox"/>
2. How long did s/he have fever?	<div style="display: flex; align-items: center;"><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div>Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></div></div>		4. At the worst time, how was the fever?	severe <input type="checkbox"/> moderate <input type="checkbox"/> mild <input type="checkbox"/>	DK <input type="checkbox"/> NA <input type="checkbox"/>

PTB & AIDS: loss of weight + cough with sputum > 21 days + repeated episodes of illnesses prior to death + no COPD (E)
and (diarrhoea or loose/liquid stool for > 21 days or severe mouth infections for > 21 days or swollen glands) (S)
and/or age < 65 or partner died recently or body rash or sores or became unconscious within 2 days of final illness (A)

PTB: cough with sputum > 21 days + fever on and off + no diarrhoea > 21 days or no loose/liquid stool for > 21 days + no COPD (E)
and/or (bloody sputum or loss of weight) (A)
OR had treatment for PTB at time of death and no diarrhoea or no loose/liquid stool for > 21 days (E)

AIDS: loss of weight + fever > 28 days + repeated episodes of illnesses prior to death (E)
and (diarrhoea or loose/liquid stool for > 21 days or severe mouth infections for > 21 days or swollen glands) (S)
and/or age < 65 or partner died recently or body rash or sores or became unconscious within 2 days of final illness (A).

Section 8: Swellings.

1. Did s/he have any swelling apart from swelling in neck groin and armpits?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	<input type="checkbox"/> → Go to next section	2. Specify location	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>	NA <input type="checkbox"/>
			3. How long did s/he have the swelling?	<div style="display: flex; align-items: center;"><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div>Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></div></div>	

Section 9: For women: Swelling or ulcer of the breast and abnormal vaginal discharge.

1. Did she have a swelling or ulcer in her breast?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	<input type="checkbox"/> → Go to q.3	3. Did she have any abnormal vaginal discharge for more than 30 days?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	<input type="checkbox"/> → Go to next section
2. How long did she have the swelling or ulcer?	<div style="display: flex; align-items: center;"><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div><div>Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></div></div>		4. What type of discharge was it?	With bad smell <input type="checkbox"/> Bloody <input type="checkbox"/> Pus-like <input type="checkbox"/>	Others <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/>

Breast Cancer: severe weight loss + swelling or ulcer in the breast for > 30 days (E)

Cervix Carcinoma: severe weight loss + abnormal vaginal bleeding for > 30 days (E)

Section 10: Difficulty in swallowing and shortness of breath.

1. *Did s/he have any difficulty to swallow that was not due to a mouth infection?

Yes ☐
No ☐
DK ☐ → Go to q.4

2. For how long did s/he have this problem to swallow?

Days ☐ Weeks ☐ Months ☐ NA ☐

3. Did this difficulty in swallowing start with problems in swallowing solids followed by problems swallowing liquids?

Yes ☐ No ☐ DK ☐ NA ☐

4. Did s/he have shortness of breath before s/he died?

Yes ☐
No ☐
DK ☐ → Go to q.6

5. How long did the shortness of breath last?

Hours ☐ Days ☐ Weeks ☐ Months ☐ NA ☐

6. If s/he had difficulty breathing, what sign appeared first, the problems

First swallowing problems ☐ At the same time ☐
First breathing problems ☐ DK ☐ NA ☐

Oesohagus Carcinoma: severe weight loss + dysphagia for > 30 days starting with solids followed by dysphagia for liquids. (E)

Section 11: Difficulty passing stool.

1. Did s/he have difficulty passing stool?

Yes ☐
No ☐
DK ☐ → Go to next section

3. Was this difficulty in passing stool continuous or on and off?

Continuous ☐ DK ☐
On and off ☐ NA ☐

2. For how long did s/he have difficulty passing stool?

Days ☐ Weeks ☐ Months ☐ NA ☐

Section 12: Abdominal pain and vomiting.

1. Did s/he have abdominal pain before s/he died?

Yes ☐
No ☐
DK ☐ → Go to q.4

2. What was the severity of the pain?

Severe ☐ Mild ☐
Moderate ☐ DK ☐ NA ☐

3.a. For how long did she have the pain?

Hours ☐ Days ☐ Weeks ☐ Months ☐ NA ☐

3.b. What type of pain was it?

Cramps ☐ Burning pain ☐ DK ☐
Dull ache ☐ Other ☐ NA ☐

3.c. Where was the pain?

Lower abdomen ☐ All over abdomen ☐ DK ☐
Upper abdomen ☐ Other ☐ NA ☐

4. Did s/he suffer from vomiting before s/he died?

Yes ☐
No ☐
DK ☐ → Go to next section

5. How did the vomitus look like?

Yellowish fluid ☐ Blood ☐ Other ☐
Coffee coloured fluid ☐ Faecal matter ☐ DK ☐
Watery fluid ☐ Food ☐ NA ☐

6. For how long did s/he suffer from vomiting?

Days ☐ Weeks ☐ Months ☐ NA ☐

Section 13: Abdominal mass.

1. Did s/he have any mass in the abdomen before s/he died?

Yes ☐
No ☐
DK ☐ → Go to next section

3. Where exactly was the mass?

Rt upper abdomen ☐ DK ☐
Lt upper abdomen ☐ NA ☐
Lower abdomen ☐ Other ☐

2. How long did s/he have the mass?

Days ☐ Weeks ☐ Months ☐ NA ☐

4. If others, specify

NA ☐

Gastro-intestinal Carcinoma: severe weight loss + abdominal mass for > 30 days (E)
and (blood in stool or vomiting blood or difficulty passing stool for > 30 days)(S)

Section 14: Jaundice.

1. Did s/he have yellow discoloration of the eyes before s/he died?

Yes ☐
No ☐
DK ☐ → Go to next section

2. How many days did s/he have this jaundice?

Days ☐ Weeks ☐ Months ☐ NA ☐

3. What was the severity of the jaundice?

severe ☐ mild ☐
moderate ☐ DK ☐ NA ☐

Hepatoma: severe weight loss + mass in right side of the abdomen for >30 days + severe abdominal pain for >30 days + jaundice (E)

Section 15: Abdominal distension.

1. Did s/he have distension of the abdomen before s/he died?

Yes ☐

No ☐

DK ☐

→ Go to next section

2. Did the distension develop rapidly or slow?

rapidly over days ☐

slowly over months ☐

slowly over weeks ☐

DK ☐

NA ☐

3. For how long did s/he have this abdominal distension?

Days ☐

Weeks ☐

Months ☐

NA ☐

Acute Abdominal Condition: severe abdominal pain + rapid onset abdominal distension + vomiting + no diarrhoea (E)

OR Acute Abdominal Condition: abdominal pain + vomitus that looked black or like blood or like faeces for < 14 days (E)

Section 16: Swelling of ankles and alcohol abuse.

1. Did s/he have swelling around the ankles?

Yes ☐

No ☐

DK ☐

→ Go to q.3

2. For how long did s/he have the swelling of the ankles?

Days ☐

Weeks ☐

Months ☐

NA ☐

3. Was the deceased an alcohol abuser?

Yes ☐

No ☐

DK ☐

Liver Cirrhosis: slow onset abdominal distension >14 days + absence of severe abdominal pain (E)

and (swelling around the ankles or jaundice or vomiting of blood) (S)

and/or previous alcohol abuse or loss of weight or slow onset unconsciousness before death (A)

Section 17: Shortness of breath or difficult breathing.

1. Did s/he have shortness of breath before s/he died?

Yes ☐

No ☐

DK ☐

→ Go to q.6

5. Did the shortness of breath develop rapidly or slowly?

rapidly over hours ☐

slowly over months ☐

slowly over days ☐

DK ☐

NA ☐

2. Was the shortness of breath continuous or on and off? If short of breath only on exertion classify as continuous

On and off ☐

DK ☐

NA ☐

Continuous ☐

→ Go to q.4

3. If s/he had it on and off, how long did such period of shortness of breath last usually?

Hours ☐

Days ☐

Months ☐

DK ☐

NA ☐

4. How long ago did s/he have this shortness of breath for the first time?

Days ago ☐

Weeks ago ☐

Months ago ☐

Years ago ☐

NA ☐

8. Did s/he have wheezing?

Yes ☐

No ☐

DK ☐

9. Was s/he a smoker?

Yes ☐

No ☐

DK ☐

10. Was s/he diagnosed by a doctor or nurse with hypertension?

Yes ☐

No ☐

DK ☐

Chronic Obstructive Pulmonary Disease (COPD): cough with sputum for > 60 days + shortness of breath on and off + no weight loss

+ no swelling around ankles (E)

and/or smoker or medically diagnosed with asthma or wheezing (A)

Congestive Heart Failure (CHF): slow onset of continuous shortness of breath + swelling around the ankles + no cough with sputum for > 21 days (E)

and/or (medically diagnosed hypertension or swelling in the right upper abdomen or abdominal distension) (A)

OR Congestive Heart Failure (CHF): medically diagnosed hypertension + no cough with sputum for > 21 days (E)

and (swelling of the ankles or continuous shortness of breath) (S)

Section 18: Paralysis and speech impairment.

1. Did s/he become paralysed during the illness prior to death?

Yes ☐

No ☐

DK ☐

→ Go to q.4

2. Which part of the body was paralysed?

right arm ☐

right leg ☐

right side of face ☐

right side of body ☐ NA ☐

left arm ☐

left leg ☐

left side of face ☐

left side of body ☐

3. For how long did s/he have this paralysis before s/he died?

Days

☐ Weeks

☐ Months

☐ Years

NA ☐

4. Did s/he develop a speech impairment shortly before death which appeared after a period of unconsciousness?

Yes ☐

No ☐

DK ☐

5. *Was s/he more than 45 years?

45 years or younger ☐

DK ☐

> 45 years ☐

6. *Did s/he become suddenly unconscious?

Yes ☐

No ☐

DK ☐

Cerebrovascular Accident (CVA): sudden onset of unconsciousness + age > 45 years + absence of (high fever or pregnancy or delivery within 2 weeks or injuries) (E)
and (paralysis of one side of the body or speech impairment after a period of unconsciousness) which appeared shortly before death (S)
and/or medically diagnosed hypertension (A)

Section 19: Sudden and severe chest pain and sudden death.

1. Did s/he have sudden and severe chest pain before s/he died?

Yes ☐

No ☐

DK ☐

→ Go to q.6

2. Was the pain continuous or on and off?

Continuous ☐

DK ☐

On and off ☐

NA ☐

3. Where was the pain?

Over the sternum ☐

Others ☐

NA ☐

Over the heart ☐

DK ☐

4. When s/he had this attack of severe chest pain prior to death, how long did it last?

< 30 min ☐

>24 hrs ☐

NA ☐

>30 min but < 24 hrs ☐

DK ☐

5. Did s/he die within 1 week after the start of the last chest pain attack?

Yes ☐

No ☐

DK ☐

NA ☐

6. *Did s/he have a cough with sputum before s/he died?

Yes ☐

No ☐

DK ☐

Ischaemic Heart Disease: sudden, severe and continuous chest pain over sternum + died within 1 week after start of the chest pain +
absence of cough with sputum (E)
and/or shortness of breath (A).

Section 20: Diarrhoea (copy section 4/12).

1. *If s/he had diarrhoea or liquid or loose stool before s/he died, how long did it last?

Days ☐

Weeks ☐

Months ☐

NA ☐

2. *When the loose or liquid stool or the diarrhoea was severe, how many times did s/he pass stool per day?

NA ☐

times

3. *What did the stool look like?

Watery ☐

Bloody ☐

DK ☐

Loose, not watery ☐

With mucus ☐

NA ☐

4. *Did s/he have abdominal pain before s/he died?

Yes ☐

No ☐

DK ☐

5. *Did s/he suffer from vomiting before s/he died?

Yes ☐

No ☐

DK ☐

Acute Diarrhoea: loose or liquid stool > 2 times/day lasting < 22 days (E)
and (blood or mucus in stool or abdominal pain or vomiting) (A)

Section 21: fever (see section 7).

1. *Did s/he have severe or continuous fever for <21 days before s/he died?

Yes ☐

No ☐

DK ☐

Acute febrile illness (AFI): severe or continuous fever for <21 days+ absence of any other infectious illness diagnosed by the VAs (E)

Section 23: Cough and chest pain and shortness of breath (copy section 2/10).

1. *Did s/he have a cough with sputum?

Yes ☐

No ☐

DK ☐

→ Go to q.3

4. *Did s/he have shortness of breath before s/he died?

Yes ☐

No ☐

DK ☐

→ Go to next section

2. *How long did the cough with sputum last?

Days ☐

Months ☐

Years ☐

NA ☐

5. *How long did the shortness of breath last?

Hours ☐

Days ☐

Weeks ☐

Months ☐

NA ☐

3. Did s/he have chest pain before s/he died?

Yes ☐

No ☐

DK ☐

Lower Respiratory Tract Infection: AFI + cough with sputum < 21 days + absence of jaundice (E)
and (chest pain or shortness of breath) (S)

Section 24: Difficulty in passing urine and puffiness of the face.

1. Did s/he have difficulty in passing urine before s/he died? Yes ☐ No ☐ DK ☐ → Go to q.4
2. For how long did s/he have problems passing urine?
 Days ☐ Weeks ☐ Months ☐ Years ☐ NA ☐
3. What type of difficulty did s/he have?
Unable to pass urine ☐ other ☐
Continuous dribbling of urine ☐ DK ☐
Burning sensation while passing urine ☐ NA ☐
Intense pain ☐
4. Did s/he have puffiness of the face? Yes ☐ No ☐ DK ☐

Section 25: Anaemia.

1. Did s/he look pale before she died? Yes, very pale ☐ Yes, mildly pale ☐ No ☐ DK ☐

Anaemia: very pale looking + absence of all other diseases diagnosed by VAs (E) and (swelling of the ankles or shortness of breath) (S)

Section 26: Change in the amount and the colour of urine.

1. Was there any change in the amount of urine passed daily before s/he died? Yes ☐ No ☐ DK ☐ → Go to q.4
2. How much urine did s/he pass in a day?
too much ☐ no urine at all ☐
too little ☐ DK ☐ NA ☐
3. For how long did s/he have this change in the amount of urine?
 Days ☐ Weeks ☐ Months ☐ NA ☐
4. Was there any change in the colour of the urine before s/he died? Yes ☐ No ☐ DK ☐ → Go to next section
5. What was the colour of the urine?
dark yellow ☐ very reddish ☐ blood stained ☐
orange ☐ coffee like ☐ DK ☐ NA ☐
6. For how long did s/he have this change in the colour of the urine?
 Days ☐ Weeks ☐ Months ☐ NA ☐

Section 27: Convulsions or spasms.

1. Did s/he have convulsions or spasms before s/he died? Yes ☐ No ☐ DK ☐ → Go to q.4
2. How many days did s/he have convulsions or spasms?
 Days ☐ NA ☐
3. When the convulsions were most frequent, how many times per day did s/he have them?
 times NA ☐
4. Could you describe the convulsions?
Repetitive jerking of whole body ☐
Repetitive jerking of part of the body ☐
Others ☐ NA ☐
5. If other, specify
 NA ☐
6. In between convulsions was s/he awake or unconscious? Unconscious ☐ DK ☐
Awake ☐ NA ☐

Section 28: Neck stiffness, neck pain.

1. Did s/he have neck stiffness before s/he died? Yes ☐ No ☐ DK ☐
2. Did s/he have severe pain in the neck before s/he died? Yes ☐ No ☐ DK ☐ NA ☐
3. How many days did s/he have neck stiffness or pain?
 days NA ☐
4. *If there was fever, at the worst time, how was the fever?
severe ☐ mild ☐
moderate ☐ DK ☐ NA ☐
5. If s/he became unconscious or confused, how soon after the onset of the disease did it start?
Suddenly ☐ Slowly over more than 2 days ☐
Rapidly within 2 days ☐ DK ☐ NA ☐

Meningitis: high fever for < 21 days + neck stiffness or severe neck pain + absence of repeated episodes of illnesses (E)

and (became unconscious within 2 days of onset of disease or convulsions) (S)

Malaria: high fever for < 21 days + absence of repeated episodes of illnesses + no meningitis (E)

and (became unconscious within 2 days of onset of disease or black urine) (S)

Section 29: Diabetes.

1. Was s/he diagnosed by a doctor or a nurse with diabetes? Yes ☐ No ☐ DK ☐
2. Did s/he have an infection in her/his lower limbs? Yes ☐ No ☐ DK ☐
3. Did s/he take regularly medicine for diabetes? Yes, pills ☐ No ☐
Yes, injections ☐ DK ☐ NA ☐

Diabetes: medically diagnosed diabetes (E)

and (rapid onset of unconsciousness or gangrene of lower limb) (S)

Section 30: Epilepsy.

1.. *Was s/he known to suffer from epilepsy? Yes ☐ No ☐ DK ☐

3. Did s/he suffer from any infection prior to the epilepsy attack?

Yes ☐ No ☐ DK ☐ NA ☐

2.. Did s/he die during or shortly after an epilepsy attack?

Yes ☐ No ☐ DK ☐

Epilepsy: known epileptic + dying during or shortly after an epileptic attack + no other infection at the time of death (E)

Section 31: Headache.

1. Did s/he have headache before s/he died?

Yes ☐

No ☐

DK ☐

→ Go to next section

3. Was the headache continuous or on and off?

Continuous ☐

DK ☐

On and off ☐

NA ☐

2.How long did s/he have headache?

Days ☐

Weeks ☐

Months ☐

NA ☐

4.At the worst time, how was the headache?

severe ☐

DK ☐

moderate ☐

NA ☐

mild ☐

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Section 1: Time and Circumstances of death.

1. Was the woman still pregnant when she died? Yes ☐ DK ☐
NO ☐ → Go to q.3
2. How many months was she pregnant when she died?
 Weeks ☐ Months ☐ NA ☐
 Pregnant for more than 6 months ☐ → Go to q.7
 Pregnant for more than 7 months ☐ → Go to q.7
3. How many months was she pregnant when the pregnancy ended?
 Weeks ☐ Months ☐ NA ☐
 Pregnant for more than 6 months ☐
 Pregnant for more than 7 months ☐
4. How many days after the end of pregnancy did the woman die?
 days NA ☐

5. Where did she deliver or where did she go for the abortion? home ☐ hospital ☐ DK ☐
clinic ☐ elsewhere ☐ NA ☐
6. How did the woman deliver?
 Spontaneous vaginal delivery ☐ Caesarean section ☐
 Instrumental delivery: forceps or vacuum ☐ Dilatation & Curetage ☐
 Oxytocica assisted delivery (IV) ☐ NA ☐
7. Did the woman suffer from diabetes during pregnancy? Yes ☐ No ☐ DK ☐
8. Did the woman suffer from severe weight loss before or during pregnancy? Yes ☐ No ☐ DK ☐
9. Did the woman suffer from repeated episodes of illness before or during pregnancy? Yes ☐ No ☐ DK ☐

Section 2: Abortion (pregnancy < 7 months).

1. Did the woman suffer from vaginal bleeding before the 7th month of pregnancy? Yes ☐
NO ☐ → Go to q.5
DK ☐ → Go to q.5
2. How serious was the bleeding? severe ☐ mild ☐
moderate ☐ DK ☐ NA ☐
3. How long did the bleeding last?
 Hours ☐ Days ☐ Weeks ☐ Months ☐ NA ☐
4. How long after the start of the bleeding did she die?
 Hours ☐ Days ☐ Weeks ☐ Months ☐ NA ☐
5. Did the woman have an induced abortion? Yes ☐ No ☐ DK ☐

6. Did the woman suffer from fever? Yes ☐
No ☐ → Go to q.8
DK ☐ → Go to q.8
7. At the worst time, how was the fever? severe ☐ mild ☐
moderate ☐ DK ☐ NA ☐
8. How long did she have fever?
 Days ☐ Weeks ☐ Months ☐ NA ☐
9. Did the woman have fits or convulsions? Yes ☐ No ☐ DK ☐
10. Did the woman have yellow discoloring of the eyes before she died? Yes ☐ No ☐ DK ☐

Abortion: severe vaginal bleeding in woman < 7 months pregnant + woman dies < 91 days of the start of the bleeding + no convulsions + no jaundice (E).

Induced abortion: known induction + woman dies < 91 days after induction of abortion (E).

OR Induced abortion: vaginal bleeding + fever + lower abdominal pain + woman < 91 days after the start of the bleeding (E).

Section 3: Convulsions, high blood pressure and swelling of the ankles (pregnancy > 6 months).

1. Did the woman suffer from convulsions? Yes ☐
NO ☐ → Go to q.6
DK ☐ → Go to q.6
2. When did the convulsions start? Before delivery ☐ NA ☐
After delivery ☐ → Go to q.4
3. How many months was she pregnant when the convulsions started?
 Weeks ☐ Months ☐ NA ☐
4. How long after the start of the convulsions did she die?
 Hours ☐ Days ☐ Weeks ☐ Months ☐ NA ☐

5. Did the woman die during convulsions or in a coma occurring after the convulsions? Yes ☐ No ☐ DK ☐ NA ☐
6. Did the woman suffer from high blood pressure during pregnancy? Yes ☐ No ☐ DK ☐
7. Did the woman suffer from swelling of the ankles during pregnancy? Yes ☐ No ☐ DK ☐
8. Did the woman suffer from stiffness of the neck before she died? Yes ☐ No ☐ DK ☐
9. Did the woman suffer from stiffness of the whole body before she died? Yes ☐ No ☐ DK ☐

Eclampsia: convulsions in a pregnancy of > 6 months OR convulsions after delivery + (woman dies < 15 days after delivery or in a coma due to the convulsions) + no high fever + no neck stiffness + no stiffness of the body (E).

Section 4: Excessive bleeding and placenta retention during late pregnancy (> 7 months) or post partum.

<p>1. Did the woman suffer from severe bleeding after the 7th month of pregnancy or after delivery? Yes <input type="checkbox"/> NO <input type="checkbox"/> → Go to q.5 DK <input type="checkbox"/></p> <p>2. When did the bleeding start? before labour started <input type="checkbox"/> > 1 day after delivery <input type="checkbox"/> during labour but before delivery <input type="checkbox"/> DK <input type="checkbox"/> shortly after delivery <input type="checkbox"/> NA <input type="checkbox"/></p> <p>3. How long after the bleeding started did she die? <input type="text"/> <input type="text"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></p>	<p>4. *Did the woman deliver the child? Yes <input type="checkbox"/> NO <input type="checkbox"/> → Go to next section DK <input type="checkbox"/></p> <p>5. How long after the delivery of the child was the placenta delivered? <input type="text"/> <input type="text"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> NA <input type="checkbox"/></p> <p>6. Was there a retention of the placenta or parts of the placenta or the membranes? retention of placenta <input type="checkbox"/> retention of membranes <input type="checkbox"/> DK <input type="checkbox"/> retention of parts of placenta <input type="checkbox"/> no retention <input type="checkbox"/> NA <input type="checkbox"/></p> <p>7. How long after the delivery of the child were the placenta or these retained parts of the placenta or the retained membranes delivered? <input type="text"/> <input type="text"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> NA <input type="checkbox"/></p>
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Antepartum bleeding: severe bleeding that started before delivery but not before the 7 month of pregnancy (E).

Postpartum bleeding: severe bleeding that started after delivery + woman dies < 4 days after delivery (E)
and/or retention (>30 minutes) of the placenta or parts of the placenta or membranes (A).

Section 5: Prolonged labour (> 24 hours).

<p>1. How long did the labour pain last? <input type="text"/> <input type="text"/> hours <input type="text"/> <input type="text"/> days</p> <p>2. *If the woman had a labour that lasted more than 24 hours, did she suffer from severe bleeding before delivery? Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/></p> <p>3. Which part of the baby came first? Head first <input type="checkbox"/> Foot first <input type="checkbox"/> Bottom first <input type="checkbox"/> DK <input type="checkbox"/> Hand first <input type="checkbox"/> NA <input type="checkbox"/></p>	<p>4. *Did the woman deliver the child? Yes <input type="checkbox"/> NO <input type="checkbox"/> → Go to next section DK <input type="checkbox"/></p> <p>5. If the woman had an assisted delivery (with forceps, vacuum extractor, oxytocica or a caesarian section), how long after the delivery did she die? <input type="text"/> <input type="text"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></p>
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Prolonged labour: labour lasted > 24 hours + (retained foetus or assisted delivery) (E).
and/or vaginal bleeding before delivery or abnormal presentation of foetus (A).

Section 6: Post partum Sepsis.

<p>1*. Did the woman have high fever before she died? Yes <input type="checkbox"/> NO <input type="checkbox"/> → Go to instruction DK <input type="checkbox"/></p> <p>2. How long did the fever last? <input type="text"/> <input type="text"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></p>	<p>3. *How long after delivery of the child did she die? <input type="text"/> <input type="text"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/></p> <p>4. Did the woman suffer from abdominal pain? Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/></p> <p>5. Did the woman suffer from smelly vaginal discharge before she died? Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/></p>
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Postpartum sepsis: high fever for < 21 days + woman dies < 15 days after delivery (E).
and/or abdominal pain or smelly vaginal discharge (A).

INSTRUCTION: go to previous chapters if no direct maternal death was diagnosed or
if the woman had repeated episodes of illnesses or if she suffered from heavy weight loss before or during pregnancy.



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Section 1: Neonates.

1. Was the child alive (breath, cry or move) at birth? Yes ☐ No ☐ → Go to q.3 DK ☐
2. How old was the child (in days) at the time of death? days
3. Did the pregnancy end earlier than expected? Yes ☐ No ☐ DK ☐
4. How many months was the mother pregnant when she delivered? Months or Weeks DK ☐
5. What was the size of the child at birth? Smaller than usual ☐ DK ☐ Very small ☐ Normal ☐ Larger than usual ☐
6. Did the child have any malformations at delivery? Yes ☐ No ☐ → Go to q.8 DK ☐
7. If yes, specify location and type of malformation NA ☐
8. Did the child have fever (hot body)? Yes ☐ No ☐ → Go to q.10 DK ☐
9. If yes, for how many days did the fever last? days NA ☐
- 9.a. Was the child's body cold on touch prior to death? Yes ☐ No ☐ DK ☐
10. Did the child suffer from spasms/convulsions? Yes ☐ No ☐ → Go to q.13 DK ☐
11. If yes, how many days after birth did the child start having spasms /convulsions? days NA ☐
12. How long did the spasms/convulsions last? days NA ☐
13. Was the child able to breath in a normal way immediately after birth? Yes ☐ No ☐ DK ☐
14. Did the child start having problems breathing some days after birth? Yes ☐ NA ☐ No ☐ → Go to q.16 DK ☐
15. How many days after birth did the child start having problems breathing ? days NA ☐
16. Was the child able to suck in a normal way immediately after birth? Yes ☐ No ☐ DK ☐
17. Did the child start having problems sucking some days after birth? Yes ☐ NA ☐ No ☐ → Go to q.19 DK ☐
18. How many days after birth did the child start having problems sucking? days NA ☐
19. Was the child able to cry in a normal way immediately after birth? Yes ☐ No ☐ DK ☐
20. Did the child stop crying in a normal way some days after birth? Yes ☐ NA ☐ No ☐ → Go to q.22 DK ☐
21. How many days after birth did the child stop crying in a normal way? days NA ☐
22. Did the child have bruises, marks or injury on the body or head at birth? Yes ☐ No ☐ DK ☐
23. Did the child have a bulging fontanelle? Yes ☐ No ☐ DK ☐
24. Did the child become unresponsive/unconscious? Yes ☐ No ☐ DK ☐

Stillbirth: the child failed to cry, breath of move after birth

Low birth weight/prematurity: pregnancy ended early or pregnancy ended at <28 weeks or < 7 months or the child was very small at birth (E)

Malformation: a malformation at birth (E)

Birth Asphyxia/birth trauma: no fever (hot body) + not able to cry in a normal way after birth + not very small at birth + no prematurity (E)

and (convulsions/spasms or not able to breath in a normal way after birth or not able to suck in a normal way after birth or bruises, marks or injury on body or head after birth) (S)

Neonatal tetanus: able to suck or cry at birth but stopped doing so at least 2 days after birth + convulsions/spasms during 2 weeks prior to death (E)

and/or mother no proof of tetanus vaccination of index pregnancy or born at home or birth assistant not trained (A)

Meningitis/Encephalitis: fever + bulging fontanelle + convulsions (E)

Section 1: Neonates (Continue).

25. Did the child have a cough? Yes ☐ No ☐ DK ☐
- 25.a. If yes, how long did the cough last? NA ☐
days
26. Did the child suffer from difficult breathing due to a blocked chest not a blocked nose? Yes ☐ No ☐ DK ☐
27. Did the child suffer from fast breathing (chest going up and down more quickly than usual)? Yes ☐ No ☐ DK ☐ → Go to q.10
28. If yes, how long did the difficult or fast breathing last? NA ☐
days
29. Did the child suffer from chest indrawing (chest or stomach moving inward in a unusual manner) ? Yes ☐ No ☐ DK ☐
30. Did the child suffer from pneumonia? Yes ☐ No ☐ DK ☐
31. Did the child suffer from crackling in the chest (rustling sounds in the chest)? Yes ☐ No ☐ DK ☐
31. a. Where there any periods when the child had short periods of stopping and restarting breathing prior to death? Yes ☐ No ☐ DK ☐
32. Did the child suffer from frequent liquid or loose stool (more frequent, and more liquid or loose than normal)? Yes ☐ No ☐ DK ☐
33. Did the child suffer from diarrhoea? Yes ☐ No ☐ DK ☐
34. If the child suffered from liquid or loose stool or from diarrhoea, for how many days was that? NA ☐
days

35. Was there blood or mucus in the child's stool? Yes, blood ☐ Yes, mucus ☐ No ☐ DK ☐ NA ☐
- 35.a. Did the child suffer from vomiting prior to death? Yes ☐ No ☐ DK ☐
- 35.b. Did the child have any swelling of the abdomen prior to death? Yes ☐ No ☐ DK ☐
36. Did the waters break before labour started? Yes ☐ No ☐ DK ☐ → Go to q.38
37. If yes, how many days before labour started? NA ☐
days
38. Did the child suffer from redness or drainage from the umbilical cord? Yes ☐ No ☐ DK ☐
39. Did the child suffer from a skin rash with bumps containing pus? Yes ☐ No ☐ DK ☐
40. Did the child have areas of skin that were red, hot or peeling prior to death? Yes ☐ No ☐ DK ☐
41. Did the child have yellow eyes or skin prior to death? Yes ☐ No ☐ DK ☐
42. Did the child have any bleeding anywhere prior to death? Yes ☐ No ☐ DK ☐
43. If yes, from where? specify location NA ☐

Lower Respiratory Tract Infection: (fever + difficult or fast breathing) or (fever + chest indrawing) or (local term for pneumonia) (E)
and/or crackling in the chest (A)

Diarrhoea/dysentery: frequent loose or liquid stool or local term for diarrhoea

Bacteraemia/Septicaemia: fever (hot body) + became unresponsive/unconscious + absence of pneumonia or meningitis (E)

and (stopped being able to suck) or (stopped being able to cry) or waters broke > 1 day before labour (S)

and/or redness or drainage from umbilical cord or skin rash with bumps containing pus) (A)



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Round

Weekblock

BSID

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Version 2, 2011-08-01

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Section 1

1.a. Did the child suffer from repeated episodes of illness before death?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	19.a. Was there wheezing prior to death?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
2. Did the child have any malformation at delivery?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	20. Did the child suffer from difficult breathing due to a blocked chest not a blocked nose?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
3. If yes, specify location and type of malformation	<div style="border: 1px solid black; width: 300px; height: 20px;"></div> NA <input type="checkbox"/>	21. Did the child suffer from fast breathing (chest going up and down more quickly than usual)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
4. Was the child very small at birth?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	21.a. If yes, how long did the difficult or fast breathing last?	<div style="border: 1px solid black; width: 40px; height: 20px;"></div> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/>
5. Did the child suffer from a severe loss of weight (ukucupha enzimbani)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	22. Did the child suffer from chest indrawing (chest or stomach moving inward in a unusual manner)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
6. Was the child very thin, thin arms and legs (amathambo), and loose skin over the arms (zishwabane izingalo)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	23. Did the child suffer from pneumonia?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
7. Did the child suffer from swelling of the body or parts of the body?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	24. Did the child suffer from crackling in the chest (rustling sounds in the chest)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
8. Did the child suffer from pitting oedema (ukuvuvuka) in the feet or legs?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	25. Did the child have a bulging fontanelle?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
9. Did the child suffer from a peeling skin (ukuxebuka)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	26. Did the child have a stiff neck?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
10. Did the child have brittle, sparse hair?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	27. Did the child suffer from spasms/convulsions?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
11. Did the child suffer from malnutrition (indlala)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	28. Did the child become unresponsive/unconscious?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
11.a. Did s/he have swelling in the neck, close to the ear, in the groin or armpit?	Yes, neck <input type="checkbox"/> Yes, armpit <input type="checkbox"/> No <input type="checkbox"/> Yes, groin <input type="checkbox"/> Yes, near the ear <input type="checkbox"/> DK <input type="checkbox"/>	29. Did the child stop being able to grasp?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
12. Did the child suffer from frequent liquid or loose stool (more frequent, and more liquid or loose than normal)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	30. Did the child stop being able to respond to a voice?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
13. Did the child suffer from diarrhoea?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	31. Did the child stop being able to follow movements with his/her eyes?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
14. If liquid or loose stool or diarrhoea, how long did it last?	<div style="border: 1px solid black; width: 40px; height: 20px;"></div> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/>	32. Did the child fail to grow?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
15. Was there blood or mucus in the child's stool?	Yes, blood <input type="checkbox"/> Yes, mucus <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/>	32.a. Did the child stop doing things s/he was previously able to do e.g. sitting, walking, talking, playing (loss of milestones) prior to death?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
15.a. Did the child have sunken eyes?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	33. Did the child have severe oral thrush?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
16. Did the child have fever (hot body)?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	34. Did the child suffer repeatedly from chest infections in the last year?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
17. If fever, how long did the fever last?	<div style="border: 1px solid black; width: 40px; height: 20px;"></div> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/>	35. Was the child treated for tuberculosis?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
18. Did the child have a cough?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	36. Did the child suffer from a brain infection in the last year?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
18. a. Was the cough severe?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/>	37. Did the child have a rash?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
19. If cough, how long did the cough last?	<div style="border: 1px solid black; width: 40px; height: 20px;"></div> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> NA <input type="checkbox"/>	38. Did the rash have blisters containing clear fluid?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/>
		39. *Was the child known to suffer from epilepsy?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
		40. Did the child die during or shortly after an epilepsy attack?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> NA <input type="checkbox"/>
		42. *Did the child die during an asthma attack?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>

Malformation: the child had a malformation at birth (E)

Malnutrition: local term for malnutrition or the child was very thin with loose skin or the child suffered from swelling of the body or parts of the body (E) and/or child had pitting oedema of feet/legs or child had peeling skin or brittle sparse hair or severe weight loss (A)

Diarrhoea/dysentery: frequent loose or liquid stool or local term for diarrhoea (E)

Lower Respiratory Tract Infection: (difficult or fast breathing + fever) or (local term for pneumonia) (E) and/or chest indrawing or cough or crackling in the chest (A)

Meningitis/Encephalitis: fever + (bulging fontanelle or stiff neck) (E) and/or convulsions/spasms (A)

Cerebral malaria: fever + loss of consciousness + convulsions + no meningitis (E)

Bacteraemia/septicaemia: fever + no meningitis + no pneumonia + no malaria (E)

and (stopped being able to grasp or stopped being able to respond to a voice or stopped being able to follow movements with his/her eyes) (S)

AIDS: malnutrition + severe oral thrush + (repeated chest infection in the last year or tuberculosis) (E)

and (chronic diarrhoea (>2 weeks) or treatment for tuberculosis or meningitis/encephalitis in the last year or failure to thrive or severe weight loss (S)

Epilepsy: known epileptic + dying during or shortly after an epileptic attack + no other infection at the time of death (E)

Tuberculosis: medically diagnosed with tuberculosis.

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