

VA Section 1: Background (FOR STILLBIRTHS, NEONATAL & CHILD DEATHS 0—59 MONTHS OLD)

V1.1	Was the deceased a singleton or multiple birth? <i>[If two or more children are born at the same time, it is counted as a multiple birth, even if one or more of the babies are born dead.]</i>	1. Singleton 2. Multiple 9. Don't know	<input type="checkbox"/> 1 or 9 → VQ1.3
V1.2	Was this the first, second, or later in the birth order?	1. First 2. Second 3. Third or more 9. Don't know	<input type="checkbox"/>
V1.3	If the mother is present, mark "Yes" and do not ask this question. Is the mother still alive?	1. Yes 2. No	<input type="checkbox"/> 1 → VQ1.6
V1.4	Did the mother die during or after the delivery?	1. During 2. After 9. Don't know	<input type="checkbox"/> 1 or 9 → VQ1.6
V1.5	How long after the delivery did the mother die? <i>[Record days if less than 28 days—if less than 24 hours, record "00" days; Record months if 28 days or more]</i>		____ ____ Days (DK = 99)
			____ ____ Months (DK = 99)
V1.6	Where was the deceased born?	1. Hospital 2. Other health provider or facility 3. On route to a health provider or facility 4. Home 5. Other (specify)..... 9. Don't know	<input type="checkbox"/>
V1.7	At the time of the delivery was the deceased: <i>[Read the question and slowly read the first four choices. Respondent should hear all four choices & then respond.]</i> <i>[Show photos]</i>	1. Very small 2. Smaller than usual 3. About average 4. Larger than usual 9. Don't know	<input type="checkbox"/>
V1.8	What was the weight of the deceased at birth?		____ ____ ____ Grams (DK = 9999)
V1.9	What was the sex of the deceased?	1. Male 2. Female 9. Don't know	<input type="checkbox"/>
V1.10	What was the delivery date? <i>Compare the delivery date just stated by the respondent to the birth date from the prior record (GQ1.4). Discuss any inconsistency with the respondent to confirm or correct the stated delivery date. You cannot change the prior record's date.</i>		____ / ____ / ____ ____ ____ ____ D D M M Y Y Y Y (DK = 99/99/9999)
V1.11	Was the child born alive or dead?	1. Alive 2. Dead 9. Don't know	<input type="checkbox"/>
V1.12	Did the baby every cry?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>

Study ID#

Village/Cluster				HH		Child			

**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

V1.13	Did the baby ever move?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V1.14	Did the baby ever breathe?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V1.15	Refer to VQ1.11–1.14. If “Dead” & no crying, movement or breathing, mark “Stillbirth.” If “Alive” & VQ1.12–1.14 = “No,” or if “Dead” and VQ1.12, 1.13 or 1.14 = “Yes,” then discuss & correct.	1. Stillbirth 2. Live birth	<input type="checkbox"/> 2 → VQ1.20																								
Stillbirths																											
V1.16	Were there any bruises or signs of injury on the baby's body at birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V1.17	Was the baby's body (skin and tissue) pulpy?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V1.18	Was any part of the baby physically abnormal at the time of delivery? (for example: body part too large or too small, additional growth on body)	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ3.1																								
V1.19	What were the abnormalities? <i>Ask for the following abnormalities [Mark all that apply – Show photos]</i>	1. Was the head size very small at the time of birth 2. Was the head size very large at the time of birth 3. Was there a mass defect on the back of head or spine..... 4. Was there any other abnormality (If “Yes,” then specify).....	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; border: none;"><u>Yes</u></td> <td style="text-align: center; border: none;"><u>No</u></td> </tr> <tr> <td style="border: none;">1. <input type="checkbox"/></td> <td style="border: none;">2. <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">1. <input type="checkbox"/></td> <td style="border: none;">2. <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">1. <input type="checkbox"/></td> <td style="border: none;">2. <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">1. <input type="checkbox"/></td> <td style="border: none;">2. <input type="checkbox"/></td> </tr> </table>	<u>Yes</u>	<u>No</u>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>														
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Inst_1: STOP. After completing VQ1.19 → SQ3.1 (Maternal history)																											
Live births																											
V1.20	How old was the child when the illness started? <i>[Record days if less than 28 days—if less than 24 hours, record “00” days; Record months if 28 days-11 months; Record years if 1 year or older.]</i>		<table style="width: 100%; border: none;"> <tr> <td style="border: none;">___ ___ Days (DK = 99)</td> </tr> <tr> <td style="border: none;">___ ___ Months (DK = 99)</td> </tr> <tr> <td style="border: none;">___ ___ Years (DK = 99)</td> </tr> </table>	___ ___ Days (DK = 99)	___ ___ Months (DK = 99)	___ ___ Years (DK = 99)																					
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V1.21	How long did the illness last? <i>[Record days if less than 28 days—if less than 24 hours, record “00” days; Record months if 28 days or more.]</i>		<table style="width: 100%; border: none;"> <tr> <td style="border: none;">___ ___ Days (DK = 99)</td> </tr> <tr> <td style="border: none;">___ ___ Months (DK = 99)</td> </tr> </table>	___ ___ Days (DK = 99)	___ ___ Months (DK = 99)																						
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V1.22	Where did the deceased die?	1. Hospital 2. Other health provider or facility 3. On route to a health provider or facility 4. Home 5. Other (specify)..... 9. Don't know	<input type="checkbox"/>																								
V1.24	What was the date of death? <i>Compare the date of death just stated by the respondent to the date of death from the prior record (GQ1.5). Discuss any inconsistency with the respondent to confirm or correct the stated date. You cannot change the prior record's date.</i>		<table style="width: 100%; border: none;"> <tr> <td style="border: none;">D</td> <td style="border: none;">D</td> <td style="border: none;">M</td> <td style="border: none;">M</td> <td style="border: none;">Y</td> <td style="border: none;">Y</td> <td style="border: none;">Y</td> <td style="border: none;">Y</td> </tr> <tr> <td style="border: none;">/</td> <td style="border: none;">/</td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> <tr> <td colspan="8" style="border: none; text-align: center;">(DK = 99/99/9999)</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	/	/							(DK = 99/99/9999)							
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**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
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V1.25	AGE AT DEATH	
Record only the calculated age <u>OR</u> the stated age. First try to calculate the age. If this is not possible, then ask the respondent for the child's age at death.		
CALCULATE THE AGE AT DEATH		
Record the delivery date from VQ1.10: $\frac{\quad}{D} \frac{\quad}{D} \frac{\quad}{M} \frac{\quad}{M} \frac{\quad}{Y} \frac{\quad}{Y} \frac{\quad}{Y} \frac{\quad}{Y}$ (Don't Know = 99/99/9999)		
Record the date of death from VQ1.24: $\frac{\quad}{D} \frac{\quad}{D} \frac{\quad}{M} \frac{\quad}{M} \frac{\quad}{Y} \frac{\quad}{Y} \frac{\quad}{Y} \frac{\quad}{Y}$ (Don't Know = 99/99/9999)		
Now, if possible, calculate the age at death (VQ1.24 – VQ1.10). If only the month and year are known, you may still be able to calculate the approximate age in months or years. Discuss the calculated age with the respondent: I have calculated that the child was (about) <CALCULATED AGE> at death. Is this correct?		
If the respondent does not agree with the calculated age, then again discuss the delivery date and date of death to make sure that these are correct. If the calculated age at death cannot be resolved, then go below to the "STATED AGE" box.		
Once the age at death is calculated, check VQ1.20 and VQ1.21 to make sure that the age at illness onset and the illness duration are consistent with the age at death. For example, the age at onset + duration cannot be greater than the age at death.		
[Record days if less than 28 days—if less than 24 hours, record "00" days; Record months if 28 days-11 months; Record years if 1 year or older.]		
After recording the calculated age → VQ1.26		
STATED AGE AT DEATH (Ask only if the calculated age cannot be determined)		
How old was the deceased at the time of death?		
Compare the age at death just stated by the respondent to the child's last known age from the prior record (GQ1.6). Discuss any inconsistency with the respondent to confirm or correct the stated age. You cannot change the prior record's age. Partly known delivery and death dates might help resolve the stated age. For example, if the child was born and died in the same month, then this is likely a neonatal death.		
Once the age at death is determined, check VQ1.20 and VQ1.21 to make sure that the age at illness onset and the illness duration are consistent with the age at death. For example, the age at onset + duration cannot be greater than the age at death.		
[Record days if less than 28 days—if less than 24 hours, record "00" days; Record months if 28 days-11 months; Record years if 1 year or older.]		
V1.26	Mark the baby's age at the time of death. [Use the calculated age (VQ1.24 – VQ1.10) if known, or the stated age (VQ1.25). If both the calculated and stated ages are unknown, then use your best judgment to mark the child's age at death.]	1. Less than 28 days old 2. 1-59 months old
		<input type="checkbox"/> 2 → SQ5b.1

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**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

SA Module 3 and VA Section 2: Maternal history (FOR STILLBIRTHS AND NN DEATHS < 28 DAYS OLD)																																													
<p>Read: Now, I would like to ask you some questions about (your / the mother's) health and (your / her) pregnancy with <NAME>.</p> <p>Here and in the following questions, read "...the mother...", "...her..." and "...she..." if the mother is not the respondent.</p>																																													
S3.1	<p>Before the pregnancy with <NAME>, did (you / the mother) suffer from any of the following known conditions:</p> <p><i>[Read out all options and check "Yes," "No" or "Don't know" for each.]</i></p> <p>If "Yes," then ask: Did (you / she) undergo treatment for this condition during the pregnancy?</p>	<ol style="list-style-type: none"> 1. High blood pressure 2. Heart disease 3. Diabetes 4. Epilepsy/convulsion 5. Other <p style="text-align: center;"><i>(specify other).....</i></p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">Suffered from</th> <th colspan="3" style="text-align: center;">Treatment</th> </tr> <tr> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> </tbody> </table>	Suffered from			Treatment			Yes	No	DK	Yes	No	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>
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S3.2	<p>During the pregnancy, did (you / the mother) see anyone for antenatal care?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> 2 or 9 → SQ3.3																																										
S3.2.1	<p>Whom did (you / she) see? Anyone else?</p> <p><i>[Probe, and record all persons seen.]</i></p>	<ol style="list-style-type: none"> 1. Health care provider 2. TBA/Religious healer 3. Relative/neighbor/friend 4. Other (specify)..... <li style="padding-left: 20px;">(_____) 9. Don't know..... 	<table style="width: 100%;"> <tr> <td style="width: 50%;"> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> </td> <td style="width: 50%; vertical-align: middle; text-align: center;"> <div style="font-size: 2em;">}</div> <div style="font-size: 2em;">→</div> SQ3.3 </td> </tr> <tr> <td style="width: 50%;"> <ol style="list-style-type: none"> 9. <input type="checkbox"/> </td> <td style="width: 50%;"></td> </tr> </table>	<ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 	<div style="font-size: 2em;">}</div> <div style="font-size: 2em;">→</div> SQ3.3	<ol style="list-style-type: none"> 9. <input type="checkbox"/> 																																							
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S3.2.2	<p>How many times did (you / the mother) receive antenatal care from a health care provider during this pregnancy?</p>	<p>_____ Times (DK = 99)</p>																																											
S3.2.3	<p>During which month of the pregnancy did (you / the mother) <u>last</u> receive antenatal care from a health care provider?</p>	<p>_____ Month (DK = 99)</p>																																											
S3.2.4	<p>During this pregnancy, did the provider do any of the following for (you / the mother) at least once?</p> <p><i>[Read out all options and check "Yes," "No" or "Don't know" for each.]</i></p> <p><i>[LOCAL ADAPTATION: Additional high energy and high protein foods to mention if the respondent asks]</i></p>	<ol style="list-style-type: none"> 1. Did the provider measure (your / her) blood pressure? 2. Did (you / she) give a urine sample? 3. Did (you / she) give a blood sample? 4. Did the provider tell (you / her) to eat more high energy foods like <HIGH ENERGY FOODS> and high protein foods like <HIGH PROTEIN FOODS> than when not pregnant? 5. Did the provider tell (you / her) about the danger signs during pregnancy? 6. Did the provider tell (you / her) where to go if (you / she) had any danger signs? 	<table style="width: 100%;"> <thead> <tr> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> </tbody> </table>	Yes	No	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>																								
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S3.3	<p>Please tell me the danger signs during pregnancy or labor and delivery that you should seek care for <u>immediately</u>.</p> <p><i>Probe: Tell me as many of the danger signs as you can.</i></p> <p><i>Probe: Can you tell me any others?</i></p> <p><i>[Check each danger sign mentioned.]</i></p>	<ol style="list-style-type: none"> 1. Vaginal bleeding 2. Convulsions/fits 3. Severe headache with blurred vision 4. Fever and too weak to get out of bed 5. Severe abdominal pain 6. Fast or difficult breathing 7. Painful contractions every 20 minutes or less for 12 hours or more 8. Broken water for 12 hours or more 9. Bloody, sticky discharge 12 hrs or more 10. No immediate danger sign mentioned 	<table style="width: 100%;"> <tr> <td style="width: 50%;"> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> </td> <td style="width: 50%; vertical-align: middle; text-align: center;"> <div style="font-size: 2em;">}</div> <div style="font-size: 2em;">→</div> <p>_____ Mentioned</p> </td> </tr> </table>	<ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 	<div style="font-size: 2em;">}</div> <div style="font-size: 2em;">→</div> <p>_____ Mentioned</p>																																								
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S3.4	<p>During this pregnancy, (were you / was the mother) given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> 2 or 9 → SQ3.5																																										

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S3.4.1	During this pregnancy, how many times did (you / she) get this injection?		___ Times (DK = 9)																																																			
S3.5	At any time before this pregnancy, did (you / the mother) receive any tetanus injection, either to protect yourself or another baby?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ3.6																																																			
S3.5.1	Before this pregnancy, how many other times did (you / she) receive a tetanus injection? [If 7 or more time, record "7."]		___ Times (DK = 9)																																																			
S3.6	<i>Skip SQ3.6-3.7.1 in areas wo/malaria.</i> During this pregnancy, did (you / the mother) sleep under an insecticide treated bednet?	1. Yes, usually or always 2. Yes, sometimes 3. Never 9. Don't know	<input type="checkbox"/>																																																			
S3.7	During this pregnancy, did (you / the mother) take any drug to prevent (you / her) from getting malaria?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ2.1																																																			
S3.7.1	During this pregnancy, how many times did (you / she) take this drug?		___ ___ Times (DK = 99)																																																			
V2.1	Now I'd like to ask you about any problems you might have had during the pregnancy. Was the late part of the pregnancy (defined as the last 3 months), labor or delivery complicated by any of the following problems that started <u>before</u> the baby was delivered? [Read each complication and mark "Yes," "No" or "Don't know" for each.] [Read "...the mother..." or "...Was she..." if the mother is not the respondent.]	<p><u>Did (you / the mother) have:</u></p> <p>1. convulsions?.....</p> <p>2. high blood pressure?</p> <p>3. severe anemia or pallor <u>and</u> shortness of breath?</p> <p>4. diabetes?.....</p> <p>5. severe headache?.....</p> <p>6. blurred vision?.....</p> <p><u>(Were you / Was she):</u></p> <p>7. too weak to get out of bed?</p> <p><u>Did (you / the mother) have:</u></p> <p>8. severe abdominal pain?</p> <p>9. fast or difficult breathing?</p> <p>10.puffy face?.....</p> <p>11.<u>any</u> vaginal bleeding before labor?.....</p> <p>12.excessive bleeding during labor or delivery?</p> <p>13.fever?</p> <p>14.smelly vaginal discharge?</p> <p><u>Was the:</u>.....</p> <p>15.child delivered not head first?</p> <p>16.cord delivered first?</p> <p>17.cord around the child's neck?.....</p> <p><u>Did (you / the mother) have:</u></p> <p>18.any other complication?</p> <p>(specify the other complication)</p>	<table border="0"> <tr> <td><u>Yes</u></td> <td><u>No</u></td> <td><u>DK</u></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> </table>	<u>Yes</u>	<u>No</u>	<u>DK</u>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>
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V2.2	Did (you / the mother) have any of the following problems that started <u>after</u> the delivery? [Read each complication and mark "Yes," "No" or "Don't know" for each.] [Read "...the mother..." if the mother is not the respondent.]	<p><u>Did (you / the mother) have:</u></p> <p>1. convulsions?.....</p> <p>2. heavy bleeding?</p> <p>3. Fever with smelly vaginal discharge or abdominal pain?</p>	<table border="0"> <tr> <td><u>Yes</u></td> <td><u>No</u></td> <td><u>DK</u></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> </table>	<u>Yes</u>	<u>No</u>	<u>DK</u>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>																																							
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V2.2	How many months long was the pregnancy?		___ ___ Months ≠ 99 → VQ2.4 (DK = 99)																																																			

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V2.3	Did the pregnancy end early, on time, or late?	1. Early 2. On time 3. Late 9. Don't know	<input type="checkbox"/>
V2.4	Was the baby moving in the last few days before the birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V2.5	When did (you / the mother) last feel the baby move? <i>[Read "...the mother..." if the mother is not the respondent.]</i> <i>[Record hours if less than 24 hours; Record days if 1 day or more.]</i>		_____ Hours before delivery <i>(DK = 99)</i> _____ Days before delivery <i>(DK = 99)</i>
V2.6	Did the water break before labor or during labor? <i>[Note: Labor begins when contractions are no more than 20 minutes apart.]</i>	1. Before 2. During 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ2.8
V2.7	How much time before labor did the water break? <i>[Record "24" if 1 day or more.]</i>		_____ Hours <i>(DK = 99)</i>
V2.8	What was the color of the liquor when the water broke?	1. Green or brown 2. Clear (normal) 3. Other (<i>specify</i>)..... 9. Don't know	<input type="checkbox"/> _____
V2.9	Was the liquor foul smelling?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V2.10	How much time did the labor and delivery take? <i>[Record "00" if less than 1 hour.]</i>		_____ Hours <i>(DK = 99)</i>
S3.8	Where did the delivery occur?	1. Hospital 2. Other health provider or facility 3. On route to a health provider or facility 4. Home 5. Other (<i>specify</i>) 9. Don't know	<input type="checkbox"/> 1-3 = Health provider 9 → SQ3.11
S3.9	Who decided that this was the right place to deliver the baby? <i>[Record the one main decision maker.]</i>	1. The woman, herself 2. Her husband 3. Her mother 4. Her mother-in-law 5. Her father-in-law 6. Other (<i>specify</i>)..... 9. Don't know	<input type="checkbox"/> _____
S3.10	<i>If she did <u>not</u> go to a health provider or facility (SQ3.8 = 4-5) for the delivery, ask: Did (you / the mother) have any concerns or problems that kept (you / her) from going to a health provider or facility for the delivery?</i> <i>If she <u>went</u> or <u>was on route</u> to a health provider or facility (SQ3.8 = 1-3) for the delivery, ask: Did (you / the mother) have to overcome any concerns or problems to go to health provider or facility for the delivery?</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ3.11

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S3.10. 1	<p>What concerns or problems did (you / she) have?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Did not think she was sick enough to need health care..... 2. No one available to go with her 3. Too much time from her regular duties... 4. Someone else had to decide (<i>specify</i>) ... 5. Too far to travel 6. No transportation available..... 7. Cost (transport, health care, other)..... 8. Not satisfied with available health care .. 9. Symptom(s) required traditional care 10. Thought she was too sick to travel..... 11. Thought she/baby will die despite care. 12. Was late at night (transportation or provider not available) 13. Fears exposure to male health provider 14. Other (<i>specify</i>)..... 99. Don't know..... 	<ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> 14. <input type="checkbox"/> 99. <input type="checkbox"/>
S3.11	<p>Who (at the facility) delivered the baby?</p> <p><i>[Read "...at the facility..." if she delivered at a health facility.]</i></p>	<ol style="list-style-type: none"> 1. Doctor 2. Nurse/midwife 3. Relative/neighbor/friend 4. Self (the mother) 5. Traditional birth attendant 6. Other (<i>specify</i>)..... 9. Don't know 	<input type="checkbox"/>
S3.12	<p>How soon after labor started did the <BIRTH ATTENDANT> first attend the mother?</p> <p><i>[Discuss that labor starts with painful contractions every 20 minutes or less.]</i></p> <p><i>[Mark days &/or hours as needed: e.g. 00 day, 06 hours]</i></p>		<p>___ Days (DK = 99)</p> <hr/> <p>___ Hours (DK = 99)</p>
S3.13	<p>Did the birth attendant use a pictorial graph to follow the progress of (your / the mother's) labor?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<input type="checkbox"/>
S3.14	<p>Did the birth attendant wash her hands with soap and water or wear surgical gloves before assisting with the birth?</p>	<ol style="list-style-type: none"> 1. Yes, washed with soap and water 2. Yes, wore surgical gloves 3. No 9. Don't know 	<input type="checkbox"/>
S3.15	<p>On what surface did (you / the mother) deliver?</p>	<ol style="list-style-type: none"> 1. Labor bed 2. Solid floor with mackintosh/cover 3. Solid washed floor 4. Solid unwashed floor 5. Dirt/soil/mud/straw floor 6. Other (<i>specify</i>)..... 9. Don't know 	<input type="checkbox"/>
V2.17	<p>Was the delivery...?</p> <p><i>[Read the choices and mark ONE.]</i></p>	<ol style="list-style-type: none"> 1. Vaginal with forceps 2. Vaginal without forceps 3. Vaginal (don't know) 4. C-section 9. Don't know 	<input type="checkbox"/>
V2.18	<p>During labor but before delivery, did (you / the mother) receive any kind of injection?</p> <p><i>[Read "...the mother..." if the mother is not the respondent.]</i></p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<input type="checkbox"/>

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S4.4	<p>If she <u>never</u> went to a health provider (SQ4.2 = 2 or SQ4.2.1 ≠ 1-4) for any of the pregnancy symptoms, ask: Did (you / the mother) have any concerns or problems that kept (you / her) from going to a health provider or facility for the symptom(s) that started <u>before</u> labor?</p> <p>If she <u>went</u> to health provider (SQ4.2.1 = 1-4) for any pregnancy symptom(s), ask: Did (you / the mother) have to overcome any concerns or problems to go to a health provider or facility for the symptom(s) that started <u>before</u> labor?</p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → Inst_1</p>
S4.4.1	<p>What concerns or problems did (you / she) have?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<p>1. Did not think was sick enough to need health care..... 2. No one available to go with her 3. Too much time from her regular duties... 4. Someone else (specify) had to decide ... 5. Too far to travel 6. No transportation available..... 7. Cost (transport, health care, other)..... 8. Not satisfied with available health care .. 9. Symptom(s) required traditional care 10. Thought she was too sick to travel..... 11. Thought she/baby will die despite care. 12. Fears exposure to male health provider 13. Other (specify)..... 99. Don't know.....</p>	<p>1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> 99. <input type="checkbox"/></p>
Inst_1: If SQ4.2 = 2 or SQ4.2.1 ≠ 1-4 (Never went to a health provider for any pregnancy symptoms) → Inst_2			
S4.5	Did any health provider or facility refer (you / her) to another health provider or facility for (any of) the symptom(s) that started <u>before</u> labor?	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → SQ4.6</p>
S4.5.1	Did (you / she) go to the provider or facility to which (you were / she was) referred?	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/></p>
S4.6	How many different health providers or facilities did (you / the mother) see for the pregnancy symptom(s) that started <u>before</u> labor?		<p>____ Health providers/facilities (DK = 99)</p>
S4.7	(Were you / was the mother) admitted to hospital for (any of) the symptom(s) that started <u>before</u> labor?	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/></p>
S4.8	<p>Please tell me everything that the provider(s) suggested that (you / the mother) do for the pregnancy symptom(s) at home?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<p>1. Take antibiotic by mouth..... 2. Take antimalarial by mouth 3. Take BP medicine by mouth..... 4. Take other medicine by mouth 5. Rest / bed rest / decrease work..... 6. Return for follow-up visit(s)..... 7. Return or referred if worse..... 8. Other (specify)..... 9. Nothing 99. Don't know.....</p>	<p>1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> → Inst_2 99. <input type="checkbox"/> → Inst_2</p>
S4.9	(Were you / Was the mother) able to follow <u>all</u> this advice?	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 9 → Inst_2</p>

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S4.10	<p><i>If <u>not</u> able to follow <u>all</u> the advice, ask:</i> Did (you / she) have any concerns or problems that kept (you / her) from following the advice?</p> <p><i>If <u>able</u> to follow <u>all</u> the advice, ask:</i> Did (you / she) have to overcome any concerns or problems to follow the advice?</p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → Inst_2</p>
S4.10.1	<p>What concerns or problems did (you / she) have?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<p>1. Did not understand instructions</p> <p>2. Too much time from her regular duties...</p> <p>3. Someone else (<i>specify</i>) decided</p> <p>4. Cost too much</p> <p>5. Problem required traditional care</p> <p>6. Advised care not needed or helpful</p> <p>7. Advised care might harm unborn child ...</p> <p>8. Thought she/baby will die despite care ..</p> <p>9. Other (<i>specify</i>).....</p> <p>99. Don't know.....</p>	<p>1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 99. <input type="checkbox"/></p>
Inst_2: Refer to SQ4.1: If no labor or delivery symptoms → Inst_8			
S4.11	<p>Now let's talk about the labor and delivery symptom(s). You said earlier that the symptom(s) that started <u>with</u> or <u>during</u> labor or delivery (was / were) <SYMPTOM(S)>.</p> <p><i>[Read and mark the SQ4.1 symptom(s) confirmed by the respondent. Correct the SQ4.1 responses if necessary.]</i></p>	<p>1. Convulsions..... <input type="checkbox"/> 2. High blood pressure <input type="checkbox"/> 3. Severe anemia or (pallor and SOB) .. <input type="checkbox"/> 4. – blank – 5. Severe headache <input type="checkbox"/> 6. Blurred vision..... <input type="checkbox"/> 7. Too weak to get out of bed..... <input type="checkbox"/> 8. Severe abdominal (not labor) pain <input type="checkbox"/> 9. Fast or difficult breathing <input type="checkbox"/></p>	<p>10. Puffy face <input type="checkbox"/> 11. <u>Any</u> bleeding before labor <input type="checkbox"/> 12. Excess bleed during L or D <input type="checkbox"/> 13. Fever <input type="checkbox"/> 14. Smelly vaginal discharge <input type="checkbox"/> 15. Early/preterm labor (<9 mnth) . <input type="checkbox"/> 16. Water broke ≥6 hrs bfr. labor .. <input type="checkbox"/> 17. Labor for 12 hours or more <input type="checkbox"/> 18. Other (<i>specified in SQ4.1</i>)..... <input type="checkbox"/></p>
S4.12	<p>Where (were you / was the mother) when (this / the first) symptom began?</p> <p><i>[Read "...the first..." if she had more than one labor or delivery symptom.]</i></p>	<p>1. Home 2. On route to a health provider or facility 3. At the health provider or facility where she went for normal labor 4. Other (<i>specify</i>)..... 9. Don't know</p>	<p><input type="checkbox"/> 3 → SQ4.17</p>
S4.13	<p>Did (you / she) <u>receive, seek or try to seek</u> any care or treatment for (<u>any</u> of) the labor or delivery symptom(s)?</p> <p><i>[Read "...any of the symptoms" if she had more than one symptom.]</i></p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → SQ4.17</p>
S4.13.1	<p>What was the <u>first</u> thing (you / she) did for the symptom(s)?</p> <p><i>[Mark <u>only</u> the <u>first</u> action taken.]</i></p>	<p>1. Home treatment (at her own home, or by a relative, neighbor, or friend) <u>Sought or tried to seek</u> care from a: 2. Hospital 3. NGO or government clinic 4. Private doctor/clinic 5. Community nurse or midwife 6. Pharmacist or drug seller 7. TBA/village doctor/quack/other non-formal or traditional provider 8. Other (<i>specify</i>)..... 99. Don't know</p>	<p><input type="checkbox"/> <input type="checkbox"/> 99 → SQ4.16</p>
S4.14	<p>Who decided that this was the right thing to do at that time?</p> <p><i>[Only one response allowed. Record the main decision maker.]</i></p>	<p>1. The woman, herself 2. Her husband 3. Her mother 4. Her mother-in-law 5. Her father-in-law 6. Other (<i>specify</i>)..... 9. Don't know</p>	<p><input type="checkbox"/></p>

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SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

S4.15	<p><i>If she did <u>not</u> go to a health provider (SQ4.13.1 = 1 or 6-8), ask: Did (you / the mother) have any concerns or problems that kept (you / her) from going to a health provider at that time?</i></p> <p><i>If she <u>went</u> to a health provider (SQ4.13.1 = 2-5), ask: Did (you / the mother) have to overcome any concerns or problems to go to the <HEALTH PROVIDER> at that time?</i></p>	<p>1. Yes 2. No 9. Don't know</p>	<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> 2 or 9 → Inst_3
S4.15.1	<p>What concerns or problems did (you / she) have?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<p>1. Did not think she was sick enough to need health care.....</p> <p>2. No one available to go with her</p> <p>3. Too much time from her regular duties...</p> <p>4. Someone else had to decide (<i>specify</i>) ...</p> <p>5. Too far to travel</p> <p>6. No transportation available.....</p> <p>7. Cost (transport, health care, other).....</p> <p>8. Not satisfied with available health care ..</p> <p>9. Symptom(s) required traditional care</p> <p>10. Thought she was too sick to travel.....</p> <p>11. Thought she/baby will die despite care.</p> <p>12. Was late at night (transportation or provider not available)</p> <p>13. Fears exposure to male health provider</p> <p>14. Other (<i>specify</i>).....</p> <p>99. Don't know.....</p>	<p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/> _____</p> <p>5. <input type="checkbox"/></p> <p>6. <input type="checkbox"/></p> <p>7. <input type="checkbox"/></p> <p>8. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p> <p>10. <input type="checkbox"/></p> <p>11. <input type="checkbox"/></p> <p>12. <input type="checkbox"/></p> <p>13. <input type="checkbox"/></p> <p>14. <input type="checkbox"/> _____</p> <p>99. <input type="checkbox"/></p>
Inst_3: If SQ4.13.1 = 2-5 (First <u>went</u> to a health provider or facility) → SQ4.16.1			
S4.16	<p>Did (you / she) <u>ever seek or try to seek</u> care from a health provider or facility for (any of) the labor or delivery symptom(s)?</p>	<p>1. Yes 2. No 9. Don't know</p>	<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> 2 or 9 → SQ4.17
S4.16.1	<p>Please tell me all the types of health providers and facilities where (you / she) <u>sought or tried to seek</u> care for (any of) the labor or delivery symptom(s).</p> <p><i>Prompt: Anywhere else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<p>1. Hospital</p> <p>2. NGO or government clinic</p> <p>3. Private doctor/clinic</p> <p>4. Community nurse or midwife</p> <p>9. Don't know.....</p>	<p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p>
S4.17	<p><i>Refer to SQ3.8 to determine the delivery place. Discuss with respondent to confirm or correct the delivery place.</i></p> <p><i>Discuss & resolve inconsistencies, for example, if SQ4.13 or 4.16 = "No," but the mother delivered in a health facility.</i></p>	<p>1. Hospital</p> <p>2. Other health provider or facility</p> <p>3. On route to a health provider or facility</p> <p>4. Home</p> <p>5. Other (<i>specify</i>).....</p> <p>9. Don't know</p>	<div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div> 1-3 = Health provider _____
S4.18	<p>So, including where (you / the mother) <u>went or tried to go</u> for the labor or delivery symptom(s) <u>and</u> for the delivery, how many health providers or facilities did (you / she) go to?</p> <p><i>[If SQ4.16 = 2 and SQ4.17 = 4 or 5 → record '00' health providers/facilities]</i></p> <p><i>[If SQ4.16 = 2 and SQ4.17 = 1-3 → record '01' health provider/facility]</i></p> <p><i>[If SQ4.16 = 2 and SQ4.17 = 9 → record '99' health providers/facilities]</i></p> <p><i>[If SQ4.16 = 9 → record '99' health providers/facilities]</i></p>		____ Health providers/facilities
Inst_4: If SQ4.12 = 3 (Symptoms began at the health provider where she went for normal labor) → SQ4.22			
Inst_5: If SQ4.16 = 2 or 9 & SQ4.17 = 4-9 (No health provider seen/sought for the symptoms/delivery) → Inst_8			
Inst_5.5: If SQ4.1 = only 1 labor or delivery symptom <u>OR</u> If SQ4.16 = 2 or 9 → SQ4.21			

Study ID#

Village/Cluster			HH			Child			

**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

S4.19	Was there any particular symptom or symptoms for which (you / the mother) went to the (first) health provider? <i>[Read "...the first health provider?" if she went to more than one provider.]</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ4.21
S4.20	For which symptom(s) did (you / she) go?	1. Convulsions..... <input type="checkbox"/> 2. High blood pressure <input type="checkbox"/> 3. Severe anemia or (pallor <u>and</u> SOB) .. <input type="checkbox"/> 4. – blank – 5. Severe headache <input type="checkbox"/> 6. Blurred vision..... <input type="checkbox"/> 7. Too weak to get out of bed <input type="checkbox"/> 8. Severe abdominal (not labor) pain <input type="checkbox"/> 9. Fast or difficult breathing <input type="checkbox"/>	10. Puffy face <input type="checkbox"/> 11. Any bleeding before labor <input type="checkbox"/> 12. Excess bleed during L or D <input type="checkbox"/> 13. Fever <input type="checkbox"/> 14. Smelly vaginal discharge <input type="checkbox"/> 15. Early/preterm labor (<9 mnth) . <input type="checkbox"/> 16. Water broke ≥6 hrs bfr. labor .. <input type="checkbox"/> 17. Labor for 12 hours or more <input type="checkbox"/> 18. Other (specified in SQ4.1)..... <input type="checkbox"/>
S4.21	How long after the labor or delivery symptom(s) began was it decided to go to the (first) health provider? <i>[Read "...to the first..." if she went or tried to go to more than one health provider.]</i> <i>[Mark days, hours &/or minutes as needed: e.g. 00 day, 02 hours, 10 minutes]</i>	_____ Days (DK = 99)	
		_____ Hours (DK = 99)	
		_____ Minutes (DK = 99)	
<p>Labor and delivery matrix instructions: Ask the following questions for the <u>first</u> and <u>last</u> health providers where she sought/tried to seek care for the labor and delivery symptoms. If she delivered at a health provider/facility or at home or on route while trying to go to a health provider/facility, then that should be the first health provider (if she went to only one) or the last health provider. Ask all the questions for the first provider before going on to the last.</p> <p>Before asking about the first health provider, read: Now I would like to ask about (your / the mother's) visit to the (first) health provider. <i>[Read "first" if she went or tried to go to more than one provider.]</i></p> <p>Before asking about the last health provider, read: Now I would like to ask about (your / the mother's) visit to the last health provider.</p>			
– LABOR AND DELIVERY MATRIX QUESTIONS –		FIRST HEALTH PROVIDER	LAST HEALTH PROVIDER
What was the name of the (first / last) health provider or facility where (you / the mother) (sought care for the labor or delivery symptom(s) / delivered the baby / tried to deliver the baby)? <i>Probe to identify the type of provider.</i>	1. Hospital (Government) 2. Hospital (NGO) 3. Hospital (Private) 4. Health center (Government) 5. Health center (NGO) 6. Health post (Government) 7. Health post (NGO) 8. Private doctor/clinic (Formal) 9. Private doctor/clinic (?Formal?) 10. Trained community nurse/midwife 99. Don't know	S4.22 <input type="checkbox"/> <input type="checkbox"/> _____ (Name of Provider/Facility)	S4.32 <input type="checkbox"/> <input type="checkbox"/> _____ (Name of Provider/Facility)
After (deciding to seek care / being referred), how much time passed before going to the <FIRST/LAST HEALTH PROVIDER>? <i>[Discuss that this might include the time needed to arrange for transportation and money to go to the provider/facility, or to provide home care or go to a traditional provider before going to the health provider.]</i> <i>[If she delivered at home, record the time from decision/referral to delivery.]</i> <i>[Mark days, hours &/or minutes as needed: e.g. 00 days, 02 hours, 10 minutes]</i>	S4.23 _____ Days (DK = 99)		S4.33 _____ Days (DK = 99)
		_____ Hours (DK = 99)	_____ Hours (DK = 99)
		_____ Minutes (DK = 99)	_____ Minutes (DK = 99)
Was there any cost to travel to the <FIRST/LAST HEALTH PROVIDER> or pay for (your / the mother's) care there?	1. Yes 2. No 9. Don't know	S4.24 <input type="checkbox"/> 2 or 9 → SQ4.25	S4.34 <input type="checkbox"/> 2 or 9 → SQ4.35

CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE

<p>How did (you / the mother) arrange for the money for these expenses? <i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Had available 2. Borrowed..... 3. Sold assets 4. Help from kin/relatives..... 5. Community fund..... 6. Govt. scheme..... 7. Other..... 9. Don't know 	<p>S4.24.1</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/> 	<p>S4.34.1</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/>
<p>What transportation method was used to go there? <i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Walk..... 2. Rickshaw/cart boat..... 3. Bus..... 4. Taxi/auto/trecker 5. Ambulance 6. Other..... 7. Could not arrange transport 9. Don't know 	<p>S4.25</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> If <u>only</u> walk 2. <input type="checkbox"/> → SQ4.26.1 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> → SQ4.26.1 9. <input type="checkbox"/> 	<p>S4.35</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> If <u>only</u> walk 2. <input type="checkbox"/> → SQ4.36.1 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> → SQ4.36.1 9. <input type="checkbox"/>
<p>How much did the transportation cost?</p>		<p>S4.26</p> <p>_____ unit (DK = 9999)</p>	<p>S4.36</p> <p>_____ unit (DK = 9999)</p>
<p>Did (you / the mother) reach the <FIRST/LAST HEALTH PROVIDER> before delivering the baby? <i>If "No," discuss with respondent to reach correct response: 2, 3 or 4.]</i></p>	<ol style="list-style-type: none"> 1. Yes, reached before delivering 2. No, delivered before setting out 3. No, delivered on route to provider 4. No, could not reach this provider – did not set out/returned home/took other action 9. Don't know 	<p>S4.26.1</p> <p><input type="checkbox"/> 2, 3 → Inst_8 4, 9 → Inst_7</p>	<p>S4.36.1</p> <p><input type="checkbox"/> 2-9 → Inst_8</p>
<p>How long did it take to travel to the <FIRST/LAST HEALTH PROVIDER>? <i>[Mark hours &/or minutes as needed: e.g. 05 hours, 30 minutes]</i></p>		<p>S4.27</p> <p>_____ Hours (DK = 99)</p>	<p>S4.37</p> <p>_____ Hours (DK = 99)</p>
		<p>_____ Minutes (DK = 99)</p>	<p>_____ Minutes (DK = 99)</p>
<p>What did the <FIRST/LAST HEALTH PROVIDER> do for (your / the mother's) (labor or delivery symptom(s) / delivery)? <i>Prompt: Was there anything else?</i> <i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Gave oxygen for the baby..... 2. Gave antibiotics by mouth..... 3. Gave antimalarial by mouth 4. Gave BP medicine by mouth..... 5. Other medicine by mouth (<i>specify</i>)..... 6. Gave medicine to stop bleeding.... 7. Gave medicine to stop convulsions..... 8. Gave medicine to strengthen labor..... 9. Gave medicine to stop labor 10. Gave medicine for baby's lungs 11. Gave IM medicine 12. Gave IV fluids or medicine 13. Blood transfusion 14. Advised to buy outside medicine... 15. Uterine massage..... 16. Did a C-section 17. Did another operation (<i>specify</i>)..... 18. Admitted to hospital..... 19. Other (<i>specify</i>) 20. Nothing..... 99. Don't know 	<p>S4.28</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> 14. <input type="checkbox"/> 15. <input type="checkbox"/> 16. <input type="checkbox"/> 17. <input type="checkbox"/> 18. <input type="checkbox"/> stayed ___ days 19. <input type="checkbox"/> 20. <input type="checkbox"/> → SQ4.30 99. <input type="checkbox"/> → SQ4.30 	<p>S4.38</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> 14. <input type="checkbox"/> 15. <input type="checkbox"/> 16. <input type="checkbox"/> 17. <input type="checkbox"/> 18. <input type="checkbox"/> stayed ___ days 19. <input type="checkbox"/> 20. <input type="checkbox"/> → SQ4.40 99. <input type="checkbox"/> → SQ4.40
<p>How much did (you / the mother) pay for these treatments and other costs related to the health care, including any admission fee, consultation, lab tests, equipment, and room and food for companions?</p>		<p>S4.29</p> <p>_____ unit (DK = 99999)</p>	<p>S4.39</p> <p>_____ unit (DK = 99999)</p>

SA Module 5a: Care of the newborn; and VA Section 3: Neonatal deaths (FOR NN DEATHS <28 DAYS OLD)

S5a.1	What tool was used for cutting the cord?	1. New/from delivery kit/boiled razor blade 2. Old razor blade 3. Scissors 4. Other (<i>specify</i>)..... 9. Don't know	<input type="checkbox"/> <hr/>										
S5a.2	What material was used for tying the cord?	1. Clean/from delivery kit/boiled piece of thread 2. Unclean piece of thread 3. Cord clamp 4. Other (<i>specify</i>)..... 9. Don't know	<input type="checkbox"/> <hr/>										
S5a.3	Was anything applied to the umbilical cord stump after birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.1										
S5a.3. 1	What was it?	1. Alcohol/other antiseptic 2. Antibiotic ointment/cream/powder 3. Mustard oil or ghee 4. Animal dung or dirt/mud 5. Other (<i>specify</i>)..... 9. Don't know	<input type="checkbox"/> <hr/>										
V3.1	Were there any bruises or signs of injury on the baby's body at birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>										
V3.2	Was any part of the baby physically abnormal at time of delivery? (for example: body part too large or too small, additional growth on body)	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.4										
V3.3	What were the abnormalities? <i>Ask for the following abnormalities: [Mark all that apply – Show photos]</i>	1. Was the head size very small at the time of birth 2. Was the head size very large at the time of birth 3. Was there a mass defect on the back of head or spine..... 4. Was there any other abnormality..... <i>(If "Yes," then specify)</i>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; border: none;"><i>Yes</i></td> <td style="text-align: center; border: none;"><i>No</i></td> </tr> <tr> <td style="text-align: center; border: none;">1. <input type="checkbox"/></td> <td style="text-align: center; border: none;">2. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center; border: none;">1. <input type="checkbox"/></td> <td style="text-align: center; border: none;">2. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center; border: none;">1. <input type="checkbox"/></td> <td style="text-align: center; border: none;">2. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center; border: none;">1. <input type="checkbox"/></td> <td style="text-align: center; border: none;">2. <input type="checkbox"/></td> </tr> </table> <hr/>	<i>Yes</i>	<i>No</i>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>
<i>Yes</i>	<i>No</i>												
1. <input type="checkbox"/>	2. <input type="checkbox"/>												
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1. <input type="checkbox"/>	2. <input type="checkbox"/>												
1. <input type="checkbox"/>	2. <input type="checkbox"/>												
V3.4	Did the baby breathe immediately after birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 → VQ3.6										
V3.5	Did the baby have difficulty breathing?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>										
V3.6	Was anything done to try to help the baby breathe at birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>										
V3.7	Did the baby cry immediately after birth?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 1 → VQ3.9										
V3.8	How long after birth did the baby first cry? <i>[Mark ONE response]</i>	1. Within 5 minutes 2. Within 6-30 minutes 3. More than 30 minutes 4. Never 9. Don't know	<input type="checkbox"/> 4 → SQ5a.4										

Study ID#

Village/Cluster				HH		Child			

**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

V3.9	Did the baby stop being able to cry?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5a.4																																										
V3.10	How long before the baby died did the baby stop crying?	1. Less than one day 2. One day or more 9. Don't know	<input type="checkbox"/>																																										
S5a.4	How long after birth was the baby first bathed?	1. Less than 1 hour 2. 1-23 hours 3. 24-72 hours (1-3 days) 4. More than 72 hours (3 days) 5. Not bathed 9. Don't know	<input type="checkbox"/>																																										
S5a.5	Was anything done to keep the baby warm on the first day after birth	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5a.6																																										
S5a.5. 1	What was done? <i>[Multiple answers allowed.]</i> <i>For each mentioned, ask:</i> How soon after birth was this done?	1. Dried/wiped 2. Wrapped in a blanket 3. Skin-to-skin contact 4. Incubator 5. Other <i>(specify other)</i>	<table border="1" style="width: 100%;"> <tr> <th style="width: 15%;">Done</th> <th colspan="5">How soon after birth</th> </tr> <tr> <td></td> <th><1hr</th> <th><6</th> <th>6-24</th> <th>>24</th> <th>DK</th> </tr> <tr> <td>1. <input type="checkbox"/> ...</td> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>4. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>2. <input type="checkbox"/> ...</td> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>4. <input type="checkbox"/></td> <td>8. <input type="checkbox"/></td> </tr> <tr> <td>3. <input type="checkbox"/> ...</td> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>4. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>4. <input type="checkbox"/> ...</td> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>4. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>5. <input type="checkbox"/> ...</td> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>4. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> </table>	Done	How soon after birth						<1hr	<6	6-24	>24	DK	1. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	9. <input type="checkbox"/>	2. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	8. <input type="checkbox"/>	3. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	9. <input type="checkbox"/>	4. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	9. <input type="checkbox"/>	5. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	9. <input type="checkbox"/>
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2. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	8. <input type="checkbox"/>																																								
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5. <input type="checkbox"/> ...	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	9. <input type="checkbox"/>																																								
S5a.6	Did (you / the mother) or a wet nurse ever breastfeed the baby?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5a.7																																										
S5a.6. 1	How long after birth was the baby first put to the breast? <i>[If immediately or less than 1 hour, record '00' hours.]</i> <i>[If less than 24 hours, record hours; otherwise record days.]</i>		<table style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;"> ____ Days (DK = 99) </td> <td style="width: 10%; text-align: center; vertical-align: middle;">OR</td> <td style="width: 40%; text-align: center;"> ____ Hours (DK = 99) </td> </tr> </table>	____ Days (DK = 99)	OR	____ Hours (DK = 99)																																							
____ Days (DK = 99)	OR	____ Hours (DK = 99)																																											
S5a.6. 2	Was the baby being breastfed at the time when the fatal illness began?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																																										
S5a.7	At the time the fatal illness began, was the baby being given any other liquid, including non-human milk or formula, fruit juice, tea or water, or any semisolid or soft foods such as cereal? <i>[Multiple answers allowed. Probe, and record all liquids and foods given.]</i>	1. Non-human milk or pre-mixed formula .. 2. Powdered formula mixed with a liquid ... 3. Juice, water and/or water-based drinks. 4. ORS 5. Drops or syrups (vitamins, medicines) 6. Semi-solid or soft foods 7. Nothing else, <u>only</u> given breast milk 9. Don't know.....	1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/>																																										
V3.11	Was the baby able to suckle in a normal way during the first day of life?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 1 → VQ3.13																																										
V3.12	Did the baby ever suckle in a normal way?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.17																																										
V3.13	Did the baby stop being able to suckle in a normal way?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.17																																										
V3.14	How long after birth did the baby stop suckling? <i>[Less than 24 hours = "00" days]</i>		____ Days (DK = 99)																																										

Study ID#

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CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
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V3.15	How long before s/he died did the baby stop suckling?	1. Less than one day 2. One day or more 9. Don't know	<input type="checkbox"/>
V3.16	Was the baby able to open her/his mouth at the time s/he stopped suckling?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.17	During the illness that led to death, did the baby have difficult breathing?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.20
V3.18	At what age did the difficult breathing start? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.19	For how many days did the difficult breathing last? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.20	During the illness that led to death, did the baby have fast breathing?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.23
V3.21	At what age did the fast breathing start? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.22	For how many days did the fast breathing last? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.23	During the illness that led to death, did the baby have indrawing of the chest? [Show photo]	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.24	During the illness that led to death, did the baby have grunting? [Demonstrate grunting]	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.25	During the illness that led to death, did the baby have spasms or convulsions?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.26	During the illness that led to death, did the baby have fever?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.29
V3.27	At what age did the fever start? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.28	How many days did the fever last? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.29	During the illness that led to death, did the baby become cold to touch?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.32
V3.30	At what age did start feeling cold to touch? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.31	How many days did the baby feel cold to touch? [Less than 24 hours = "00" days]		___ ___ Days (DK = 99)
V3.32	During the illness that led to death, did the baby become lethargic, after a period of normal activity?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>

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**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
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V3.33	During the illness that led to death, did the baby become unresponsive or unconscious?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.34	During the illness that led to death, did the baby have a bulging fontanelle? <i>[Show photo]</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.35	During the illness that led to death, did the baby have pus drainage from the umbilical cord stump?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.36	During the illness that led to death, did the baby have redness of the umbilical cord stump?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.38
V3.37	Did the redness of the umbilical cord stump extend onto the abdominal skin?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.38	During the illness that led to death, did the baby have skin bumps containing pus or a single large area with pus?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.39	During the illness that led to death, did the baby have ulcer(s) (pits)?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.40	During the illness that led to death, did the baby have an area(s) of skin with redness and swelling?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.41	During the illness that led to death, did s/he have areas of the skin that turned black?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.42	During the illness that led to death, did the baby bleed from anywhere?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.44
V3.43	Record from where did the baby bleed:		
V3.44	During the illness that led to death, did s/he have more frequent loose or liquid stools than usual?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ3.46
V3.45	How many stools did the baby have on the day that diarrhea/loose liquid stools were most frequent?		____ Stools (DK = 99)
V3.46	During the illness that led to death, did s/he vomit everything?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.47	During the illness that led to death, did s/he have yellow skin?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.48	During the illness that led to death, did the baby have yellow eyes?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V3.49	Did the infant appear to be healthy and then just die suddenly?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
S5a.8	<i>Check SQ4.17 to determine if the baby was born in a health facility (codes 1-2):</i>	1. Yes, born in a health facility 2. Not born in a health facility 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5a.10
S5a.8.1	Did the baby leave the delivery facility alive or did s/he die in the facility?	1. Yes, left alive 2. Died in the facility 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ6.1

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**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
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S5a.8. 2	How soon after birth did the baby leave the facility? <i>[Mark hours if less than 1 day. 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S5a.9	Did (you / the mother) receive any counselling by a health worker prior to discharge?	1. Yes 2. No 9. Don't know <input style="width: 30px; height: 20px; margin-left: 10px;" type="checkbox"/> 2 or 9 → SQ5a.10																																																																																																																																																																																																		
S5a.9. 1	What (were you / was she) counselled on? <i>[Multiple answers allowed].</i> Probe: Anything else?	1. Breastfeeding 2. Immunization 3. Post-natal care attendance 4. Danger signs of newborn illness 5. Other (specify) 9. Don't know 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 9. <input type="checkbox"/>																																																																																																																																																																																																		
S5a.10	Was the baby ever seen by a health worker or nurse at home or in the community, or by a doctor or nurse at a health facility <u>before</u> the fatal illness began? <i>[Multiple answers allowed.]</i> For each mentioned, ask: How many times was the baby seen by a <PROVIDER TYPE at PLACE> before the fatal illness began? Then ask: When was the baby first seen by (this / <u>any</u> of these) provider(s)?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 15%; text-align: center;">Seen</th> <th style="width: 15%; text-align: center;">Times</th> <th style="width: 30%; text-align: center;">First visit</th> </tr> </thead> <tbody> <tr> <td>1. CHW or nurse at home/in community....</td> <td style="text-align: center;">1. <input type="checkbox"/> ...</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> </tr> <tr> <td>2. Doctor or nurse at a health facility</td> <td style="text-align: center;">2. <input type="checkbox"/> ...</td> <td style="text-align: center;">.....</td> <td style="text-align: center;">.....</td> </tr> <tr> <td>3. Never seen</td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td></td> <td></td> </tr> <tr> <td>9. Don't know.....</td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td></td> <td></td> </tr> </tbody> </table> <div style="margin-left: 100px;"> Days old (<1 = 00; DK = 99) </div>		Seen	Times	First visit	1. CHW or nurse at home/in community....	1. <input type="checkbox"/>	2. Doctor or nurse at a health facility	2. <input type="checkbox"/>	3. Never seen	3. <input type="checkbox"/>			9. Don't know.....	9. <input type="checkbox"/>																																																																																																																																																																																
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S5a.11	Before the fatal illness began, did <NAME> suffer from any of the following known conditions: <i>[Read out all conditions and check "Yes," "No" or "Don't know" for each.]</i> If "Yes," then ask: Was s/he provided any treatment for this condition?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="3" style="text-align: center;">Suffered from</th> <th colspan="3" style="text-align: center;">Treatment</th> </tr> <tr> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>1. 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SA Module 5b: Preventive care of post-neonates (FOR CHILD DEATHS 28 DAYS—59 MONTHS OLD)																								
<i>Read:</i> Now I would like to ask you about the care of the child before the fatal illness began.																								
S5b.1	Where (do you / does the mother) cook?	1. Inside the house 2. Outside the house 3. In a structure outside the house 9. Don't know	<input type="checkbox"/>																					
S5b.2	When (you / the mother) cooked, was <NAME> usually beside or carried by (you / her)?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																					
S5b.3	<i>Skip SQ5b.3 in areas wo/malaria.</i> Before (her / his) fatal illness began, did <NAME> sleep under an insecticide treated bednet?	1. Yes, usually or always 2. Yes, sometimes 3. Never 9. Don't know	<input type="checkbox"/>																					
S5b.4	Did (you / the mother) or a wet nurse ever breastfeed <NAME>?	3. Yes 4. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5b.5																					
S5b.4.1	Was <NAME> being breastfed at the time (her / his) fatal illness began?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 1 or 9 → SQ5b.5																					
S5b.4.2	How old was <NAME> when s/he was last breastfed?	_____ Months (<1 = 00; DK = 99)																						
S5b.5	At the time the fatal illness began, was <NAME> being given any other liquid, including non-human milk or formula, fruit juice, tea or water, or any solid, semisolid, or soft foods? <i>[Multiple answers allowed. Probe, and record all liquids and foods given.]</i>	1. Non-human milk or pre-mixed formula ... 2. Powdered formula mixed with a liquid ... 3. Juice, water and/or water-based drinks. 4. ORS 5. Drops or syrups (vitamins, medicines)... 6. Solid, semi-solid or soft foods..... 7. Nothing else, <u>only</u> given breast milk 9. Don't know.....	1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/> <div style="margin-left: 20px;"> } → SQ5b.6 } → SQ5b.6 </div>																					
S5b.5.1	On most days <u>before</u> the illness began, how many <u>times</u> did <NAME> eat solid, semisolid, or soft foods other than liquids during the day or night?	_____ Times (DK = 99)																						
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S5b.5.2	Which of the following food types did <NAME> typically eat <u>every</u> day? <i>[Read out all options and check "Yes," "No" or "Don't know" for each.]</i>	1. Grains, roots and tubers 2. Legumes and nuts 3. Dairy products (milk, yogurt, cheese) 4. Flesh foods (meat, fish, poultry, organs) 5. Eggs 6. Vitamin-A rich fruits and vegetables 7. Other fruits and vegetables	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Yes</th> <th style="text-align: left; padding: 2px;">No</th> <th style="text-align: left; padding: 2px;">DK</th> </tr> </thead> <tbody> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> </tbody> </table>	Yes	No	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>
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1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>																						
S5b.6	Did <NAME> drink any liquids or semi-solid foods from a bottle with a nipple or teat?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																					
S5b.7	Now I would like to ask about the child's vaccinations. Do you have a card where <NAME>'s vaccinations are written down? <i>If "Yes," ask, May I see it please?</i>	1. Yes, seen 2. Yes, but not seen 3. No card	<input type="checkbox"/> 2 or 3 → SQ5b.8																					

Study ID#

Village/Cluster				HH				Child			

**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

.8	A Hep B vaccination, that is, an injection in the right thigh, sometimes given at the same time as DPT?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5b.9																																																												
.9	How many times was a Hep B vaccination received?		____ Times (DK = 99)																																																												
S5b.9	Were any of the vaccinations <NAME> received given as part of a national immunization day campaign?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ5b.10																																																												
S5b.9.1	At which national immunization day campaigns did <NAME> receive vaccinations? [Record all campaigns mentioned.]	1. <CAMPAIGN 1> (TYPE/DATE)..... 2. <CAMPAIGN 1> (TYPE/DATE)..... 3. <CAMPAIGN 1> (TYPE/DATE)..... 4. <CAMPAIGN 1> (TYPE/DATE).....	1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/>																																																												
S5b.10	In the (six months / <NAME'S AGE>) before the fatal illness, did <NAME> receive one or more vitamin A doses like this? [Read the question with the child's age if s/he lived less than 6 months.] [Show ampoule/capsule/syrup]	1. Yes, 1 dose 2. Yes, 2 or more doses 3. No 9. Don't know	<input type="checkbox"/>																																																												
S5b.11	Before the fatal illness began, did <NAME> suffer from any of the following known conditions: [Read out all conditions and check "Yes," "No" or "Don't know" for each.] If "Yes," then ask: Was s/he provided any treatment for this condition?	1. Low height or weight (malnutrition)..... 2. Malformation (from the time of birth): a. Head, neck and/or back b. Mouth/palate c. Heart d. Arms and/or legs 3. Asthma 4. Heart disease 5. Tuberculosis 6. Epilepsy/convulsion 7. HIV/AIDS 8. Other (specify other).....	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: center;">Suffered from</th> <th colspan="3" style="text-align: center;">Treatment</th> </tr> <tr> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> <th style="text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. 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VA Section 4: Infant and child deaths (FOR CHILD DEATHS 28 DAYS—59 MONTHS OLD)

Read: Now I'd like to ask you about <NAME>'s illness.

V4.1	During the illness that led to death, did the <NAME> have a fever?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.6
V4.2	How many days did the fever last? [Less than 24 hours = "00" days]		____ Days (DK = 99)
V4.3	Did the fever continue until death?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.6
V4.4	How severe was the fever?	1. Mild 2. Moderate 3. Severe 9. Don't know	<input type="checkbox"/>
V4.5	What was the pattern of the fever?	1. Continuous 2. On and off 3. Only at night 9. Don't know	<input type="checkbox"/>

V4.6	During the illness that led to death, did <NAME> have more frequent loose or liquid stools than usual?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.12
V4.7	How many stools did <NAME> have on the day that loose liquid stools were most frequent?		____ Stools (DK = 99)
V4.8	How many days before death did the frequent loose or liquid stools start? <i>[Less than 24 hours = "00" days]</i>		____ Days (DK = 99)
V4.9	Did the frequent loose or liquid stools continue until death?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 1 or 9 → VQ4.11
V4.10	How many days before death did the loose or liquid stools stop? <i>[Less than 24 hours = "00" days]</i>		____ Days (DK = 99)
V4.11	Was there visible blood in the loose or liquid stools?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.12	During the illness that led to death, did the child have a cough?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.16
V4.13	For how many days did the cough last? <i>[Less than 24 hours = "00" days]</i>		____ Days (DK = 99)
V4.14	Was the cough very severe?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.15	Did the child vomit after s/he coughed?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.16	During the illness that led to death, did <NAME> have difficult breathing?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.18
V4.17	For how many days did the difficult breathing last? <i>[Less than 24 hours = "00" days]</i>		____ Days (DK = 99)
V4.18	During the illness that led to death, did <NAME> have fast breathing?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.20
V4.19	For how many days did the fast breathing last? <i>[Less than 24 hours = "00" days]</i>		____ Days (DK = 99)
V4.20	During the illness that led to death, did s/he have indrawing of the chest?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.21	During the illness that led to death, did her/his breathing sound like any of the following? <i>[Demonstrate each sound]</i>		
V4.22	Stridor	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.23	Grunting	1. Yes 2. No 9. Don't know	<input type="checkbox"/>

V4.24	Wheezing	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.25	Did <NAME> experience any generalized convulsions or fits during the illness that led to death?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.26	Was <NAME> unconscious during the illness that led to death?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.28
V4.27	How long before death did unconsciousness start?	1. Less than 6 hours 2. 6-23 hours 3. 24 hours or more 9. Don't know	<input type="checkbox"/>
V4.28	Did <NAME> have a stiff neck during the illness that led to death? <i>[Demonstrate]</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.29	Did <NAME> have a bulging fontanelle during the illness that led to death? <i>[Show photo]</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.30	During the month before s/he died, did <NAME> have a skin rash?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.35
V4.31	Where was the rash?	1. Face 2. Trunk/Abdomen 3. Extremities 4. Everywhere 9. Don't know	<input type="checkbox"/>
V4.32	Where did the rash start?	1. Face 2. Trunk/Abdomen 3. Extremities 4. Everywhere 9. Don't know	<input type="checkbox"/>
V4.33	How many days did the rash last?		____ ____ Days (DK = 99)
V4.34	Did the rash have blisters containing clear fluid?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.35	During the illness that led to death, did <NAME>'s limbs (legs, arms) become very thin? <i>[Show photo]</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
V4.36	During the illness that led to death, did <NAME> have swollen legs or feet?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.38
V4.37	How long did the swelling last? <i>[Record days or weeks.]</i>		____ ____ Days (DK = 99)
			____ ____ Weeks (DK = 99)
V4.38	During the illness that led to death, did <NAME>'s skin flake off in patches?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>

V4.39	Did <NAME>'s hair change in color to a reddish or yellowish color?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V4.40	Did <NAME> have a protruding belly?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V4.41	During the illness that led to death, did <NAME> suffer from "lack of blood" or "pallor"?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V4.42	During the illness that led to death, did <NAME> have swelling in the armpits?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V4.43	During the illness that led to death, did <NAME> have a whitish rash inside the mouth or on the tongue?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>																								
V4.44	During the illness that led to death, did <NAME> bleed from anywhere?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → VQ4.46																								
V4.45	<i>Record from where s/he bled:</i>																										
V4.46	During the illness that led to death, did s/he have areas of the skin that turned black?	3. Yes 4. No 8. Don't know	<input type="checkbox"/>																								
V4.47	<p>Did <NAME> suffer from an injury or accident such as...?</p> <p><i>[Ask the respondent each in sequence and mark each as "Yes," "No" or "Don't know."]</i></p>	<p>1. a road traffic crash/injury?</p> <p>2. a fall?</p> <p>3. drowning?</p> <p>4. poisoning?</p> <p><u>Did s/he suffer:</u></p> <p>5. a bite or sting by a venomous animal? ..</p> <p>6. a burn?</p> <p>7. from violence (homicide, abuse)?</p> <p>8. any other injury?</p> <p><i>(If "Yes," then specify).....</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Yes</th> <th style="text-align: left; border-bottom: 1px solid black;">No</th> <th style="text-align: left; border-bottom: 1px solid black;">DK</th> </tr> </thead> <tbody> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> </tbody> </table> <p style="text-align: right; margin-top: 10px;">All = 2 or 9 → SQ6.1</p>	Yes	No	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>
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V4.48	Was the injury or accident intentionally inflicted by someone else?	1. Yes 2. No 8. Don't know	<input type="checkbox"/>																								
V4.49	<p>How long did <NAME> survive after the injury or accident?</p> <p><i>[Record hours if less than 24 hours—Less than 1 hour = "00" hours; Record days if 1 day or more.]</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50px; border-bottom: 1px solid black;"></td> <td style="width: 50px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Hours</td> </tr> <tr> <td colspan="3"><i>(DK = 99)</i></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: right;">Days</td> </tr> <tr> <td colspan="3"><i>(DK = 99)</i></td> </tr> </table>				Hours	<i>(DK = 99)</i>					Days	<i>(DK = 99)</i>														
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SA Module 6: Care-seeking for the child's fatal illness (FOR NN & CHILD DEATHS 0—59 MONTHS OLD)

Read: Now, I'd like to ask you about <NAME>'s fatal illness and the care and treatments that s/he received.

S6.1	Who first noticed that <NAME> was ill?	1. The respondent 2. Other relative, neighbor, friend 3. CHW or nurse at home or in community 4. Doctor or nurse at a health facility 5. Other (<i>specify</i>)..... _____	<input type="checkbox"/> _____																
S6.2	Earlier you said that <NAME> had <SYMPTOM(S)> during her/his illness. <i>[Read back all the child's symptoms from the list at the end of the VA.]</i> How did <SQ6.1 PERSON> first know that <NAME> was ill? Which of these symptoms did s/he have at that time? What symptoms did s/he have next? On what day of the illness did these symptoms start? <i>[Probe until all the symptoms are recorded in the order they appeared.]</i>	Symptoms in order of appearance	Illness day the symptom started																
		1.																	
		2.																	
		3.																	
		4.																	
		5.																	
		6.																	
S6.3	When <SQ6.1 PERSON> first noticed that <NAME> was ill, was s/he... <i>[Read the choices for each condition.]</i>	1. Feeding normally, poorly, or not at all.... 2. Alert, drowsy, or unconscious..... 3. Normally active, less active than normal, or not moving	<table border="1" style="font-size: small; border-collapse: collapse; width: 100%;"> <tr> <td style="text-align: center;"><u>Normal</u></td> <td style="text-align: center;"><u>Medium</u></td> <td style="text-align: center;"><u>Abnormal</u></td> <td style="text-align: center;"><u>DK</u></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> </table>	<u>Normal</u>	<u>Medium</u>	<u>Abnormal</u>	<u>DK</u>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>
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S6.4	Did <NAME> receive, or did you <u>seek</u> or <u>try to seek</u> , any care or treatment for the fatal illness?	1. Yes 2. No—care not needed, given or sought 3. No—died immediately 9. Don't know	<input type="checkbox"/> 2 → SQ6.6 3 or 9 → VQ5.10																

S6.5 Please tell me everything you did for <NAME>'s fatal illness inside the home and all the places outside the home you took or tried to take (her / him) for health care. Start with the first care or treatment <NAME> received and then, in order, tell me all the other care and treatments s/he received. Also tell me when and for what symptoms you took each action.

[Include any provider <NAME> did not reach because s/he died before leaving home or on route.]

(1) Check one other care or health provider box for each action row. (2) For neonatal deaths only: If the illness began at the health provider where the child was delivered, then mark that as Action 1 and check the "illness began at provider" box. (3) Record the illness day each action was taken. (4) Ensure no action was taken for a symptom before it started (in SQ6.1).

Action #	(1) Other care			(1) Health Providers				(2) Illness began at provider where child was delivered	(3) Illness day the action was taken	(4) For what symptom(s) was the action taken?
	Home care (own, relative, neighbor, friend)	Traditional or non-formal provider	Pharmacist or drug seller	Trained CH Worker, nurse, or midwife	Private doctor (formal/unsure)	NGO or govt. clinic	Hospital			
	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____-____ (DK = 99)	
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____-____ (DK = 99)	

Study ID#

Village/Cluster				HH		Child	

**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(DK = 99)
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(DK = 99)
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(DK = 99)
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		(DK = 99)

**Inst_1: (For neonatal deaths only) If illness began at health provider where child was delivered:
And did not fill L&D matrix (module 4) → SQ6.10; And filled L&D matrix (module 4) → SQ6.16**

S6.6	<p>If no care given or sought, ask: Who decided that <NAME> did not need any care or treatment for the illness?</p> <p>If any care given or sought, ask: Who decided that <ACTION 1> was the first thing to do for <NAME>'s illness?</p> <p>[Record the one main decision maker.]</p>	<p>1. Child's mother</p> <p>2. Child's father</p> <p>3. Child's aunt.....</p> <p>4. Child's uncle</p> <p>5. Child's grandmother</p> <p>6. Child's paternal grandfather</p> <p>7. Child's maternal grandfather</p> <p>8. Other (specify).....</p> <p>9. Don't know</p>	<p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/></p> <p>5. <input type="checkbox"/></p> <p>6. <input type="checkbox"/></p> <p>7. <input type="checkbox"/></p> <p>8. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p>
S6.7	<p>If <u>never</u> taken to a health provider, ask: Did you have any concerns or problems that kept you from taking <NAME> to a health provider during his/her illness?</p> <p>If <u>taken</u> to a health provider, ask: Did you have to overcome any concerns or problems to take <NAME> to the (first) health provider?</p>	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → Inst_2</p>
S6.7.1	<p>What concerns or problems did you have?</p> <p>Prompt: Was there anything else?</p> <p>[Multiple answers allowed.]</p>	<p>1. Did not think child was sick enough to need health care.....</p> <p>2. No one available to go with caregiver.....</p> <p>3. Too much time from her regular duties...</p> <p>4. Someone else (specify) had to decide ...</p> <p>5. Too far to travel</p> <p>6. No transportation available.....</p> <p>7. Cost (transport, health care, other).....</p> <p>8. Not satisfied with available health care ..</p> <p>9. Problem required traditional care</p> <p>10. Thought child was too sick to travel</p> <p>11. Thought child will die no matter what....</p> <p>12. Was late at night (transportation or provider not available)</p> <p>13. Other (specify).....</p> <p>99. Don't know</p>	<p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/></p> <p>5. <input type="checkbox"/></p> <p>6. <input type="checkbox"/></p> <p>7. <input type="checkbox"/></p> <p>8. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p> <p>10. <input type="checkbox"/></p> <p>11. <input type="checkbox"/></p> <p>12. <input type="checkbox"/></p> <p>13. <input type="checkbox"/></p> <p>99. <input type="checkbox"/></p>

**Inst_2: If SQ6.4 = 2 (No care given) or
If SQ6.5 ≠ "Health Provider" (Never took and never tried to take to a health provider) → SQ6.39**

S6.8	<p>Refer to SQ6.5 for the first health provider and related symptoms: You mentioned that you took <NAME> to the (first) health provider, I mean the <FIRST HEALTH PROVIDER> for <SYMPTOM(S)>. How long had <NAME> had (this / these) symptom(s) when it was decided to take him/her to the <FIRST HEALTH PROVIDER>?</p> <p>[Read "...to the first..." if took or tried to take to more than one health provider.]</p> <p>[Mark days, hours &/or minutes as needed: e.g. 00 day, 02 hours, 10 minutes]</p>	<p>____ Days (DK = 99)</p>
		<p>____ Hours (DK = 99)</p>
		<p>____ Minutes (DK = 99)</p>

<p>Did the child reach the <FIRST/LAST HEALTH PROVIDER> before s/he died? <i>[If "No," discuss with respondent to determine correct response: 2, 3 or 4.]</i></p>	<p>1. Yes, reached before child died 2. No, died before setting out 3. No, died on route to this provider 4. No, could not reach this provider – did not set out/returned home/took other action 9. Don't know</p>	<p>S6.14.1 <input type="checkbox"/> 2, 3 → SQ6.39 <input type="checkbox"/> 4, 9 → Inst_4</p>	<p>S6.29.1 <input type="checkbox"/> 2-9 → SQ6.39</p>
<p>How long did it take to travel to the <FIRST/LAST HEALTH PROVIDER>? <i>[Mark hours &/or minutes as needed: e.g. 02 hours, 10 minutes]</i></p>	<p>S6.15 _____ Hours (DK = 99) _____ Minutes (DK = 99)</p>	<p>S6.30 _____ Hours (DK = 99) _____ Minutes (DK = 99)</p>	
<p>What did the <FIRST/LAST HEALTH PROVIDER> do for <NAME>'s problem? <i>Prompt: Was there anything else?</i> <i>[Multiple answers allowed.]</i></p>	<p>1. Gave oxygen 1. <input type="checkbox"/> 2. Helped breathe with bag or mask.. 2. <input type="checkbox"/> 3. Gave fluids by mouth 3. <input type="checkbox"/> 4. Gave antibiotics by mouth 4. <input type="checkbox"/> 5. Gave antimalarial by mouth..... 5. <input type="checkbox"/> 6. Gave ORS 6. <input type="checkbox"/> 7. Gave Vitamin A 7. <input type="checkbox"/> 8. Gave other medicine by mouth 8. <input type="checkbox"/> 9. Gave IM medicine 9. <input type="checkbox"/> 10. Gave IV fluids or medicine 10. <input type="checkbox"/> 11. Advised to buy outside medicine... 11. <input type="checkbox"/> 12. Did an operation (specify) 12. <input type="checkbox"/> 13. Admitted to hospital..... 13. <input type="checkbox"/> stayed ___ days 14. Other (specify)..... 14. <input type="checkbox"/> 15. Nothing..... 15. <input type="checkbox"/> → SQ6.18 99. Don't know 99. <input type="checkbox"/> → SQ6.18</p>	<p>S6.16 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> stayed ___ days 14. <input type="checkbox"/> 15. <input type="checkbox"/> → SQ6.18 99. <input type="checkbox"/> → SQ6.18</p>	<p>S6.31 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> stayed ___ days 14. <input type="checkbox"/> 15. <input type="checkbox"/> → SQ6.33 99. <input type="checkbox"/> → SQ6.33</p>
<p>How much did you pay for these treatments and other costs related to the health care, including the admission fee, consultation, lab tests, equipment, and room and food for companions?</p>	<p>S6.17 _____ unit (DK = 99999)</p>	<p>S6.32 _____ unit (DK = 99999)</p>	
<p>Did the <FIRST/LAST HEALTH PROVIDER> refer <NAME> to another health provider or facility?</p>	<p>1. Yes 2. No 9. Don't know</p>	<p>S6.18 <input type="checkbox"/> 2 or 9 → SQ6.19</p>	<p>S6.33 <input type="checkbox"/> 2 or 9 → SQ6.34</p>
<p>Why was <NAME> referred? <i>[Multiple answers allowed.]</i></p>	<p>1. The provider was not capable of managing the problem..... 1. <input type="checkbox"/> 2. Required supplies (e.g., drugs, IV, oxygen) not available..... 2. <input type="checkbox"/> 3. Required equipment (e.g., xray machine) not available..... 3. <input type="checkbox"/> 9. Don't know 9. <input type="checkbox"/></p>	<p>S6.18.1 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 9. <input type="checkbox"/></p>	<p>S6.33.1 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 9. <input type="checkbox"/></p>
<p>Did <NAME> leave the <FIRST/LAST HEALTH PROVIDER> alive?</p>	<p>1. Yes, left alive 2. No, died at this provider</p>	<p>S6.19 <input type="checkbox"/> 2 → VQ5.4</p>	<p>S6.34 <input type="checkbox"/> 2 → VQ5.4</p>
<p>Did the <FIRST/LAST HEALTH PROVIDER> suggest that you do anything for <NAME>'s illness after leaving?</p>	<p>1. Yes 2. No 9. Don't know</p>	<p>S6.20 <input type="checkbox"/> 2 or 9 → Inst_3</p>	<p>S6.35 <input type="checkbox"/> 2 or 9 → SQ6.37</p>

<p>What did the <FIRST/LAST HEALTH PROVIDER> suggest that you do?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Increase breastfeeding..... 2. Give extra fluids 3. Continue feeding 4. Give ORS 5. Give antibiotic by mouth..... 6. Give antimalarial by mouth..... 7. Give vitamin A by mouth 8. Return for follow-up visit..... 9. Return or referred if worse 10. Complete the present referral..... 11. Other (<i>specify</i>)..... 99. Don't know 	<p>S6.20.1</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 99. <input type="checkbox"/> → <i>Inst_3</i> 	<p>S6.35.1</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 99. <input type="checkbox"/> → <i>SQ6.37</i> 																																
<p>Were you able to follow <u>all</u> the advice?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<p>S6.21</p> <p><input type="checkbox"/> 9 → <i>Inst_3</i></p>	<p>S6.36</p> <p><input type="checkbox"/> 9 → <i>SQ6.37</i></p>																																
<p><i>If not able to follow all the advice, ask:</i> Did you have any concerns or problems that kept you from following the advice?</p> <p><i>If able to follow all the advice, ask:</i> Did you have to overcome any concerns or problems to follow the advice?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<p>S6.21.1</p> <p><input type="checkbox"/> 2 or 9 → <i>Inst_3</i></p>	<p>S6.36.1</p> <p><input type="checkbox"/> 2 or 9 → <i>SQ6.37</i></p>																																
<p>What concerns or problems did you have?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Did not understand instructions..... 2. Too much time from regular duties..... 3. Someone else (<i>specify</i>) decided 4. Cost too much 5. Problem required traditional care ... 6. Thought advised care not needed..... 7. Thought care might harm the child..... 8. Thought child will die despite care .. 9. No time before go to next provider..... 10. The child died too soon..... 11. Other (<i>specify</i>) 99. Don't know 	<p>S6.21.2</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 99. <input type="checkbox"/> 	<p>S6.36.2</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 99. <input type="checkbox"/> 																																
Inst_3: Check SQ6.5 → If taken to another health provider → SQ6.23																																			
<p><i>If not taken to another health provider, ask:</i> After leaving the (<FIRST HEALTH PROVIDER> / <LAST HEALTH PROVIDER>), was <NAME>...</p> <p><i>[Read the choices for each condition.]</i></p>	<ol style="list-style-type: none"> 1. Feeding normally, poorly, or not at all..... 2. Alert, drowsy, or unconscious 3. Normally active, less active than normal, or not moving..... 	<p>S6.22</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Nrml</th> <th style="text-align: left; border-bottom: 1px solid black;">Med</th> <th style="text-align: left; border-bottom: 1px solid black;">Abnrm</th> <th style="text-align: left; border-bottom: 1px solid black;">DK</th> </tr> </thead> <tbody> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> </tbody> </table>	Nrml	Med	Abnrm	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	<p>S6.37</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Nrml</th> <th style="text-align: left; border-bottom: 1px solid black;">Med</th> <th style="text-align: left; border-bottom: 1px solid black;">Abnrm</th> <th style="text-align: left; border-bottom: 1px solid black;">DK</th> </tr> </thead> <tbody> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td>2. <input type="checkbox"/></td> <td>3. <input type="checkbox"/></td> <td>9. <input type="checkbox"/></td> </tr> </tbody> </table>	Nrml	Med	Abnrm	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>
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<p><i>If not taken to another health provider, ask:</i> Did you have any concerns or problems that kept you from taking <NAME> to another health provider?</p> <p><i>If taken to another health provider, ask:</i> Did you have to overcome any concerns or problems to take <NAME> to another health provider?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<p>S6.23</p> <p><input type="checkbox"/> 2 or 9 → <i>Inst_4</i></p>	<p>S6.38</p> <p><input type="checkbox"/> 2 or 9 → <i>SQ6.39</i></p>																																

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Village/Cluster HH Child

**CHILD HEALTH EPIDEMIOLOGY REFERENCE GROUP
SB/NN/CHILD VERBAL/SOCIAL AUTOPSY QUESTIONNAIRE**

<p>What concerns or problems did you have? <i>Prompt: Was there anything else?</i> <i>[Multiple answers allowed.]</i></p>	<ol style="list-style-type: none"> 1. Thought no more care needed..... 2. No one available to go with her..... 3. Too much time from regular duties. 4. Someone else (<i>specify</i>) decided 5. Too far to travel..... 6. No transportation available..... 7. Cost (transport, health care, other) 8. Not satisfied with available care 9. Problem required traditional care ... 10. Thought child too sick to travel 11. Thought child will die despite care 12. Was late at night..... 13. The child died before going..... 14. Other (<i>specify</i>) 99. Don't know 	<p>S6.23.1</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> → SQ6.39 14. <input type="checkbox"/> 99. <input type="checkbox"/> 	<p>S6.38.1</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> 14. <input type="checkbox"/> 99. <input type="checkbox"/>
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Inst_4: Check SQ6.5 → If taken to another health provider... → go to SQ6.24 (LAST PROVIDER)

S6.39	<p>How many days after (first noticing the illness / <LAST ACTION SQ6.5> / leaving the first/last health provider) did <NAME> die? <i>[If SQ6.4 = 2 (No care given), then read: "...first noticing the illness..."]</i></p>	<p>_____ Days (<1 = 00; DK = 99)</p>
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Inst_5: If SQ6.4 = 2 (No care given) or if SQ6.5 ≠ "Health Provider" (Never took and never tried to take to a health provider) → VQ5.10

VA Section 5: Health records (FOR STILLBIRTHS, NEONATAL & CHILD DEATHS 0—59 MONTHS OLD)

V5.4	Do you have any health records that belonged to the deceased?	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<input type="checkbox"/> 2 or 9 → VQ5.10																																										
V5.5	Can I see the health records?	<ol style="list-style-type: none"> 1. Yes 2. No 	<input type="checkbox"/> 2 → VQ5.10																																										
V5.6	Record the dates of the two most recent visits	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td colspan="4"></td> </tr> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> <tr> <td colspan="6" style="text-align: center;">(DK = 99/99/9999)</td> </tr> <tr> <td colspan="6" style="text-align: center;"> </td> </tr> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td colspan="4"></td> </tr> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> <tr> <td colspan="6" style="text-align: center;">(DK = 99/99/9999)</td> </tr> </table>							D	D	M	M	Y	Y	(DK = 99/99/9999)																		D	D	M	M	Y	Y	(DK = 99/99/9999)						
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D	D	M	M	Y	Y																																								
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V5.7	Record the two most recent weights on those dates	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">_____</td> <td style="text-align: right;">Grams</td> </tr> <tr> <td colspan="2" style="text-align: center;">(DK = 9999)</td> </tr> <tr> <td colspan="2" style="text-align: center;"> </td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: right;">Grams</td> </tr> <tr> <td colspan="2" style="text-align: center;">(DK = 9999)</td> </tr> </table>	_____	Grams	(DK = 9999)				_____	Grams	(DK = 9999)																																		
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V5.8	Record the date of the last note	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> </td> <td style="text-align: center;"> </td> <td colspan="4"></td> </tr> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> <tr> <td colspan="6" style="text-align: center;">(DK = 99/99/9999)</td> </tr> </table>							D	D	M	M	Y	Y	(DK = 99/99/9999)																														
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V5.9	<i>Transcribe the note</i>		
	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>		
V5.10	Was a death certificate issued?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → SQ1.1
V5.11	Can I see the death certificate?	1. Yes 2. No	<input type="checkbox"/> 2 → SQ1.1
V5.12	<i>Record the immediate cause of death from the death certificate</i>		
V5.13	<i>Record the first underlying cause of death from the death certificate</i>		
V5.14	<i>Record the second underlying cause of death from the death certificate</i>		
V5.15	<i>Record the third underlying cause of death from the death certificate</i>		
V5.16	<i>Record the contributing cause of death from the death certificate</i>		

SA Module 1: The mother and her household (FOR STILLBIRTHS, NN & CHILD DEATHS 0—59 MONTHS OLD)

Read: Now I would like to ask you some other questions about (yourself / the child's mother).

[Read "...the child's mother." if the respondent is not the mother.]

Inst_1: If GQ4.3 = 1 (Respondent is the mother) → SQ1.4

S1.2	How old (is the child's mother / was the child's mother when she died)? <i>[Read "...was the child's mother..." if she died.]</i>	____ ____ Years (DK = 99)
S1.3	How many years of school did the mother complete?	____ ____ Years (<1 = 00; DK = 99)
S1.4	(Are you / Is/Was the child's mother)... <i>[Read "...Is/Was the child's mother..." if the respondent is not the mother.]</i> <i>[Read the choices to the respondent.]</i>	<input type="checkbox"/> 5 or 9 → Inst_2
S1.4.1	How old (were you when you /was she when she) first married (or lived with a man)? <i>[Read "...was she when she..." if the respondent is not the mother.]</i> <i>[Read "...married or lived with a man?" if SQ1.4 = "2. Living with a man"]</i>	____ ____ Years (DK = 99)

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S1.4.2	<p>How many years of school did (your / her) (husband / partner) complete?</p> <p><i>[Read "...her..." if the respondent is not the mother.]</i> <i>[Read "...partner..." if she is living with a man.]</i></p>	<p>____ Years (<1 = 00; DK = 99)</p>	
<p>Inst 2: Read: Now I would like to ask you some questions about (your / the mother's) household. Please remember that all information will be kept confidential.</p> <p><i>[SBs & NN deaths: If the respondent is not the mother, read "...the mother's..." and ask SQ1.5–1.11 about the mother's household.</i></p> <p><i>[Older deaths: Always read "...your..." and ask SQ1.5–1.11 about the respondent's household.]</i></p>			
S1.5	<p>Who was the main breadwinner of (your / the mother's) family during the (last days of the pregnancy / child's fatal illness)?</p> <p><i>[SBs/NN deaths: Read "...last days..."; Older deaths: Read "...child's..."]</i></p>	<p>1. Child's father 2. Child's mother 3. Other 9. Don't know</p>	<p><input type="checkbox"/> 9 → SQ1.7</p>
S1.6	<p>At that time, what kind of work did the main breadwinner mostly do?</p>	<p>1. Farmer/agricultural worker 2. Poultry or cattle raising 3. Domestic servant 4. Home-based manufacturing 5. Unskilled laborer 6. Semi-skilled laborer/service provider 7. Factory worker, blue collar service 8. Business owner 9. Professional/technician 10. Other (specify) 11. Overseas worker 99. Don't know</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>
S1.7	<p>Is this the house (where we are now) where (you / the mother) stayed during the (last days of the pregnancy / child's fatal illness)?</p> <p><i>[SBs/NN deaths: Read "...last days..." Older deaths: Read "...child's..."]</i></p> <p><i>[Read "...where we are now..." if needed to clarify which house you are talking about.]</i></p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 1 → SQ1.10 9 → VQ5.17</p>
S1.8	<p>Where did (you / the mother) stay at that time?</p> <p><i>Probe: Where did (you / the mother) stay during the illness events?</i></p> <p><i>[Mark "1" only if her usual residence was not her in-laws or other relatives.]</i></p>	<p>1. Her own home at that time (other than with her in-laws) (Interviewer: Use this code just if she moved after the death.) 2. Her in-law's home 3. Her parent's home 4. Her brother's home 5. Other (specify) 9. Don't know</p>	<p><input type="checkbox"/> 9 → VQ5.17</p>
S1.9	<p>What is the address of the place where (you / she) stayed?</p> <p>State _____</p> <p>District _____</p> <p>Block _____</p> <p>Village _____</p>	<p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	

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S1.10	<p><u>At the time of the illness events</u>, how long had (you / the mother / your <RELATIVES> / the mother's <RELATIVES>) been living continuously in (this / that) community?</p> <p><i>[Read "...<RELATIVES..." if SQ1.8 = 2-5 (s/he stayed with her/his relatives)].</i></p>	<p>____ ____ Years (<1 = 00; DK =99)</p>
S1.11	<p>How long does it take to reach the health provider or facility where (you / the mother) <u>normally</u> (go(es) / went) from (this / that) place?</p> <p><i>[Mark hours &/or minutes as needed: e.g. 01 hour, 30 minutes]</i></p>	<p>____ ____ Hours (DK = 99)</p> <hr/> <p>____ ____ Minutes (DK = 99)</p>

Inst 3 → SQ2.1.1 (if including optional Module 2) or VQ5.17

SA Module 2: Social capital (OPTIONAL MODULE—FOR SBs, NN & CHILD DEATHS 0–59 MONTHS OLD)

Read: Now, I have some questions about (your / the mother's / your <RELATIVES'> / the mother's <RELATIVES'>) community.

[SBs and NN deaths: If the respondent is not the mother, read "...the mother's..." or "...the mothers' <RELATIVES'>..." and ask SQ2.1.1–SQ2.3.1 about the mother and her community or her relatives' community.

Older deaths: Always read "...your..." or "...your <RELATIVES'>..." and ask SQ2.1.1–SQ2.3.1 about the respondent and her/his community or her/his relatives' community.

All deaths: Ask about the relatives' community if s/he stayed with her/his relatives during the illness events.]

S2.1.1	<p>In the last 3 years, did the people in your (village / neighborhood) work together on any of the following issues that affect the entire community or part of the community?</p> <p><i>Read all the issues and mark ("X") Yes, No or DK for each one; then enter the code.]</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr><td>1. Education/schools</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>2. Health services/clinics</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>3. Paid job opportunities</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>4. Credit/finance</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>5. Roads</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>6. 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Other</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td colspan="4" style="text-align: center;">(specify)</td></tr> </tbody> </table>		Yes	No	DK	1. Education/schools	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	2. Health services/clinics	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	3. Paid job opportunities	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	4. Credit/finance	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	5. Roads	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	6. Public transportation	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	7. 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S2.2	<p>(Were you / Was the mother) able to turn to any persons, groups or organizations in the community for help during (the pregnancy / (or) the child's fatal illness)?</p> <p><i>[Read "...the pregnancy?" for SBs; or "...the pregnancy or the child's fatal illness?" for NN deaths; or "...the child's fatal illness for older deaths.]</i></p>	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → SQ2.3.1</p>																																																											

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S2.2.1	<p>Did (you / she) turn to any of the following for help?</p> <p><i>[Read all the options and mark ("X") Yes, No or DK for each; then enter the code.]</i></p>	<ol style="list-style-type: none"> 1. Family..... 2. Neighbors..... 3. Friends 4. Religious leader or group 5. Community leader 6. Police..... 7. Patron/employer/benefactor 8. Political leader 9. Mutual support group s/he belongs to ... 10. Assistance organization to which s/he does not belong 11. Other <p><i>(specify).....</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Yes</th> <th style="text-align: left; border-bottom: 1px solid black;">No</th> <th style="text-align: left; border-bottom: 1px solid black;">DK</th> </tr> </thead> <tbody> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> </tbody> </table>	Yes	No	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>
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S2.2.2	<p>(Is this / Are these) the same person(s) or group(s) (you / she) would usually turn to for help with a serious problem?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<p><input type="checkbox"/></p>																																							
S2.3.1	<p>Have (you or your / the mother or her) family ever been denied any of the following community services?</p> <p><i>Read all the options and mark ("X") Yes, No or DK for each; then enter the code.]</i></p>	<ol style="list-style-type: none"> 1. Education/schools 2. Health services/clinics 3. Paid job opportunities..... 4. Credit/finance 5. Transportation 6. Water distribution 7. Sanitation services 8. Agricultural extension 9. Justice/conflict resolution..... 10. Security/police services..... 11. Other <p><i>(specify).....</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Yes</th> <th style="text-align: left; border-bottom: 1px solid black;">No</th> <th style="text-align: left; border-bottom: 1px solid black;">DK</th> </tr> </thead> <tbody> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> <tr><td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td></tr> </tbody> </table>	Yes	No	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>			
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V5.17	<p><i>Read:</i> Now I have three last questions about the child's mother.</p> <p>Has the deceased's (biological) mother ever been tested for "HIV"?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 8. Refused to answer 9. Don't know 	<p><input type="checkbox"/> 2-9 → VQ5.19</p>																																							
V5.18	<p>Was the "HIV" test ever positive?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 8. Refused to answer 9. Don't know 	<p><input type="checkbox"/></p>																																							
V5.19	<p>Has the deceased's (biological) mother ever been told she had "AIDS" by a health worker?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 8. Refused to answer 9. Don't know 	<p><input type="checkbox"/></p>																																							

