06 September 2007

GHANA MATERNAL MORTALITY SURVEY 2007
VERBAL AUTOPSY QUESTIONNAIRE

GHANA STATISTICAL SERVICE

IDENTIFICATION

LOCALITY NAME ______________________

NAME OF HOUSEHOLD HEAD ______________________

CLUSTER NUMBER . . . . [ ][ ][ ][ ]

STRUCTURE NUMBER . . . . [ ][ ][ ]

HOUSEHOLD NUMBER . . . . [ ][ ][ ]

REGION . . . . [ ][ ]

DISTRICT . . . . [ ][ ]

LARGE CITY/SMALL CITY/TOWN/RURAL (LARGE CITY=1, SMALL CITY=2, TOWN=3, RURAL=4) [ ]

NAME OF MAIN RESPONDENT ______________________

NAME OF DECEASED WOMAN ______________________

LINE NUMBER OF DECEASED WOMAN FROM HOUSEHOLD QUESTIONNAIRE . . . . [ ][ ]

RELATIONSHIP OF THE MAIN RESPONDENT TO THE DECEASED
(FATHER = 1, MOTHER = 2, HUSBAND = 3, BROTHER/SISTER = 4, CHILD = 5
OTHER RELATIVE = 6, NO RELATION = 7) [ ]

INTERVIEWER VISITS

	1	2	3	FINAL VISIT	
DATE	________	________	________	DAY	[ ][ ]
				MONTH	[ ][ ]
				YEAR	2 0 0 7
INTERVIEWER'S NAME	________	________	________	INT. NUMBER	[ ][ ][ ]
RESULT*	________	________	________	RESULT	[ ]
NEXT VISIT: DATE	________	________		TOTAL NUMBER OF VISITS	[ ]
TIME	________	________			

*RESULT CODES:

1 COMPLETED
2 NOT AT HOME
3 POSTPONED
4 REFUSED
5 PARTLY COMPLETED
6 APPROPRIATE PERSON NOT FOUND
7 OTHER ______________________ (SPECIFY)

LANGUAGE OF QUESTIONNAIRE: [1] LANGUAGE OF INTERVIEW: [ ] LANGUAGE OF RESPONDENT [ ]

LANGUAGE CODES: ENGLISH = 1, AKAN = 2, GA = 3, EWE = 4, NZEMA = 5, DAGBANI = 6 OTHER = 7

TRANSLATOR USED:
(YES = 1, NO = 2) [ ]

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME ________	NAME ________		
DATE ________ [ ][ ]	DATE ________ [ ][ ]	[ ][ ]	[ ][ ]

SECTION 1. DECEASED WOMAN'S BACKGROUND

INFORMED CONSENT

IDEALLY THE MAIN RESPONDENT SHOULD HAVE BEEN PRESENT AT THE TIME OF DEATH OF THE WOMAN FOR WHOM INFORMATION ON THE CAUSE OF DEATH IS BEING COLLECTED AND SHOULD HAVE THE BEST KNOWLEDGE ABOUT THE CIRCUMSTANCES AROUND THE WOMAN'S DEATH.

Hello. My name is _______________________________________ and I am working with the Ghana Statistical Service. We are conducting a national survey that asks about women's health issues. We would very much appreciate your participation in this survey. A few months ago when we visited your house, we were informed about the death of (NAME OF WOMAN AGE 12-49 WHO HAS DIED). I am here now to ask you about the circumstances that led to her death. This information will help the government to improve women's health services. The survey will take between 20 and 45 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer: ____________________ Date: ____________

RESPONDENT AGREES TO BE INTERVIEWED . . . . . 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED . . . 2 → END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME.	HOUR . . . . [ ][ ] MINUTES . . . . [ ][ ]	
102	In what day, month and year was (NAME) born?	DAY . . . . [ ][ ] DON'T KNOW DAY . . . . 98 MONTH . . . . [ ][ ] DON'T KNOW MONTH . . . . 98 YEAR . . . . [ ][ ][ ][ ]	
103	In what day, month and year did (NAME) die?	DAY . . . . [ ][ ] DON'T KNOW DAY . . . . 98 MONTH . . . . [ ][ ] DON'T KNOW MONTH . . . . 98 YEAR . . . . [2][0][ ][ ]	
103A	CHECK 103: DIED IN 2002, 2003, 2004, 2005, 2006 OR 2007 [ ] ↓ DIED BEFORE 2002 [ ] →		END
104	How old was (NAME) when she died? RECORD AGE IN COMPLETED YEARS. COMPARE AND CORRECT 102, 103 AND/OR 104 IF INCONSISTENT.	AGE AT DEATH . . . . [ ][ ]	
105	CHECK 104: AGE AT DEATH 12-49 [ ] ↓ AGE AT DEATH <12 OR 50 AND ABOVE [ ] →		END
106	What was (NAME'S) marital status?	NEVER MARRIED . . . . 1 MARRIED/LIVING WITH A PARTNER . . 2 SEPARATED . . . . 3 DIVORCED . . . . 4 WIDOWED 5	
107	What is the highest level of school (NAME) had attended: primary, middle/JSS, secondary/SSS, or higher?	PRIMARY . . . . 1 MIDDLE/JSS . . . . 2 SECONDARY/SSS . . . . 3 HIGHER . . . . 4 NEVER ATTENDED SCHOOL . . . . 5 DON'T KNOW 8	
108	Where did (NAME) die?	HOME . . . . 1 HEALTH FACILITY . . . . 2 SHRINE/PRAYER CAMP . . . . 3 OTHER ____________ 6 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
109	Where was (NAME'S) usual place of residence?	IN THIS HOUSE/LOCALITY . . . . 1 IN A DIFFERENT VILLAGE/TOWN . . . 2 OTHER ______________ 6 (SPECIFY)	
110	Where did the burial take place?	IN THIS HOUSE/LOCALITY . . . . 1 IN A DIFFERENT VILLAGE/TOWN . . . 2 OTHER ______________ 6 (SPECIFY)	

SECTION 2. OPEN HISTORY QUESTIONS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now could you please tell me about the illnesses and events leading to (NAME'S) death?		

NO.	QUESTIONS AND FILTERS		CODING CATEGORIES			SKIP
202	Before (NAME) died did any medical staff person ever say she had NAME OF DISEASE? READ EACH DISEASE BELOW AND RECORD IF RESPONDENT ANSWERS 'YES', ASK: For how many months or years prior to death was (NAME) diagnosed with NAME OF DISEASE?					
				MONTHS	YEARS	
01	High blood pressure?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	HIGH BLOOD PRESSURE	1 [ ][ ]	2 [ ][ ]	
02	Heart disease?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	HEART DISEASE	1 [ ][ ]	2 [ ][ ]	
03	Stroke?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	STROKE	1 [ ][ ]	2 [ ][ ]	
04	Mental disorder (including depression)?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	MENTAL	1 [ ][ ]	2 [ ][ ]	
05	HIV/AIDS?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	HIV/AIDS	1 [ ][ ]	2 [ ][ ]	
06	Diabetes?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	DIABETES	1 [ ][ ]	2 [ ][ ]	
07	Tuberculosis (TB)?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	TB	1 [ ][ ]	2 [ ][ ]	
08	Epilepsy?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	EPILEPSY	1 [ ][ ]	2 [ ][ ]	
09	Cancer? PROBE: Cancer of ________ ________	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	CANCER	1 [ ][ ]	2 [ ][ ]	
10	Asthma?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	ASTHMA	1 [ ][ ]	2 [ ][ ]	
11	Malaria?	YES . . . . 1 NO . . . . . . 2 DON'T KNOW. . 8	MALARIA	1 [ ][ ]	2 [ ][ ]	
12	Other chronic ilness:		OTHER ________	1 [ ][ ]	2 [ ][ ]	
203	What do you think was the cause of death? (WRITE EXACTLY AS THE RESPONDENT TELLS YOU). ________ ________ ________ ________ ________ ________ ________ ________					

SECTION 3. SIGNS AND SYMPTOMS DURING THE FINAL ILLNESS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	At this time I would like to ask you some questions concerning symptoms that (NAME) had/showed when she was ill. Some of these questions may not appear directly related to her health. Please bear with me and answer all the questions. Your answers will help us to get a clear picture of all possible symptoms that she may have had.		
301	For how long was (NAME) ill before she died?	DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ]	
302	Did (NAME) have a fever? IF YES, ASK: For how long did she have fever?	NO FEVER .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	NO FEVER → 303
302A	Was the fever continous or on and off?	CONTINOUS .... 1 ON AND OFF .... 2 DON'T KNOW 8	
302B	Did she have fever only at night?	YES .... 1 NO .... 2 DON'T KNOW 8	
302C	Did she have chills/rigor?	YES .... 1 NO .... 2 DON'T KNOW 8	
303	Did (NAME) have a cough? IF YES, ASK: For how long did she have a cough?	NO COUGH .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	NO COUGH → 304
303A	Was the cough severe?	YES .... 1 NO .... 2 DON'T KNOW 8	
303B	Was the cough productive with sputum?	YES .... 1 NO .... 2 DON'T KNOW 8	
303C	Did she cough out blood?	YES .... 1 NO .... 2 DON'T KNOW 8	
303D	Did she have night sweats?	YES .... 1 NO .... 2 DON'T KNOW 8	
304	Did (NAME) have trouble breathing? IF YES, ASK: For how long did she have breathlessness?	NO BREATHLESSNESS .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	NO BREATHLESSNESS → 305
304A	Was she unable to carry out daily routines due to breathlessness?	YES .... 1 NO .... 2 DON'T KNOW 8	
304B	Was she breathless while lying flat?	YES .... 1 NO .... 2 DON'T KNOW 8	
304C	Did she have wheezing?	YES .... 1 NO .... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
305	Did (NAME) have a chest pain? IF YES, ASK: For how long did she have a chest pain?	NO CHEST PAIN . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 306
305A	How did the chest pain start?	SUDDENLY . . . . 1 GRADUALLY . . . . 2 DON'T KNOW 8	
305B	Did she have severe chest pain? IF YES: How long did it last?	LESS THAN HALF AN HOUR . . . . 1 HALF HOUR TO 24 HOURS . . . . 2 MORE THAN 24 HOURS . . . . 3 NO SEVERE CHEST PAIN . . . . 4 DON'T KNOW 8	
305C	Was the chest pain located below the breastbone (sternum)?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
305D	Was the chest pain located over the heart and spread to the left arm?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
305E	Was the chest pain located over the ribs (sides)?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
305F	Was chest pain continous or on and off?	CONTINOUS . . . . 1 ON AND OFF . . . . 2 DON'T KNOW 8	
305G	Did the pain get worse while coughing?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
305H	Did she have palpitations?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
306	Did (NAME) have diarrhea? IF YES, ASK: For how long did she have diarrhea?	NO DIARRHEA . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 307
306A	Was the diarhea continous or on and off?	CONTINOUS . . . . 1 ON AND OFF . . . . 2 DON'T KNOW 8	
306B	At any time during the final ilness was there blood in the stool?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
306C	When the diarhea was worst, how many times did she pass stools in a day?	NUMBER OF TIMES . . . . [ ][ ] DON'T KNOW 98	
307	Did (NAME) vomit? IF YES, ASK: How long did she vomit?	NO VOMITTING . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 308
307A	What did it look like?	COFFEE-COLORED FLUID . . . . 1 BRIGHT RED/BLOOD RED . . . . 2 OTHER ______________________ 6 (SPECIFY) DON'T KNOW 8	
307B	When the vomitng was severe, how many times did she vomit in a day?	NUMBER OF TIMES . . . . [ ][ ] DON'T KNOW 98	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
308	Did (NAME) have abdominal pain? IF YES, ASK: How long did she have abdominal pains?	NO ABDOMINAL PAIN ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 309
308A	Was the abdominal pain severe?	YES .... 1 NO .... 2 DON'T KNOW 8	
309	Did (NAME) have abdominal distention? IF YES, ASK: How long did she have abdominal distention?	NO ABDOMINAL DISTENTION .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 310
309A	How quickly did the distention develop?	RAPIDLY, WITHIN DAYS .... 1 GRADUALLY, OVER MONTHS ...... 2 DON'T KNOW 8	
309B	Was there a period of a day or longer during which she did not pass any stool?	YES .... 1 NO .... 2 DON'T KNOW 8	
310	Did (NAME) have any mass in the abdomen? IF YES, ASK: How long did she have the mass?	NO MASS IN THE ABDOMEN .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 311
310A	Where was the mass located?	RIGHT UPPER ABDOMEN .... 1 LEFT UPPER ABDOMEN .... 2 LOWER ABDOMEN .... 3 ALL OVER ABDOMEN .... 4 DON'T KNOW 8	
311	Did (NAME) have any difficulty or pain while swallowing solids? IF YES, ASK: How long did she have difficulty or pain while swallowing solids?	NO DIFFICULTY SWALLOWING SOLIDS ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
312	Did she have any difficulty or pain while swallowing liquids? IF YES, ASK: How long did she have difficulty or pain while swallowing liquids?	NO DIFFICULTY SWALLOWING LIQUIDS ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
313	Did (NAME) have a headache? IF YES, ASK: How long did she have a headache?	NO HEADACHE ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 314
313A	Was the headache severe?	YES .... 1 NO .... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
314	Did she have stiff or painful neck? IF YES, PROBE: For how long did she have stiff or painful neck?	NO STIFF OR PAINFUL NECK . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	
315	Did she have mental confusion? IF YES, PROBE: For how long did she have mental confusion?	NO MENTAL CONFUSION . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 316
315A	How did the mental confusion start?	SUDDENLY . . . . 1 FAST (WITHIN A DAY) . . . . 2 SLOWLY (OVER MANY DAYS) . . . . . . 3 DON'T KNOW 8	
316	Did she become unconscious? IF YES, ASK: For how long was she unconscious?	WAS NOT UNCONSCIOUS . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 317
316A	How did the unconsciousness start?	SUDDENLY . . . . 1 FAST (WITHIN A DAY) . . . . 2 SLOWLY (OVER MANY DAYS) . . . . . . 3 DON'T KNOW 8	
317	Did she have convulsions? IF YES, ASK: For how long did she have convulsions?	NO CONVULSIONS . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	
318	Was she unable to open her mouth? IF YES, ASK: How long was she unable to open her mouth?	NO PROBLEM OPENING MOUTH . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	
319	Did she have stiffness of the whole body? IF YES, ASK: For how long did she have the stiffness?	NO STIFFNESS . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
320	Did she have paralysis of one side of the body? IF YES, ASK: For how long was one side of her body paralyzed?	NO PARALYSIS OF ONE SIDE ..... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 321
320A	How did the paralysis of one side of her body start?	SUDDENLY .... 1 FAST (WITHIN A DAY) .... 2 SLOWLY (OVER MANY DAYS) ...... 3 DON'T KNOW 8	
321	Did she have paralysis in the lower limbs? IF YES, ASK: For how long did she have paralysis in the lower limbs?	NO PARALYSIS OF LOWER LIMBS .. 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 322
321A	How did the paralysis in the lower limbs start?	SUDDENLY .... 1 FAST (WITHIN A DAY) .... 2 SLOWLY (OVER MANY DAYS) ...... 3 DON'T KNOW 8	
322	Did she have difficulty passing urine? IF YES, ASK: For how long did she have difficulty passing urine?	NO DIFFICULTY .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
323	Was there any change in the color of her urine? IF YES, ASK: How long did she have a change in the color of her urine?	NO CHANGE IN URINE COLOR .. 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
324	During the final illness, did (NAME) ever pass blood in the urine? IF YES, ASK: For how long did she have blood in the urine?	NO BLOOD IN URINE ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
325	Was there any change in the amount of urine she passed daily? IF YES, ASK: For how long did she have a change in the amount of urine she passed?	NO CHANGE IN URINE AMOUNT ..... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 326
325A	How much urine did she pass?	TOO MUCH .... 1 TOO LITTLE .... 2 NO URINE AT ALL .... 3 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
326	During the ilness that led to her death, did (NAME) have any skin rash? IF YES, ASK: For how long did she have the skin rash?	NO SKIN RASH . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 327
326A	Where was the rash located?	FACE . . . . 1 TRUNK . . . . 2 ARMS AND LEGS . . . . 3 OTHER ______________________ 6 (SPECIFY) DON'T KNOW 8	
326B	What did the rash look like?	MEASLES RASH . . . . 1 RASH WITH CLEAR FLUID . . . . 2 RASH WITH PUS . . . . 3 DON'T KNOW 8	
326C	Did she have red eyes?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
326D	Did she have bleeding from the nose, mouth or anus?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
327	Did she have weight loss? IF YES, ASK: For how long had she been losing weight?	NO WEIGHT LOSS . . . . 000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 328
327A	Did she look very thin and wasted?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
328	Did she have mouth sores? IF YES, ASK: For how long did she have mouth sores?	NO MOUTH SORES . . . . .000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	
329	Did she have any swelling? IF YES, ASK: For how long did she have swelling?	NO SWELLING . . . . .000 DAYS . . . . 1 [ ][ ] MONTHS . . . . 2 [ ][ ] DON'T KNOW 998	→ 330
329A	Where was the sweling? CIRCLE ALL MENTIONED.	FACE . . . . A JOINTS . . . . B ANKLES . . . . C WHOLE BODY . . . . D OTHER ______________________ X (SPECIFY) DON'T KNOW . . . . Y	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
330	Did she have any lumps? IF YES, ASK: For how long did she have lumps?	NO LUMPS ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 331
330A	Where were the lumps? CIRCLE ALL THAT APPLY	NECK .... A ARMPIT .... B GROIN .... C OTHER ________________________ X (SPECIFY) DON'T KNOW .... Y	
331	Did she have yellow discoloration of the eye? IF YES, ASK: For how long did she have the yellow discoloration of the eye?	NO DISCOLORATION ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
332	Did she look pale (lack of blood) or have pale palms, eyes or nail beds? IF YES, ASK: For how long was she pale?	NOTHING PALE ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
333	Did she have an ulcer, abscess, or sore anywhere on the body? IF YES, ASK: For how long did she have the ulcer, abscess or sore?	NO ULCER/ABSCESS/SORE ....000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	→ 401
333A	What was the location of the ulcer, abscess, or sore? CIRCLE ALL MENTIONED.	NECK .... A ARMPIT .... B GROIN .... C FACE .... D JOINTS .... E ANKLES .... F GENITALS .... G WHOLE BODY .... H OTHER ________________________ X (SPECIFY) DON'T KNOW .... Y	

SECTION 4. SIGNS AND SYMPTOMS DURING THE FINAL ILLNESS RELATED TO REPRODUCTIVE HEALTH

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Did (NAME) have an ulcer or swelling in the breast? IF YES, ASK: For how long did she have ulcer or swelling?	NO ULCER/SWELLING IN BREAST 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
402	Did (NAME) have excessive vaginal bleeding during menstrual periods? IF YES, ASK: For how long did she have excessive vaginal bleeing during menstrual periods?	NO EXCESSIVE BLEEDING .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
403	Did (NAME) have vaginal bleeding in between menstrual periods? IF YES, ASK: For how long did the condition last?	NO VAGINAL BLEEDING .... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
404	Did (NAME) have abnormal vaginal discharge? IF YES, ASK: For how long did she have abnormal vaginal discharge?	NO ABNORMAL DISCHARGE ..... 000 DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
405	Was (NAME) pregnant at the time of death?	YES .... 1 NO .... 2 UNSURE 8	NO, UNSURE → 406
405A	How long was (NAME) pregnant?	DAYS .... 1 [ ][ ] MONTHS .... 2 [ ][ ] DON'T KNOW 998	
405B	How many pregnancies did (NAME) have in total, including the last one?	NUMBER OF PREGNANCIES [ ][ ]	
405C	During the last 3 months of pregnany, did (NAME) suffer from any of the following ilnesses? Anything else? CIRCLE ALL MENTIONED.	VAGINAL BLEEDING .... A FOUL-SMELLING VAGINAL DISCHARGE .... B PUFFY FACE .... C HEADACHE .... D BLURRED VISION .... E CONVULSION .... F FEBRILE ILLNESS .... G SEVERE ABDOMINAL PAIN THAT WAS NOT LABOR PAINS ... H PALLOR AND SHORTNESS OF BREATH (BOTH PRESENT) ... I OTHER ________________________ X (SPECIFY) NONE .... Y DON'T KNOW .... Z	
405D	Did (NAME) die during labour, but undelivered?	YES .... 1 NO .... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
406	Did (NAME) give birth recently?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 → 407
406A	How many days after giving birth did (NAME) die?	NUMBER OF DAYS [ ][ ] DON'T KNOW 98	
406B	Was there excessive bleeding on the day labor started?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
406C	Was there excessive bleeding during labor before the baby was delivered?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
406D	Was there excessive bleeding after the baby was delivered?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
406E	Did (NAME) have difficulty in delivering the placenta?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
406F	Was (NAME) in labor for more than 24 hours?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
406G	Was it a normal vaginal delivery?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→406I →406I
406H	What type of delivery was it?	FORCEPS/VACUUM . . . . . 1 CAESARIAN SECTION . . . . . 2 OTHER ______ 6 (SPECIFY) DON'T KNOW 8	
406I	Did (NAME) have foul-smelling vaginal discharge?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
406J	Where did (NAME) give birth? IF SOURCE IS A HOSPITAL, HEALTH CENTER, OR CLINIC WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. ______ NAME OF PLACE	HOME RESPONDENT'S HOME . . . . . 01 OTHER HOME . . . . . 02 PUBLIC SECTOR GOVT. HOSPITAL/CLINIC . . . . . 03 GOVT. HEALTH CENTER . . . . . 04 GOVT. HEALTH POST . . . . . 05 OTHER PUBLIC ______ 06 (SPECIFY) PRIVATE MEDICAL SECTOR PVT. HOSPITAL/CLINIC . . . . . 07 MATERNITY HOME . . . . . 08 OTHER PRIVATE ______ 09 (SPECIFY) SHRINE/PRAYER CAMP 10 OTHER ______ 96 (SPECIFY) DON'T KNOW 98	
406K	Who assisted with the delivery? PROBE: Anyone else? PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED. IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.	HEALTH PERSONNEL DOCTOR . . . . . A NURSE/MIDWIFE . . . . . B AUXILIARY MIDWIFE . . . . . C OTHER PERSON TRADITIONAL BIRTH ATTENDANT D RELATIVE/FRIEND . . . . . E OTHER ______ X (SPECIFY) NO ONE . . . . . Y DON'T KNOW . . . . . Z	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
407	During the 6 weeks before she died, was (NAME) pregnant?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	2, 8 → 408
407A	How far along was (NAME) in her pregnancy? First three months (1st trimester)? Second three months (2nd trimester)? Last three months (3rd trimester)?	1ST TRIMESTER . . . 1 2ND TRIMESTER . . . 2 3RD TRIMESTER . . . 3 DON'T KNOW . . . 8	
407B	Was (NAME) doing something or using any method to delay or avoid pregnancy at the time when she became pregnant?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407C	Did (NAME) want to become pregnant at that time?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407D	Did (NAME) have heavy bleeding around the time the pregnancy ended?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407E	During the last 3 days before (NAME) died, did she have severe abdominal pain?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407F	Did (NAME) have fever before she died?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	2, 8 → 407I
407G	Did (NAME) have fever that started at anytime in the 3 days before her death?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407H	Did (NAME) have fever with shivering?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407I	Did (NAME) have foul smelling dicharge in the 6 weeks before her death?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407J	Did (NAME) have any medical treatment in the 6 weeks before she died?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	2, 8 → 407L
407K	Did (NAME) have the following treatment: Operation? Blood transfusion? Antibiotics? Any other treatment? (SPECIFY)	YES NO DK OPERATION 1 2 8 BLOOD TRANSFUSION 1 2 8 ANTIBIOTICS 1 2 8 OTHER 1 2 8 ____________ (SPECIFY)	
407L	As far as you know, did (NAME) want to do anything to attempt to end the pregnancy?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	
407M	As far as you know, did (NAME) attempt to end the pregnancy?	YES . . . 1 NO . . . 2 DON'T KNOW . . . 8	2, 8 → 408

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
407N	How long before her death did (NAME) first attempt to end the pregnancy?	DAYS . . . . 1 [ ][ ] WEEKS . . . . 2 [ ][ ] MONTHS . . . . 3 [ ][ ] DON'T KNOW 998	
407O	Did (NAME) take medicine or receive treatment to attempt to end the pregnancy?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	→ 501
408	Did (NAME) have an abortion recently before she died?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	2, 8 → 501
408A	Did (NAME) die during the abortion?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
408B	How many days before death did (NAME) have the abortion?	NUMBER OF DAYS [ ][ ] DON'T KNOW 98	
408C	How many months pregnant was (NAME) when she had the abortion?	MONTHS . . . . [ ][ ] DON'T KNOW 98	
408D	Did (NAME) have any heavy bleeding after the abortion?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	
408E	Did the abortion occur by itself, spontaneously?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	→501 →501
408F	Did (NAME) take medicine or treatment to end the pregnancy?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	

SECTION 5. HISTORY OF INJURY/ACCIDENT

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	Did (NAME) suffer from any injury or accident that led to her death?	YES . . . . . . 1 NO . . . . . . 2 DON'T KNOW 8	 NO/DON'T KNOW → 504
502	What kind of injury/accident was it?	ROAD TRAFFIC ACCIDENT . . . . . . 01 FALL . . . . . . 02 DROWNING . . . . . . 03 POISONING . . . . . . 04 BURNS . . . . . . 05 VIOLENCE/ASSAULT /HOMICIDE/ ABUSE . . . . . . 06 OTHER ______________ 96 (SPECIFY) DON'T KNOW 98	
503	Was the injury/accident intentionally inflicted by someone else?	YES . . . . . . 1 NO . . . . . . 2 DON'T KNOW 8	
504	Do you think (NAME) committed suicide?	YES . . . . . . 1 NO . . . . . . 2 DON'T KNOW 8	
505	Did (NAME) suffer from any animal/insect bite that led to her death?	YES . . . . . . 1 NO . . . . . . 2 DON'T KNOW 8	 NO/DON'T KNOW → 601
506	What type of animal/insect was it?	DOG . . . . . . 1 SNAKE . . . . . . 2 OTHER ______________ 6 (SPECIFY) DON'T KNOW 8	

SECTION 6. TREATMENT AND HEALTH SERVICE USE FOR FINAL ILNESS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Did (NAME) receive any treatment for the illness that led to death?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	2, 8 → 608
602	What type of treatment did (NAME) receive? PROBE: Anything else? CIRCLE ALL MENTIONED	ORS TREATMENT . . . . A INTRAVENOUS FLUIDS . . . . B TREATMENT/FOOD THROUGH TUBE C GIVEN DRUGS . . . . D OPERATION . . . . E BLOOD TRANSFUSION . . . . F OTHER ______________ X (SPECIFY) DON'T KNOW . . . . Y	
603	Where did (NAME) receive treatment during the illness that led to death? Anywhere else? CIRCLE ALL MENTIONED. IF SOURCE IS A HOSPITAL, HEALTH CENTER, OR CLINIC WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. ______________________ NAME OF PLACE	HOME RESPONDENT'S HOME . . . . A OTHER HOME . . . . B PUBLIC SECTOR GOVT. HOSPITAL/CLINIC . . . . C GOVT. HEALTH CENTER . . . . D GOVT. HEALTH POST . . . . E OTHER PUBLIC ______________ F (SPECIFY) PRIVATE MEDICAL SECTOR PVT. HOSPITAL/CLINIC . . . . G MATERNITY HOME . . . . H OTHER PRIVATE______________ I (SPECIFY) SHRINE/PRAYER CAMP . . . . J OTHER ______________ K (SPECIFY) DON'T KNOW L	
604	CHECK 603: AT LEAST ONE CATEGORY C-I CIRCLED ☐ ↓ NO CATEGORY C-I CIRCLED ☐ → 608		608
605	In the month before her death, how many times did (NAME) have contact with (NAME OF PLACE/S MENTIONED IN Q.603 C-I)? IF MORE THAN ONE FORMAL PLACE MENTIONED IN Q.603 ADD THE NUMBER OF TIMES OF CONTACT IN EACH PLACE	NUMBER OF TIMES . . . . ☐☐ DON'T KNOW 98	
606	Did a health worker tell you or anyone the cause of death?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	2, 8 → 608
607	What did s/he say? WRITE DOWN EXACTLY WHAT THE RESPONDENT SAYS ______________________ ______________________ ______________________ ______________________ ______________________		

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
608	Did (NAME) have any operation for the illness?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	 2, 8 → 611
609	How long before death did (NAME) have the operation?	DAYS . . . . 1 [ ][ ] WEEKS . . . . 2 [ ][ ] MONTHS . . . . 3 [ ][ ] DON'T KNOW 998	
610	Which part of her body was she operated on?	ABDOMEN . . . . 1 CHEST . . . . 2 HEAD . . . . 3 OTHER ______________ 6 (SPECIFY) DON'T KNOW 8	
611	Did she have a measles vaccination?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	

SECTION 7. RISK FACTORS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	Did (NAME) drink alcohol?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 2, 8 → 706
702	How long had (NAME) been drinking?	MONTHS . . . . . 1 [ ][ ] YEARS . . . . . 2 [ ][ ] DON'T KNOW 998	
703	How often did (NAME) drink alcohol?	DAILY . . . . . 1 WEEKLY . . . . . 2 ONCE IN A WHILE/RARELY . . . . . 3 DON'T KNOW 8	
704	Did (NAME) stop drinking before death?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 2, 8 → 706
705	How long before death did (NAME) stop drinking?	DAYS . . . . . 1 [ ][ ] WEEKS . . . . . 2 [ ][ ] MONTHS . . . . . 3 [ ][ ] YEARS . . . . . 4 [ ][ ] DON'T KNOW 998	
706	Did (NAME) use snuff or smoke tobacco (cigarette, cigar, pipe, etc.	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 2, 8 → 801
707	How long had (NAME) been smoking?	MONTHS . . . . . 1 [ ][ ] YEARS . . . . . 2 [ ][ ] DON'T KNOW 998	
708	How often did (NAME) smoke?	DAILY . . . . . 1 WEEKLY . . . . . 2 ONCE IN A WHILE/RARELY . . . . . 3 DON'T KNOW 8	
709	How many cigarettes/cigars/pipes did (NAME) smoke daily?	NUMBER OF CIGARETTES . . [ ][ ] DON'T KNOW 98	
710	Did (NAME) stop smoking before death?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	 2, 8 → 801
711	How long before death did (NAME) stop smoking?	DAYS . . . . . 1 [ ][ ] WEEKS . . . . . 2 [ ][ ] MONTHS . . . . . 3 [ ][ ] YEARS . . . . . 4 [ ][ ] DON'T KNOW 998	

SECTION 8. DATA EXTRACTED FROM DEATH CERTIFICATE

801	Do you have a death certifcate for (NAME)?	YES . . . . 1 NO . . . . 2 DON'T KNOW 8	(NO, DON'T KNOW) → 901
802	COPY DAY, MONTH AND YEAR OF DEATH FROM THE DEATH CERTIFICATE.	DAY [ ][ ] MONTH [ ][ ] YEAR [ ][ ][ ][ ]	
803	COPY DAY, MONTH AND YEAR OF ISSUE OF DEATH CERTIFICATE.	DAY [ ][ ] MONTH [ ][ ] YEAR [ ][ ][ ][ ]	
804	RECORD THE CAUSE OF DEATH FROM THE FIRST (TOP) LINE OF THE DEATH CERTIFICATE: ____________________		
805	RECORD THE CAUSE OF DEATH FROM THE SECOND LINE OF THE DEATH CERTIFICATE (IF ANY): ____________________		
806	RECORD THE CAUSE OF DEATH FROM THE THIRD LINE OF THE DEATH CERTIFICATE (IF ANY): ____________________		
807	RECORD THE CAUSE OF DEATH FROM THE FOURTH LINE OF THE DEATH CERTIFICATE (IF ANY): ____________________		

SECTION 9. DATA EXTRACTED FROM OTHER HEALTH RECORDS

901	Do you have any other documents like (READ EACH OF THE DOCUMENTS LISTED FROM 901A-901H) or others that have a record of the death? IF YES ASK THE RESPONDENT TO SHOW YOU THESE DOCUMENTS THAT HAVE A RECORD OF THE DEATH. FOR EACH TYPE OF HEALTH RECORD SUMMARIZE DETAILS FOR LAST 2 VISITS (IF MORE THAN 2) AND RECORD DATE OF ISSUE		
	DOCUMENT	RECORDED CAUSE OF DEATH	DATE OF ISSUE DAY MONTH YEAR
901A	BURIAL PERMIT: 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901B	POST MORTEM RESULTS 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901C	MCH/ANC CARD 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901D	HOSPITAL PRESCRIPTION FORM 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901E	TREATMENT CARDS 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901F	HOSPITAL DISCHARGE FORM 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901G	LABORATORY RESULTS 1 . . . YES → 2 . . . NO ↓	(CAUSE OF DEATH)	
901H	COMMUNITY REGISTER 1 . . . YES → 2 . . . NO ↓ (SPECIFY)	(CAUSE OF DEATH)	
901I	OTHER HOSPITAL DOCUMENTS 1 . . . YES → 2 . . . NO ↓ (SPECIFY)	(CAUSE OF DEATH)	
902	RECORD THE TIME.		HOURS . . . . MINUTES . . . .

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S/EDITOR'S OBSERVATIONS

NAME OF SUPERVISOR/EDITOR: ______________________ DATE: ______________________