BANGLADESH DEMOGRAPHIC AND HEALTH SURVEY 2017-18
VERBAL AUTOPSY FORM 2
DEATH OF CHILD AGED 4 WEEKS TO 5 YEARS

NIPORT, MOHFW
icddr,b
Mitra and Associates

IDENTIFICATION

CLUSTER NUMBER _____

HOUSEHOLD NUMBER _____

RURAL = 1, CITY CORPORATION = 2, OTHER THAN CC = 3 _____

NAME OF HOUSEHOLD HEAD _____

NAME AND LINE NUMBER OF RESPONDENT _____

NAME AND LINE NUMBER OF DEAD CHILD _____

INTERVIEWING VISITS

	1	2	3	FINAL VISIT
DATE				DAY / MONTH / YEAR (2 0 1)
INTERVIEWER'S NAME				INTER-VIEWER'S ID
RESULT*				RESULT
NEXT VISIT: DATE				TOTAL NUMBER OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 NO HOUSEHOLD MEMBER AT HOME
3 MOTHER/KNOWLEDGABLE RESPONDENT NOT PRESENT
4 MOTHER OR KNOWLEDGABLE RESPONDENT POSTPONED
5 MOTHER OR KNOWLEDGABLE RESPONDENT REFUSED
6 DWELLING VACANT/DESTROYED/NOT FOUND
7 OTHER _____ (SPECIFY)

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____	NAME _____		
DATE _____	DATE _____		

Introductory statement:
My name is _____. I am working for Mitra and Associates, a private research organization located in Dhaka. We are conducting a survey about health all over Bangladesh under the authority of the National Institute of Population Research and Training (NIPORT), Medical Education and Family Welfare Division, Ministry of Health and Family Welfare (MOHFW). The information we collect will help the government to plan health services. Your household was selected for the survey. I would like to ask you some questions about your household. The questions usually take about 30 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

Why the study being done?
The survey aims to provide information to address the monitoring and evaluation needs of the Fourth Health, Population and Nutrition Sector Program (HPNSP) and to provide managers and policy makers involved in this program with the information that they need to effectively plan and execute future interventions.

What is involved in the study?
You have been selected as respondents in this survey. I would like to ask you some questions about your household and household members.

What will you have to do if you agree to participate?
Since, you have been selected as respondents in this study. I shall be thankful if you provide your valuable response on certain issues. If some questions cause you embarrassment or make you feel uncomfortable, you can refuse to answer them. The survey usually takes about 30 minutes to complete.

What are the risks and benefits of this study?
By providing information you will not have any risk what so ever, rather this will help the government and policy planners to evaluate, strengthen and refocus national effort to improve health, population and nutrition programs.

Confidentiality:
Whatever information you provide will be kept strictly confidential. It will be used for research purposes and will be seen only by staff and researchers at the organizations mentioned.

Is there any compensation for participating in the study?
Your participation in the study is voluntary and promises no financial benefit.

Right to refuse or withdraw:
Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

Who do I contact if I have a question or problem?
If you wish to know more about your rights as a participant in this study you may write the Bangladesh Medical Research Council (BMRC), Mohakhali, Dhaka or Mitra and Associates, Main Road 1, House 35, Senpara Parbata, Mirpur 10, Dhaka or Phone 9025410, 9025412. If you have further questions regarding the nature of this study you may also contact NIPORT, 13/1 Sheikh Shaheb Bazar, Azimpur, Dhaka-1205 or Phone 9662495, 58611206.

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

May I begin the interview now?

Signature of respondent _____ Date: _____

RESPONDENT AGREES TO BE INTERVIE' . . . 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIE\ . . . 2 → END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 2. BASIC INFORMATION ABOUT RESPONDENT			
200	COPY NAME OF DECEASED CHILD FROM Q. 212 OF WOMAN'S QUESTIONNAIRE	_____ (NAME)	
201	RECORD THE TIME AT THE START OF THE INTERVIEW FILL BOTH BOXES	HOURS ..... ☐☐ MINUTES ..... ☐☐	
202	NAME OF THE RESPONDENT	_____ (NAME)	
203	What is your relationship to (NAME) ?	FATHER ..... 1 MOTHER ..... 2 SIBLING ..... 3 NO RELATION ..... 4 OTHER RELATIVE _____ (SPECIFY) 6	
204	Did you live with (NAME) in the period leading to her/his death?	YES ..... 1 NO 2	
SECTION 3. INFORMATION ON THE DECEASED AND DATE/PLACE OF DEATH			
302	Was (NAME) female or male?	FEMALE ..... 1 MALE 2	
303	When was (NAME) born? RECORD DATE OF BIRTH OF THE DISEASED FROM Q215 OF WOMAN'S QUESTIONNAIRE	☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR	
303A	In what season did (NAME) die?	SUMMER ..... 1 MONSOON ..... 2 AUTUMN ..... 3 LATE AUTUMN ..... 4 WINTER ..... 5 SPRING ..... 6 DON'T KNOW 8	
304	How old was (NAME) when s/he died? EITHER ONE CODE	DAYS ..... 1 ☐☐ MONTHS ..... 2 ☐☐	
305	When did (NAME) die? RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR	
306	CHECK 304: AGE AT DEATH 29 DAYS TO LESS THAN 5 YEARS ☐	AGE AT DEATH 0-28 DAYS ☐ →	USE VA FORM 1
		AGE AT DEATH 5 YEARS AND ABOVE ☐ →	END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
307	Where did (NAME) die?	HOSPITAL . . . . . 1 OTHER HEALTH FACILITY . . . . . 2 ON THE WAY TO HEALTH FACILITY OR TO A PROVIDER . . . . . 3 HOME . . . . . 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	

SECTION 4. RESPONDENT'S ACCOUNT OF ILLNESS/EVENTS LEADING TO DEATH

401	Could you tell me about the illness/events that led to (NAME)s death?	
402	CAUSE OF DEATH 1 ACCORDING TO RESPONDENT	
403	CAUSE OF DEATH 2 ACCORDING TO RESPONDENT	
403A	ANY OF THE FOLLOWING WORDS OF INTEREST MENTIONED IN THE ABOVE NARRATIVE? ABDOMEN . . . . . A CANCER . . . . . B DEHYDRATION . . . . . C DENGUE FEVER . . . . . D DIARRHEA . . . . . E FEVER . . . . . F HEART PROBLEMS . . . . . G JAUNDICE (YELLOW SKIN OR EYES) . . . . . H PNEUMONIA . . . . . I RASH . . . . . J NONE OF THE ABOVE . . . . . K	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 5. HISTORY OF PREVIOUSLY KNOWN MEDICAL CONDITIONS			
501	I would like to ask you some questions concerning previously known medical conditions the deceased had; injuries and accidents that the deceased suffered; and signs and symptoms that (NAME) had/showed when s/he was ill. Some of these questions may not appear to be directly related to his/her death. Please bear with me and answer all the questions. The answers will help us to get a clear picture of all possible symptoms that (NAME) had. Please tell me if the deceased suffer from any of the following illnesses:		
502	Heart disease?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
503	Diabetes?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
504	Asthma?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
505	Epilepsy?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
506	Malnutrition?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
507	Cancer?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 509
508	Can you specify the type or site of cancer?	TYPE/SITE _____	
509	Tuberculosis?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510	HIV/AIDS?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510A	Did (s)he have a recent positive test by a health professional for malaria?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510B	Did (s)he have a recent negative test by a health professional for malaria?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510C	Was there any diagnosis by a health professional of dengue fever?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510D	Was there any diagnosis by a health professional of measles?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510E	Was there any diagnosis by a health professional of sickle cell disease?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510F	Was there any diagnosis by a health professional of kidney disease?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
510G	Was there any diagnosis by a health professional of liver disease?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
511	Did s/he suffer from any other medically diagnosed illness?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 601
512	Can you specify the illness?	ILLNESS _____	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 6 HISTORY OF INJURIES/ACCIDENTS			
601	Did (NAME) suffer from any injury or accident that led to her/his death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 606
602	What kind of injury or accident did (NAME) suffer?	ROAD TRAFFIC ACCIDENT ..... 01 FALL ..... 02 DROWNING ..... 03 POISONING ..... 04 BURNS ..... 05 VIOLENCE/ASSAULT ..... 06 FALL FROM HEIGHT ..... 07 INJURED BY FIREARMS ..... 08 STAB INJURY ..... 09 HANGING STRANGULATION ..... 10 BLUNT FORCE INJURY ..... 11 NATURAL CALAMITIES ..... 12 ELECTROCUTION ..... 13 OTHER _____ 96 (SPECIFY) DON'T KNOW 98	→ 602C
602A	Where was (NAME) when the accident happened?	PEDESTRIAN ..... 1 IN A CAR/SMALL VEHICLE ..... 2 IN A BUS/LARGE VEHICLE ..... 3 ON A MOTORISED CYCLE ..... 4 ON A NON-MOTORISED CYCLE ..... 5 OTHER 6	
602B	With what other object/person did the road traffic accident happen?	PEDESTRIAN ..... 1 IN A CAR/SMALL VEHICLE ..... 2 IN A BUS/LARGE VEHICLE ..... 3 ON A MOTORISED CYCLE ..... 4 ON A NON-MOTORISED CYCLE ..... 5 OTHER 6	
602C	Was (NAME) injured in a non-road traffic accident?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
603	Was the injury intentionally inflicted by someone else?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
606	Did (NAME) suffer from any animal/insect bite that led to her/his death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 608
607	What type of animal/insect?	DOG ..... 1 SNAKE ..... 2 INSECT ..... 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
608	CHECK 304: FOR AGE AT DEATH UNDER ONE YEAR ↓ ONE YEAR OR OLDER →		→ 801

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 7. SYMPTOMS AND SIGNS NOTED DURING THE FINAL ILLNESS OF INFANTS			
701	At birth what was (NAME)'s size, smaller than normal, normal or larger than normal?	SMALLER THAN NORMAL ..... 1 NORMAL ..... 2 LARGER THAN NORMAL ..... 3 DON'T KNOW 8	
702	Was (NAME) born prematurely?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 704
703	How many weeks or months premature? INDICATE PERIOD OF PREGNANCY	WEEKS ..... 1 ☐☐ MONTHS ..... 2 ☐☐ DON'T KNOW 998	
704	Was (NAME) growing normally?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
704A	What was (NAME)'s birth weight?	KILOGRAMS ..... ☐.☐ DON'T KNOW 98	
704B	Was any part of (NAME) physically abnormal at the time of delivery, for example a is body part too large or too small?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
704C	Did (NAME) have a swelling or a defect on the back at time of birth?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
704D	Did (NAME) have a very large head at time of birth?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
704E	Did (NAME) have a very small head at time of birth?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
705	Did the child have bulging of the fontanelle (soft part at the top of the head was swollen) ?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 801
706	For how many days before death did (NAME) have the bulging?	DAYS ..... ☐☐ DON'T KNOW 98	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 8. STATUS OF MOTHER AND SYMPTOMS NOTED DURING THE FINAL ILLNESS FOR ALL CHILDREN			
801	How is the mother's health now?	HEALTHY ..... 1 ILL ..... 2 DON'T KNOW 8	
801A	Did (NAME)'s mother receive professional assitance during the delivery?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
801B	Has (NAME)'s biological mother ever been tested for HIV?	YES ..... 1 NO ..... 2 DON'T KNOW 8	802
801C	Has (NAME)'s biological mother ever been told she had HIV/AIDS by a health worker?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
802	For how many days and months was (NAME) ill before (NAME) died?	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW 998	
802A	Did (NAME) appear healthy and then died suddenly?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
803	Did (NAME) have a fever?	YES ..... 1 NO ..... 2 DON'T KNOW 8	808
804	For how long did (NAME) have a fever?	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW 998	
805	Was the fever severe?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
806	Was the fever continuous or on and off?	CONTINUOUS ..... 1 ON AND OFF ..... 2 DON'T KNOW 8	
807	Did (NAME) have chills/rigor?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
807A	Did (NAME) have night sweats?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
808	Did (NAME) have a cough?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 812
809	For how long did (NAME) have a cough?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 998	
809A	Was the cough productive, with sputum?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
809B	Did (NAME) cough up blood?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
809C	Did (NAME) make a whooping sound when coughing?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
810	Was the cough severe?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
811	Did (NAME) vomit after he/she coughed?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
812	Did (NAME) have fast breathing?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 814
813	For how long did (NAME) have fast breathing?	DAYS ..... [ ][ ] DON'T KNOW 9 8	
814	Did (NAME) have difficulty in breathing?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 820
815	For how many days did (NAME) have difficulty in breathing?	DAYS ..... [ ][ ] DON'T KNOW 9 8	
816	Did (NAME) have chest indrawing?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 818

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
817	For how long did (NAME) have chest indrawing?	DAYS ..... ☐☐ DON'T KNOW 9 8	
818	Did (NAME) have noisy breathing (grunting or wheezing)? DEMONSTRATE	YES ..... 1 NO ..... 2 DON'T KNOW 8	
819	Did (NAME) have flaring of the nostrils?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
820	Did (NAME) have diarrhoea?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 824
821	For how long did (NAME) have diarrhoea?	DAYS ..... ☐☐ DON'T KNOW 9 8	
822	When the diarrhoea was most severe, how many times did (NAME) pass stool in a day?	NUMBER ..... ☐☐ DON'T KNOW 9 8	
823	At any time during the final illness was there blood in the stool?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
824	Did (NAME) have vomiting?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 827
825	For how many days did (NAME) vomit?	DAYS ..... ☐☐ DON'T KNOW 9 8	
826	When the vomiting was most severe, how many times did (NAME) vomit in a day?	DAYS ..... ☐☐ DON'T KNOW 9 8	
826A	Did she vomit blood?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
826B	Was the vomit black?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
827	Did (NAME) have abdominal pain?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 830
828	For how many days or months did (NAME) have abdominal pain?	DAYS ..... 1 ☐☐ MONTHS ..... 2 ☐☐ DON'T KNOW 9 9 8	
829	Was the abdominal pain severe?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
830	Did (NAME) have abdominal distension?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 833A

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
831	For how many days or months did (NAME) have abdominal distension?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
832	Did the distension develop rapidly within days or gradually over months?	RAPIDLY WITHIN DAYS ..... 1 GRADUALLY OVER MONTHS ..... 2 DON'T KNOW 8	
833	Was there a period of a day or longer during which (NAME) did not pass any stool?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
833A	Did (NAME) have a more than usually portruding abdomen?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 834
833B	For how many days or months did (NAME) have a more than usually portruding abdomen?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
834	Did (NAME) have any mass in the abdomen?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 836
835	For how many days or months did (NAME) have the mass in the abdomen?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
836	Did (NAME) have headache?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 839
837	For how many days or months did (NAME) have headache?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
838	Was the headache severe?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
839	Did (NAME) have a stiff or painful neck?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 841
840	For how many days did (NAME) have a stiff or painful neck?	DAYS ..... [ ][ ] DON'T KNOW 9 8	
841	Did (NAME) become unresponsive or unconscious?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 844

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
842	For how many days was (NAME) unconscious?	DAYS ..... [ ][ ] DON'T KNOW 9 8	
843	Did the unconsciousness start suddenly, quickly within a single day, or slowly over many days?	SUDDENLY ..... 1 FAST (IN A DAY) ..... 2 SLOWLY (MANY DAYS) ..... 3 DON'T KNOW 8	
844	Did (NAME) have convulsions?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 846
844A	Did the convulsions occur in the whole body?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
845	For how many days or months did (NAME) have convulsions?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
846	Did (NAME) have paralysis of the lower limbs?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 849
847	For how many days or months did (NAME) have paralysis of the lower limbs?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
848	Did the paralysis of the lower limbs start suddenly, quickly within a single day, or slowly over many days?	SUDDENLY ..... 1 FAST (IN A DAY) ..... 2 SLOWLY (MANY DAYS) ..... 3 DON'T KNOW 8	
849	Was there any change in the amount of urine (NAME) passed daily?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 851A
850	For how many days or months did (NAME) have the change in the amount of urine (NAME) passed daily?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
851	How much urine did (NAME) pass?	TOO MUCH ..... 1 TOO LITTLE ..... 2 NO URINE AT ALL ..... 3 DON'T KNOW 8	
851A	During the final illness, did (NAME) ever pass blood in the urine?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
852	During the illness that led to death, did (NAME) have any skin rash?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 856
853	For how many days did (NAME) have the skin rash?	DAYS ..... [ ][ ] DON'T KNOW 9 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
854	Was the rash located on: 1 The face? 2 The trunk? 3 On the arms and legs? 4 Any other place?	YES NO DK FACE ..... 1 2 8 TRUNK ..... 1 2 8 ARMS AND LEGS ..... 1 2 8 OTHER PLACE _____ (SPECIFY) 1 2 8	
855	What did the rash look like?	MEASLES RASH ..... 1 RASH WITH CLEAR FLUID ..... 2 RASH WITH PUS ..... 3 DON'T KNOW 8	
856	Did (NAME) have red eyes?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
857	Did (NAME) have bleeding from the nose, mouth, or anus?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
858	Did (NAME) have weight loss?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 860
859	For how days or months before death did (NAME) have the weight loss?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 DON'T KNOW 9 9 8	
860	Did (NAME) look very thin and wasted?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
860A	Did (NAME) have sores or ulcers anywhere in the body?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 861
860B	Did the sores have clear fluid or pus?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
860C	Did (NAME) have an ulcer (pit) on the foot?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 861
860D	Did the ulcer on the foot ooze pus?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 861
860E	For how many days did the ulcer ooze pus?	DAYS ..... [ ][ ] DON'T KNOW 98	
861	Did (NAME) have mouth sores or white patches in the mouth or on the tongue?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 863
862	For how many days did (NAME) have mouth sores or white patches in the mouth or on the tongue?	DAYS ..... [ ][ ] DON'T KNOW 9 8	
863	Did (NAME) have any swelling?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 864C

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
864	For how many days or months did (NAME) have the swelling?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
864A	Was the swelling on: 1 The face? 2 The joints? 3 The ankles? 4 The whole body? 5 Any other place?	YES NO DK FACE ..... 1 2 8 JOINTS ..... 1 2 8 ANKLES ..... 1 2 8 WHOLE BODY ..... 1 2 8 OTHER PLACE ..... 1 2 8 SPECIFY:	
864B	During the illness that led to death, did (NAME) have swollen legs or feet?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
864C	During the illness that led to death, did (NAME) have areas of the skin that turned black?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
864D	Did (NAME) have difficulty swallowing?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 866
864E	For how many days before death did (NAME) have difficulty swallowing? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... [ ][ ] DON'T KNOW 9 8	
864F	Was the difficulty in swallowing with solids, liquids or both?	SOLID ..... 1 LIQUID ..... 2 BOTH 3	
866	Did (NAME) have any lumps?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 869
867	For how days or months did (NAME) have the lumps?	DAYS ..... 1 [ ][ ] MONTHS ..... 2 [ ][ ] DON'T KNOW 9 9 8	
868	Were the lumps on: 1 The neck? 2 The armpit? 3 The groin? 4 Any other place?	YES NO DK NECK ..... 1 2 8 ARMPIT ..... 1 2 8 GROIN ..... 1 2 8 OTHER PLACE ..... 1 2 8 SPECIFY	
869	Did (NAME) have yellow discoloration of the eyes?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 871

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
870	For how many days or months did (NAME) have the yellow discoloration of the eyes?	DAYS . . . . . 1 [ ][ ] MONTHS . . . . . 2 [ ][ ] DON'T KNOW 9 9 8	
871	Did (NAME)'s hair color change to reddish or yellowish?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 873
872	For how many days or months did (NAME) have reddish/yellowish hair?	DAYS . . . . . 1 [ ][ ] MONTHS . . . . . 2 [ ][ ] DON'T KNOW 9 9 8	
873	Did (NAME) look pale (thinning/lack of blood) or have pale palms, eyes or nail beds?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 875
874	For how many days did (NAME) look pale (thinning/lack of blood) or have pale palms, eyes, or nail beds?	DAYS . . . . . [ ][ ] DON'T KNOW 9 8	
875	Did (NAME) have sunken eyes?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 901
876	For how many days did (NAME) have sunken eyes?	DAYS . . . . . [ ][ ] DON'T KNOW 9 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 9. TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS			
901	Was (NAME) vaccinated for measles?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
901A	Do you have (NAME)'s vaccination card?	YES ..... 1 NO ..... 2 DON'T KNOW 8	902
901B	May I see the vaccination card? NOTE THE VACCINES THE CHILD RECEIVED.	_____ _____ _____ _____ _____	
902	Did (NAME) receive any treatment for the illness that led to death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	909
903	Can you please list the drugs (NAME) was given for the ilness that led to death? COPY FROM PRESCRIPTION/DISCHARGE NOTES IF AVAILABLE	_____ _____ _____	
904	What type of treatment did (NAME) receive:	YES NO DK	
	1 Oral rehydration salts and/or intravenous fluids (drip) treatment?	ORS/DRIP TREATMENT 1 2 8	
	2 Blood transfusion?	BLOOD TRANSFUSION 1 2 8	
	3 Treatment/food through a tube passed through the nose?	THROUGH THE NOSE 1 2 8	
	4 Any other treatment?	OTHER _____ (SPECIFY) 1 2 8	
904A	Did (NAME) receive injectable antibiotics?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 904C
904B	Did (NAME) need injectable antibiotics?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
904C	Did (NAME) receive antiretroviraltherapy (ART)?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 905
904D	Did (NAME) need antiretroviraltherapy (ART)?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
904E	Did (NAME) receive treatment from health facility?	YES ..... 1 NO 2	→ 905A

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
905	Did (NAME) ever receive treatment from any health facility? Any other facility? PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ _____	**PUBLIC SECTOR** MEDICAL COLLEGE HOSPITAL . . . . . A SPECIALIZED GOVT HOSPITAL . . . . . B DISTRICT HOSPITAL . . . . . C MCWC . . . . . D UPAZILA HEALTH COMPLEX . . . . . E UH & FAMILY WELFARE CENTRE . . . . . F COMMUNITY CLINIC . . . . . G SAT. CLINIC/EPI OUTREACH . . . . . H HEALTH ASSISTANT (HA) . . . . . I FAMILY WELFATE ASSISTANT (FWA) . . . . . J OTHER PUBLIC SECTOR _____ K (SPECIFY) **NGO SECTOR** NGO STATIC CLINIC . . . . . L NGO SATELLITE CLINIC . . . . . M NGO DEPO HOLDER . . . . . N NGO FIELD WORKER . . . . . O OTHER NGO SECTOR P _____ (SPECIFY) **PRIVATE MEDICAL SECTOR** PRIVATE MEDICAL COLLEGE HOSPITAL . . . . Q PRIVATE HOSPITAL . . . . . R PRIVATE CLINIC . . . . . S QUALIFIED DOCTOR'S CHAMBER . . . . . T NON-QUALIFIED DOCTOR'S CHAMBER . . . . U PHARMACY/DRUG STORE . . . . . V OTHER PRIVATE MEDICAL SECTOR _____ W (SPECIFY) **OTHER** _____ X (SPECIFY)	
905A	In the final days before death, did (NAME) travel to a hospital or health facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	905H
905B	Was a motorised transport used to go to the hospital?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
905C	Were there any problems during admission to the hospital or health facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
905D	In the hospital or health facility, were there any problems with the way (NAME) was treated in terms of medical treatment, procedures, interpersonal attitudes, respect or dignity?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905E	In the hospital or health facility, were there any problems getting medications or diagnostic tests?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905F	Did it take more than 2 hours to get from (NAME)'s house to the nearest hospital or health facility?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905G	Was (NAME) discharged from hospital very ill?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905H	In the final days before death were there any doubts about whether medical care was needed?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905I	In the final days before death, was traditional medicine used?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905J	In the final days before death, did anyone use a telephone or cell phone to call for help?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905K	Over the course of the illness, did the total costs of care and treatment prohibit other household payments?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
905L	CHECK 905: CODE A TO W CIRCLED	☐ →	909
906	In the month before death, how many contacts with formal health services did (NAME) have?	NUMBER OF CONTACTS ..... ☐☐ DON'T KNOW 9 8	
907	Did a health care worker tell you the cause of death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	909
908	What did the health care worker say?	_____ _____ _____	
909	Did (NAME) have any operation for the illness?	YES ..... 1 NO ..... 2 DON'T KNOW 8	1001
910	How many days before death did (NAME) have the operation?	DAYS ..... ☐☐ DON'T KNOW 9 8	
911	On what part of the body was the operation?	ABDOMEN ..... 1 CHEST ..... 2 HEAD ..... 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 10. DATA ABSTRACTED FROM BIRTH AND DEATH CERTIFICATES			
1001	Was (NAME)'s birth registered?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 1004
1002	WRITE BIRTH REGISTRATION NUMBER FILL IN FROM RIGHT TO LEFT	DON'T KNOW 99999999999999998	
1003	WRITE DATE OF BIRTH REGISTRATION NUMBER COPY DAY, MONTH AND YEAR OF BIRTH CERTIFICATE.	DAY MONTH YEAR	
1004	Was (NAME)'s death registered?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 1101
1005	WRITE DEATH REGISTRATION NUMBER FILL IN FROM RIGHT TO LEFT	DON'T KNOW 999999998	
1006	WRITE DATE OF DEATH REGISTRATION NUMBER COPY DAY, MONTH AND YEAR OF DEATH CERTIFICATE.	DAY MONTH YEAR	
1007	RECORD THE CAUSE OF DEATH FROM THE FIRST (TOP) LINE OF THE DEATH CERTIFICATE:		
1008	RECORD THE CAUSE OF DEATH FROM THE SECOND LINE OF THE DEATH CERTIFICATE (IF ANY):		
1009	RECORD THE CAUSE OF DEATH FROM THE THIRD LINE OF THE DEATH CERTIFICATE (IF ANY):		
1010	RECORD THE CAUSE OF DEATH FROM THE FOURTH LINE OF THE DEATH CERTIFICATE (IF ANY):		

SECTION 11. DATA ABSTRACTED FROM OTHER HEALTH RECORDS			
1101	OTHER HEALTH RECORDS AVAILABLE	YES ..... 1 NO 2	→ 1111
1102	FOR EACH TYPE OF HEALTH RECORD SUMMARIZE DETAILS FOR LAST 2 VISITS (IF MORE THAN 2) AND RECORD DATE OF ISSUE		
1103	BURIAL PERMIT (CAUSE OF DEATH) _____		
1104	POST MORTEM RESULTS (CAUSE OF DEATH) _____		
1105	MCH/ANC CARD (RELEVANT INFORMATION) _____		
1106	HOSPITAL PRESCRIPTION (RELEVANT INFORMATION) _____		
1107	TREATMENT CARDS (RELEVANT INFORMATION) _____		
1108	HOSPITAL DISCHARGE (RELEVANT INFORMATION) _____		
1109	LABORATORY RESULTS (RELEVANT INFORMATION) _____		
1110	OTHER HOSPITAL DOCUMENTS SPECIFY: _____		
1111	RECORD THE TIME AT THE END OF INTERVIEW FILL BOTH BOXES	HOURS ..... MINUTES	☐☐ ☐☐

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR: _____ DATE: _____