BANGLADESH DEMOGRAPHIC AND HEALTH SURVEY 2017-18
VERBAL AUTOPSY FORM 1
FOR NEONATAL DEATHS (0-28 DAYS OF AGE)

NIPORT, MOHFW
icddr,b
Mitra and Associates

IDENTIFICATION

CLUSTER NUMBER _____

HOUSEHOLD NUMBER _____

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

NAME OF HOUSEHOLD HEAD _____

NAME AND LINE NUMBER OF RESPONDENT _____

NAME AND LINE NUMBER OF DEAD CHILD _____

INTERVIEWER VISITS

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

*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		

NTRODUCTION AND CONSENT

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). Your household was selected for the survey.We are collecting information on the causes of death in the community. This information will help the government to plan health and family planning services. We would very much appreciate your participation in this survey. We learned during our earlier visit that (NAME) had died recently. As part of the survey we want to ask you about the circumstances leading to the death of the (NAME). The questions usually take about 30-45 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 is 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 a respondent in this survey. I would like to ask you some questions about the circumstances leading to the death of your child.

What will you have to do if you agree to participate?
Since you have been selected as a respondent 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.

What are the risks and benefits of this study?
By providing information you will not have any risk whatsoever, 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?

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
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 START OF 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	CHECK 215: NAME'S DATE OF BIRTH RECORD DATE OF BIRTH OF THE DECEASED FROM Q. 215 OF WOMAN'S QUESTIONNARE. RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	☐☐ 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? IF LESS THAN ONE DAY RECORD '00'	DAYS ..... ☐☐	
305	When did (NAME) die? RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	☐☐ DAY ☐☐ MONTH ☐☐☐☐ YEAR	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
306	CHECK 304: AGE AT DEATH 0-28 DAYS ☐ ↓ AGE AT DEATH 29 DAYS AND ABOVE ☐ →		USE VA FORM 2
307	Where did (NAME) die?	HOSPITAL . . . . . 1 OTHER HEALTH FACILITY . . . . . 2 ON THE WAY TO A 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? ASPHYXIA . . . . . A INCUBATOR . . . . . B LUNG PROBLEM . . . . . C PNEUMONIA . . . . . D PRETERM DELIVERY . . . . . E NONE OF THE ABOVE . . . . . F	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 5. PREGNANCY HISTORY			
501	I would like to ask you some questions concerning you when you were pregnant with (NAME), during the delivery of (NAME) and shortly after delivery of (NAME). Some of these questions may not appear to be directly related to (NAME's) death. Please answer all the questions.The answers will help us to get a clear picture of all possible symptoms that (NAME) had.		
502	How many births, including stillbirths, did you have before (NAME)?	NUMBER OF BIRTHS/ STILLBIRTHS . . . . . [ ][ ] DON'T KNOW 98	
503	How many months or weeks was the pregnancy when (NAME) was born?	MONTHS . . . . . 1 [ ][ ] WEEKS . . . . . 2 [ ][ ] DON'T KNOW 98	
504	Did the pregnancy with (NAME) end earlier than expected?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 506
505	How many weeks before the expected date of delivery was (NAME) born? IF LESS THAN ONE WEEK RECORD '00'	WEEKS . . . . . [ ][ ] DON'T KNOW 98	
506	During the pregnancy with (NAME) did you suffer from:	**YES NO DK**	
	1 High blood pressure?	HIGH BLOOD PRESSURE 1 2 8	
	2 Heart disease?	HEART DISEASE 1 2 8	
	3 Diabetes?	DIABETES 1 2 8	
	4 Epilepsy/convulsion?	EPILEPSY/CONVULSION 1 2 8	
	5 Did she suffer from any other medically diagnosed illness?	OTHER . . . . . 1 2 8 _____ (SPECIFY)	
507	During the last 3 months of pregnancy with (NAME) did you suffer from:	**YES NO DK**	
	01 Vaginal bleeding?	VAGINAL BLEEDING 1 2 8	
	02 Smelly vaginal discharge?	SMELLY VAGINAL DISCHARGE 1 2 8	
	03 Puffy face?	PUFFY FACE 1 2 8	
	04 Headache?	HEADACHE 1 2 8	
	05 Blurred vision?	BLURRED VISION 1 2 8	
	06 Convulsion?	CONVULSION 1 2 8	
	07 Febrile illness?	FEBRILE ILLNESS 1 2 8	
	08 Severe abdominal pain that was not labor pain?	SEVERE ABDOMINAL PAIN (NOT LABOR PAIN) 1 2 8	
	09 Pallor and shortness of breath (both present)?	PALLOR/SHORTNESS OF BREATH (BOTH) 1 2 8	
	10 Did she suffer from any other illness?	OTHER ILLNESS . . . . . 1 2 8 _____ (SPECIFY)	
508	Was (NAME) a single or multiple birth?	SINGLE . . . . . 1 → 601 TWIN . . . . . 2 TRIPLET OR MORE . . . . . 3 DON'T KNOW . . . . . 8 → 601	
509	What was the birth order of (NAME)?	FIRST . . . . . 1 SECOND . . . . . 2 THIRD OR HIGHER . . . . . 3 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 6. DELIVERY HISTORY			
601	Where was (NAME) born?	HOSPITAL . . . . . 1 OTHER HEALTH FACILITY . . . . . 2 HOME . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
602	Who assisted with the delivery? 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 DURING THE DELIVERY.	HEALTH PERSONNEL QUALIFIED DOCTOR . . . . . A NURSE/MIDWIFE/ PARAMEDIC . . . . . B FAMILY WELFARE VISITOR (FWV) . . . . . C COMMUNITY SKILLED BIRTH ATTENDANT (CSBA) . . . . . D SUB-ASSISTANT COMMUNITY MEDICAL OFFICER (SACMO) . . . . . E COMMUNITY HEALTH CARE PROVIDER (CHCP) . . . . . F HEALTH ASSTANT (HA) . . . . . G FAMILY WELFARE ASSISTANT . . . . . H NGO WORKER . . . . . I OTHER PERSON TRAINED TBA (TTBA) . . . . . J UNTRAINED TBA (UTBA) . . . . . K UNQUALIFIED DOCTOR . . . . . L RELATIVES . . . . . M NEIGHBOURS/FRIENDS . . . . . N OTHER _____ X (SPECIFY) NO ONE ASSISTED . . . . . Y	
603	When did the water break?	BEFORE LABOUR STARTED . . . . . 1 DURING LABOR . . . . . 2 WATER DID NOT BREAK . . . . . 3 → 606 DON'T KNOW 8	
604	How many hours after the water broke was (NAME) born?	LESS THAN 24 HOURS . . . . . 1 24 HOURS OR MORE . . . . . 2 DON'T KNOW 8	
605	Was the water foul smelling?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
606	Did (NAME) stop moving in the womb?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 608
607	When did (NAME) stop moving in the womb?	BEFORE LABOR STARTED . . . . . 1 DURING LABOR . . . . . 2 DON'T KNOW 8	
608	Did (PERSON WHO ASSISTED DELIVERY IN 602) listen for fetal heart sounds during labor?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 610
609	Were fetal heart sounds present?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
610	Was there excess bleeding on the day labor started or during delivery?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
611	Did (NAME)'s mother have a fever on the day labor started?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
612	How long did the labor pains last?	LESS THAN 12 HOURS ..... 1 12-23 HOURS ..... 2 24 HOURS OR MORE ..... 3 DID NOT HAVE LABOR PAIN ..... 4 DON'T KNOW 8	
613	Was it a normal vaginal delivery?	YES ..... 1 → 615 NO ..... 2 DON'T KNOW ..... 8 → 615	
614	What type of delivery was it?	FORCEPS/VACUUM ..... 1 CAESAREAN SECTION ..... 2 → 701 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
615	Which part of (NAME) came first?	HEAD ..... 1 BOTTOM ..... 2 FEET ..... 3 ARM/HAND ..... 4 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
616	Did the umbilical cord come out before (NAME) was born?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

SECTION 7. CONDITION OF THE BABY SOON AFTER BIRTH

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	
701A	CHECK 505: (NAME) BORN MORE THAN FOUR WEEKS EARLY?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 703
702	Was (NAME) born prematurely? CHECK THE ANSWER FROM 504	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 704
703	How many months or weeks along was the pregnancy? CHECK THE ANSWER FROM 503	MONTHS ..... 1 ☐☐ WEEKS ..... 2 ☐☐ DON'T KNOW 998	
704	What was (NAME)'s birth weight?	KILOGRAMS ..... ☐.☐ DON'T KNOW 98	
705	Was anything applied to the umbilical cord stump after birth?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 707

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
706	What was it?	ANTIBIOTICS (POWDER/OINTMT.) ..... A ANTISEPTIC (DETOL/SAVLON/ HEXISOL) ..... B SPIRIT/ALCOHOL ..... C MUSTARD OIL WITH GARLIC ..... D CHEWED RICE ..... E TUMERIC JUICE/POWDER ..... F GINGER JUICE ..... G SHIDUR ..... H BORIC POWDER ..... I GENTIAN VIOLET (BLUE INK) ..... J TALCUM POWDER ..... K OTHER _____ X SPECIFY DON'T KNOW ..... Z	
707	Did (NAME) show any signs of injury or broken bones?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 709
708	Where were marks or signs of injury?	_____ _____ _____	
709	Did (NAME) show any sign of paralysis?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
710	Did (NAME) have any malformation?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 712
711	What kind of malformation did (NAME) have?	SWELLING/DEFECT ON THE BACK ..... A VERY LARGE HEAD ..... B VERY SMALL HEAD ..... C DEFECT OF LIP AND/OR PALATE ..... D OTHER _____ X (SPECIFY) DON'T KNOW ..... Z	
712	What was the colour of (NAME) at birth?	NORMAL ..... 1 PALE ..... 2 BLUE ..... 3 DON'T KNOW 8	
713	Did (NAME) breathe after birth, even a little?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
714	Was (NAME) given assistance to breathe?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
715	Did (NAME) ever cry after birth, even a little?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
716	Did (NAME) ever move, even a little?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
717	CHECK 713, 715, AND 716 FOR CODES 'NO': ALL THREE CODES 'NO': THE BABY DIDN'T BREATHE, THE BABY DIDN'T CRY, THE BABY DIDN'T MOVE OTHER:		→ 801
718	If (NAME) did not cry, breathe or move, was (NAME) born dead?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 801
719	Was (NAME) macerated, that is, showed signs of decay?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1001

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 8. HISTORY OF INJURIES/ACCIDENTS			
801	Did (NAME) suffer from any injury or accident that led to her/his death?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 804
802	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	→ 802C
802A	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 (SPECIFY)	
802B	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 (SPECIFY)	
802C	Was (NAME) injured in a non-road traffic accident?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
803	Was the injury intentionally inflicted by someone else?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
804	Did (NAME) suffer from any animal/insect bite that led to her/his death?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 901A
805	What type of animal/insect?	DOG . . . . . 1 SNAKE . . . . . 2 INSECT . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 9. NEONATAL ILLNESS HISTORY			
901A	How old was (NAME) when the disease or event leading to her/his death started?	DAYS ..... [ ][ ] DON'T KNOW 98	
901B	Before the illness or event that led to her/his death, was (NAME) growing normally?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
901C	For how many days was (NAME) ill before she/he died? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... [ ][ ] DON'T KNOW 98	
901	Was (NAME) ever able to suckle or bottle-feed?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 905
902	How soon after birth did (NAME) suckle or bottle-feed?	HOURS ..... 1 [ ][ ] DAYS ..... 2 [ ][ ] DON'T KNOW 998	
903	Did (NAME) stop suckling or bottle-feeding?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 905
904	How many days after birth did (NAME) stop suckling or bottle-feeding? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... [ ][ ] DON'T KNOW 98	
905	Was (NAME) exclusively breastfed?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
906	Did (NAME) have convulsions?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 908
907	How soon after birth did the convulsions start? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... [ ][ ] DON'T KNOW 98	
908	Did (NAME) become stiff and arched backwards?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
909	Was the soft part at the top of (NAME)'s head (fontanelle) swollen or bulging?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 910A
910	How many days after birth did (NAME) have the swelling or bulging? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... [ ][ ] DON'T KNOW 98	
910A	During the illness that led to death was the soft top part of (NAME)'s head (fontanelle) sunken?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 911

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
910B	How many days after birth did (NAME) have the sunken top of head? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
911	Did (NAME) become unresponsive or unconscious after birth?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→912A
912	How many days after birth did (NAME) become unresponsive or unconscious? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
912A	Did (NAME) become unresponsive or unconscious in last illness?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
912B	Did (NAME) become unresponsive or unconscious in 24 hours before she/he died?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
913	Did (NAME) have a fever?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→915
914	How many days after birth did (NAME) have a fever? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
914A	Did the fever continue until death?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
915	Did (NAME) become cold to the touch?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→917
916	How many days after birth did (NAME) become cold to the touch? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
917	Did (NAME) have a cough?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→919
918	How many days after birth did (NAME) start to cough? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
919	Did (NAME) have fast breathing?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→921
920	How many days after birth did (NAME) start breathing fast? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
921	Did (NAME) have difficulty breathing?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→922B
922	How many days after birth did (NAME) start having difficulty in breathing? IF LESS THAN ONE DAY RECORD '00'.	DAYS . . . . . ☐☐ DON'T KNOW 98	
922A	For how many days did the difficulty breathing last?	DAYS . . . . . ☐☐ DON'T KNOW 98	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
922B	During the illness that led to death, did (NAME) become lethargic after a normal activity?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
923	Did (NAME) have chest indrawing?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
924	Did (NAME) have noisy breathing (grunting or wheezing)? DEMONSTRATE	YES ..... 1 NO ..... 2 DON'T KNOW 8	
925	Did (NAME) have flaring of the nostrils?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
926	Did (NAME) have diarrhoea?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→930
927	How many days after birth did (NAME) have diarrhoea? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... ☐☐ DON'T KNOW 98	
927A	How long did the diarrhoea last? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... ☐☐ DON'T KNOW 98	
928	When the diarrhoea was most severe, how many times did (NAME) pass stools in a day?	NUMBER OF TIMES A DAY ..... ☐☐ DON'T KNOW 98	
929	Was there blood in the stools?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
930	Did (NAME) have vomiting?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→933
931	How many days after birth did vomiting start? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... ☐☐ DON'T KNOW 98	
932	When the vomiting was most severe, how many times did (NAME) vomit in a day?	NUMBER OF TIMES A DAY ..... ☐☐ DON'T KNOW 98	
932A	Did (NAME) vomit in the week preceding death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
933	Did (NAME) have a more than usually protruding abdomen?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→935
934	How many days after birth did (NAME) have abdominal distension?	DAYS ..... ☐☐ DON'T KNOW 98	
935	Did (NAME) have redness or discharge from the umbilical cord stump?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
936	Did (NAME) have a pustular skin rash?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
937	Did (NAME) have yellow palms or soles?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→939A
938	How many days after birth did the yellow palms or soles begin? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... ☐☐ DON'T KNOW 98	
939	For how many days did (NAME) have yellow palms or soles? IF LESS THAN ONE DAY RECORD '00'.	DAYS ..... ☐☐ DON'T KNOW 98	
939A	Did (NAME) appear healthy and then died suddenly?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

SECTION 10. MOTHER'S HEALTH AND CONTEXTUAL FACTORS

	ASK THE RESPONDENT ABOUT HER PREGNANCY WITH (NAME).		
1001	How old were you at the time (NAME) died?	YEARS ..... ☐☐ DON'T KNOW 98	
1002	Did you receive antenatal care?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002A	Did you have any complications in the last 3 months of the pregnancy before labor?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002B	What was the color of the water when the water broke?	GREEN OR BROWN ..... 1 CLEAR ..... 2 WATER DID NOT BREAK ..... 3 OTHER ..... 6 DON'T KNOW 8	
1002C	Did you receive any vaccinations since reaching adulthood during this pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002D	During labor, did you have a fever?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1002E	During the last 3 months of pregnancy, labor, or delivery, did you have high blood pressure?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002F	Did you have diabetes mellitus?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002G	Did you have foul smelling vaginal discharge during pregnancy or after delivery?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002H	During the last 3 months of pregnancy, labor or delivery did you mother suffer from convulsions?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002I	During the last 3 months of pregnancy (NAME), did you suffer from blurred vision?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002J	Did you have severe anemia?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1002K	Did you have vaginal bleeding during the last 3 months of pregnancy but before labor started?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1003	Did you receive tetanus toxoid (TT) vaccine?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1005
1004	How many doses?	NUMBER OF DOSES ..... ☐☐ DON'T KNOW 98	
1005	How is your health now?	HEALTHY ..... 1 ILL ..... 2 DON'T KNOW 8	
1005A	Have you ever been tested for HIV/AIDS?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1005B	Have you ever been told she had HIV/AIDS by a health worker?	YES ..... 1 NO ..... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 11 TREATMENT AND HEALTH SERVICE USE FOR THE FINAL ILLNESS			
1101	Did (NAME) receive any treatment for the illness that led to death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1201
1101A	Did (NAME) receive oral rehydration salts?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1101C
1101B	Did (NAME) need oral rehydration salts?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1101C	Did (NAME) receive intravenous fluids (drops) treatment?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1101E
1101D	Did (NAME) need intravenous fluids (drops) treatment?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1101E	Did (NAME) receive a blood transfusion?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1101G
1101F	Did (NAME) need a blood transfusion?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1101G	Did (NAME) receive treatment/food through a tube passed through the nose?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1101I
1101H	Did (NAME) need treatment/food through a tube passed through the nose?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1101I	Did (NAME) receive injectable antibiotics?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1101K
1101J	Did (NAME) need injectable antibiotics?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1101K	Did (NAME) receive antiretroviral therapy (ART)?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1101M
1101L	Did (NAME) need antiretroviral therapy (ART)?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1101M	Did (NAME) have an operation for the illness?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 1102
1101N	Did (NAME) need an operation for the illness?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1102	Can you please list the treatments (NAME) was given for the illness that led to death? COPY FROM PRESCRIPTION/DISCHARGE NOTES IF AVAILABLE	_____ _____ _____ _____ _____	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1103	Please tell me at which of the following places or facilities (NAME) received treatment during the illness that led to death:	HOME YOUR HOME . . . . . A OTHER HOME . . . . . B PUBLIC SECTOR MEDICAL COLLEGE HOSPITAL . . . . . C SPECIALIZED GOVT HOSPITAL . . . . . D DISTRICT HOSPITAL . . . . . E MCWC . . . . . F UPAZILLA HEALTH COMPLEX . . . . . G UH & FAMILY WELFARE CENTRE . . . . . H COMMUNITY CLINIC . . . . . I SAT. CLINIC/EPI OUTREACH . . . . . J OTHER PUBLIC SECTOR _____ K (SPECIFY) NGO SECTOR NGO STATIC CLINIC . . . . . L NGO SAT CLINIC . . . . . M PRIVATE MED. SECTOR . . . . . . PVT. MED COLL. HOSPITAL . . . . . N PVT. HOSPITAL . . . . . O PVT. CLINIC . . . . . P QUALIFIED DOCTOR . . . . . Q UNQUALIFIED DOCTOR . . . . . R PHARMACY . . . . . S OTHER PRIVATE MEDICAL . . . . . T OTHER _____ X (SPECIFY)	
1103A	CHECK Q.1103: CODE C TO T CIRCLED ☐ ↓ OTHER CODE CIRCLED ☐ →		1201
1104	In the month before death, how many contacts with formal health services did (NAME) have?	NUMBER OF CONTACTS . . . . . ☐☐ DON'T KNOW 98	
1104A	Record the name and address of any hospital, health centre or clinic where help was sought. IF TREATMENT IS TAKEN FROM MORE THAN ONE FACILITY, MENTION THE NAME AND ADDRESS OF LAST FACILITY	_____ _____	
1104B	Was a motorised transport used to go to the hospital?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1104C	Were there any problems during admission to the hospital or health facility?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1104D	In the hospital or health facility, were there any problems with the way (NAME)was treated in terms of medical treatment, procedures, intrepersonal attitudes, respect or dignity?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1104E	In the hospital or health facility, were there any problems getting medications or diagnostic tests?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
1104F	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	
1104G	In the final days before death were there any doubts about whether medical care was needed?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1104H	In the final days before death, was traditional medicine used?	YES ..... 1 NO ..... 2 DON'T KNOW 8	
1104I	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	
1104J	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	
1105	Did a health service provider tell you the cause of death?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→1201
1106	What did the health service provider say?	_____ _____ _____	

SECTION 12 DATA ABSTRACTED FROM BIRTH AND DEATH CERTIFICATES

1201	Was (NAME)'s birth registered?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→1204
1202	WRITE BIRTH REGISTRATION NUMBER FILL IN FROM RIGHT TO LEFT	☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐ DON'T KNOW 99999999999999998	
1203	WRITE DATE OF BIRTH REGISTRATION COPY DAY, MONTH AND YEAR OF BIRTH CERTIFICATE.	☐☐ ☐☐ ☐☐☐☐ DAY MONTH YEAR	
1204	Was (NAME)'s dealth registered?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→1301
1205	WRITE DEATH REGISTRATION NUMBER FILL IN FROM RIGHT TO LEFT	☐☐☐☐☐☐☐☐☐ DON'T KNOW 999999998	
1206	WRITE DATE OF DEATH REGISTRATION COPY DAY, MONTH AND YEAR OF DEATH CERTIFICATE.	☐☐ ☐☐ ☐☐☐☐ DAY MONTH YEAR	
1207	RECORD THE CAUSE OF DEATH FROM THE FIRST (TOP) LINE OF THE DEATH CERTIFICATE: _____		
1208	RECORD THE CAUSE OF DEATH FROM THE SECOND LINE OF THE DEATH CERTIFICATE (IF ANY): _____		
1209	RECORD THE CAUSE OF DEATH FROM THE THIRD LINE OF THE DEATH CERTIFICATE (IF ANY): _____		
1210	RECORD THE CAUSE OF DEATH FROM THE FOURTH LINE OF THE DEATH CERTIFICATE (IF ANY): _____		
1211	RECORD THE CONTRIBUTORY CAUSE OF DEATH FROM THE DEATH CERTIFICATE (CHAPTER 2): _____		

SECTION 13. DATA ABSTRACTED FROM OTHER HEALTH RECORDS			
1301	OTHER HEALTH RECORDS AVAILABLE	YES ..... 1 NO 2	→ 1311
1302	FOR EACH TYPE OF HEALTH RECORD SUMMARIZE DETAILS FOR LAST 2 VISITS (IF MORE THAN 2) AND RECORD DATE OF ISSUE. (RECORD INFORMATION ABOUT MOTHER AND STILLBORN DECEASED CHILD)		
1303	BURIAL PERMIT (CAUSE OF DEATH) _____		
1304	POST MORTEM RESULTS (CAUSE OF DEATH) _____		
1305	VACCINATION/MCH/ANC CARD (RELEVANT INFORMATION) _____		
1306	HOSPITAL PRESCRIPTION (RELEVANT INFORMATION) _____		
1307	TREATMENT CARDS (RELEVANT INFORMATION) _____		
1308	HOSPITAL DISCHARGE (RELEVANT INFORMATION) _____		
1309	LABORATORY RESULTS (RELEVANT INFORMATION) _____		
1310	OTHER HOSPITAL DOCUMENTS SPECIFY: _____		
1311	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: