

TAZAMA VERBAL AUTOPSY QUESTIONNAIRE 3 DEATH OF A PERSON AGED 13 YEARS AND ABOVE

ID/CONTROL/REFERENCE NUMBER

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SECTION 1.1 INTERVIEWER VISITS																		
	1	2	3	FINAL VISIT														
DATE	_____	_____	_____	DAY <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> MONTH <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> YEAR <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px; text-align: center;">2</td><td style="width: 20px; height: 20px; text-align: center;">0</td><td style="width: 20px; height: 20px;"></td></tr></table> INT. NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>					2	0								
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INTERVIEWER'S NAME	_____	_____	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>														
RESULT*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESULT <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>														
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td></tr></table>														
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">1 COMPLETED</td> <td style="width: 25%;">2 NOT AT HOME</td> <td style="width: 25%;">3 POSTPONED</td> <td style="width: 25%;">4 REFUSED</td> </tr> <tr> <td>5 PARTLY COMPLETED</td> <td>6 NO APPROPRIATE RESPONDENT FOUND</td> <td>7 OTHER _____</td> <td>(SPECIFY)</td> </tr> </table>					1 COMPLETED	2 NOT AT HOME	3 POSTPONED	4 REFUSED	5 PARTLY COMPLETED	6 NO APPROPRIATE RESPONDENT FOUND	7 OTHER _____	(SPECIFY)						
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SECTION 1.2 ADDITIONAL DEMOGRAPHIC INFORMATION (FOR USE IN SAMPLE VITAL REGISTRATION OR DEMOGRAPHIC SURVEILLANCE SITE)																		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> VILLAGE NAME _____ SUBVILLAGE NAME _____ BALOZI NAME _____ NAME OF THE DECEASED _____ </td> <td style="width: 50%; vertical-align: top;"> VILLAGE NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> SUB VILLAGE NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> BALOZI NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> HOUSEHOLD NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> LINE NUMBER OF THE DECEASED <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> </td> </tr> <tr> <td colspan="2" style="padding-top: 10px;"> RESIDENT IN ENUMERATION AREA 1 BODY BROUGHT HOME FOR BURIAL 2 HOME-COMING SICK 3 </td> </tr> </table>					VILLAGE NAME _____ SUBVILLAGE NAME _____ BALOZI NAME _____ NAME OF THE DECEASED _____	VILLAGE NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> SUB VILLAGE NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> BALOZI NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> HOUSEHOLD NUMBER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> LINE NUMBER OF THE DECEASED <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>											RESIDENT IN ENUMERATION AREA 1 BODY BROUGHT HOME FOR BURIAL 2 HOME-COMING SICK 3	
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SAMPLE INFORMED CONSENT STATEMENT																		
<p>Hello. My name is _____ and I am working with TAZAMA. We are collecting information on the causes of death in the community. We would very much appreciate your participation in this effort. We want to ask you about the circumstances leading to the death of the deceased. Whatever information you provide will be kept strictly confidential. No information identifying you or the deceased will ever be released to anyone outside of this information-collection activity. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You may also stop the interview completely at any time without any consequences at all. However, we hope that you will participate in this survey since the results will help the government improve services for people.</p> <p>At this time, do you want to ask me anything about the purpose or content of this interview?</p> <p>May I begin the interview now?</p> <p>Signature of interviewer: _____ Date: _____</p> <p>RESPONDENT AGREES TO BE INTERVIEWED... 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED... 2 → END</p>																		

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
SECTION 2. BASIC INFORMATION ABOUT RESPONDENT											
201	RECORD THE TIME AT START OF INTERVIEW (RECORD IN 24 HOURS)	HOUR <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MINUTES <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>									
202	NAME OF THE RESPONDENT	_____ (NAME)									
203	What is your relationship to the deceased?	FATHER 1 MOTHER 2 SPOUSE 3 SIBLING 4 CHILD 5 OTHER RELATIVE 6 (SPECIFY) _____ NO RELATION 8									
204	Did you live with the deceased in the period leading to her/his death?	YES 1 NO 2									
SECTION 3. INFORMATION ON THE DECEASED AND DATE/PLACE OF DEATH											
301	What was the name of the deceased?	_____ (NAME)									
302	Was the deceased female or male?	FEMALE 1 MALE 2									
303	When was the deceased born? RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	DAY <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table> MONTH <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table> YEAR <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td></tr></table>									
304	How old was the deceased when s/he died? RECORD 998 IF KNOT KNOWN	AGE IN YEARS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>									
305	What was her/his occupation, that is, what kind of work did s/he mainly do?	FARMER 1 TRADER 2 GOV'T/PRIV'T COMP EMPLOYEE 3 OTHER 6 (SPECIFY) _____ DON'T KNOW 8									
306	What was the highest level of formal education the deceased attended?	NONE 1 PRIMARY 2 SECONDARY 3 HIGHER 4 DON'T KNOW 8									
307	What was her/his marital status?	NEVER MARRIED 1 MARRIED/LIVING WITH A PARTNER 2 WIDOWED 3 DIVORCED 4 SEPARATED 5 DON'T KNOW 8									
308	When did s/he die? RECORD '98' IF DON'T KNOW DAY OR MONTH RECORD '9998' IF DON'T KNOW YEAR	DAY <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table> MONTH <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table> YEAR <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td></tr></table>									
309	Where did s/he die?	HOSPITAL 1 OTHER HEALTH FACILITY 2 HOME 3 TRADITIONAL HEALER 4 OTHER 6 (SPECIFY) _____ DON'T KNOW 8									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
SECTION 4.1 COMMON KISWAHILI TERMS IN RESPONDENT OPEN HISTORY				
	Please ring Yes or No to indicate whether the following terms ; terms were used by respondent			
411	Dawa za jadi/mitishamba	YES	NO	
412	Homa	YES	NO	
413	Imani ya uchawi	YES	NO	
414	Kichomi	YES	NO	
415	Kifafa	YES	NO	
416	Kikohozi	YES	NO	
417	Kipindupindu	YES	NO	
418	Kisukari	YES	NO	
419	Kuharisha	YES	NO	
420	Kukatwa mapanga	YES	NO	
421	Kupigwa	YES	NO	
422	Kushikwa ugoni	YES	NO	
423	Kutoa mimba	YES	NO	
424	Kuvimba tezi	YES	NO	
425	Majipu	YES	NO	
426	Mapigo ya moyo kwenda mbio	YES	NO	
427	Matatizo ya figo	YES	NO	
428	Matatizo ya ini	YES	NO	
429	Matatizo ya tumbo	YES	NO	
430	Maumivu ya kifua	YES	NO	
431	Maumivu ya kichwa	YES	NO	
432	Miguu kuvimba	YES	NO	
433	Miguu kuwaka moto	YES	NO	
434	Mitego	YES	NO	
435	Mkanda wa jeshi	YES	NO	
436	Pombe	YES	NO	
437	Saratani	YES	NO	
438	TB	YES	NO	
439	Ugonjwa wa kisasa/ugonjwa wa vijana/UKUMWI	YES	NO	
440	Upele	YES	NO	
441	Upungufu wa damu	YES	NO	
442	Vidonda mdomoni	YES	NO	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 5. HISTORY OF PREVIOUSLY KNOWN MEDICAL CONDITIONS			
501	<p>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 the deceased 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. They will help us to get a clear picture of all possible symptoms that the deceased had.</p> <p>Please tell me if the deceased suffer from any of the following illnesses:</p>		
502	High blood pressure?	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 → 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	
511	Did s/he suffer from any other medically diagnosed illness?	YES 1 NO 2 DON'T KNOW 8	→ 601 → 601
512	Can you specify the illness?	ILLNESS _____ _____	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																
SECTION 7. SYMPTOMS AND SIGNS ASSOCIATED WITH ILLNESS OF WOMEN																																																			
701	Did she have an ulcer or swelling in the breast?	YES 1 NO 2 DON'T KNOW 8	→ 703 → 703																																																
702	For how long did she have an ulcer or swelling in the breast?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8																																																	
703	Did she have excessive vaginal bleeding during menstrual periods	YES 1 NO 2 DON'T KNOW 8	→ 705 → 705																																																
704	For how long did s/he have the excessive vaginal bleeding during menstrual periods?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8																																																	
705	Did she have vaginal bleeding in between menstrual periods?	YES 1 NO 2 DON'T KNOW 8	→ 707 → 707																																																
706	For how long did she have vaginal bleeding in between menstrual periods?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8																																																	
707	Did she have abnormal vaginal discharge ?	YES 1 NO 2 DON'T KNOW 8	→ 800 → 800																																																
708	For how long did she have abnormal vaginal discharge?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8																																																	
SECTION 8. SYMPTOMS AND SIGNS ASSOCIATED WITH PREGNANCY																																																			
800	Was she aged 50 or more when she died? (check questions 303 and 304)	YES 1 NO 2 DON'T KNOW 8	→ 901																																																
801	Was she pregnant at the time of death?	YES 1 NO 2 DON'T KNOW 8	→ 806 → 806																																																
802	How long was she pregnant?	WEEKS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8																																																	
803	How many pregnancies had she had, including this one?	PREGNANCIES <input type="text"/> <input type="text"/> DON'T KNOW 9 8																																																	
804	During the last 3 months of pregnancy, did she suffer from any of the following illnesses:	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>01 Vaginal bleeding?</td> <td>VAGINAL BLEEDING 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>02 Smelly vaginal discharge?</td> <td>SMELLY VAGINAL DISCHARGE ... 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>03 Puffy face?</td> <td>PUFFY FACE 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>04 Headache?</td> <td>HEADACHE 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>05 Blurred vision?</td> <td>BLURRED VISION 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>06 Convulsion?</td> <td>CONVULSION 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>07 Febrile illness?</td> <td>FEBRILE ILLNESS 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>08 Severe abdominal pain that was not labor pain?</td> <td>SEVERE ABDOMINAL PAIN (NOT LABOR PAIN) 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>09 Pallor and shortness of breath (both present)?</td> <td>PALLOR/SHORTNESS OF BREATH (BOTH) 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>10 Did she suffer from any other illness?</td> <td>OTHER ILLNESS 1</td> <td>2</td> <td>8</td> </tr> <tr> <td></td> <td>SPECIFY: _____ ↴</td> <td></td> <td></td> </tr> </tbody> </table>		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: _____ ↴			
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805	Did she die during labor, but undelivered?	YES 1 NO 2 DON'T KNOW 8									
806	Did she give birth recently?	YES 1 NO 2 DON'T KNOW 8	→ 818 → 818								
807	How many days after giving birth did she die?	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 9 9 8									
808	Was there excessive bleeding on the day labor started?	YES 1 NO 2 DON'T KNOW 8									
809	Was there excessive bleeding during labor before delivering the baby?	YES 1 NO 2 DON'T KNOW 8									
810	Was there excessive bleeding after delivering the baby?	YES 1 NO 2 DON'T KNOW 8									
811	Did she have difficulty in delivering the placenta?	YES 1 NO 2 DON'T KNOW 8									
812	Was she in labor for unusually long (more than 24 hours)?	YES 1 NO 2 DON'T KNOW 8									
813	Was it a normal vaginal delivery?	YES 1 NO 2 DON'T KNOW 8	→ 815 → 815								
814	What type of delivery was it?	FORCEPS/VACUUM 1 CAESAREAN SECTION 2 OTHER 6 (SPECIFY) DON'T KNOW 8									
815	Did she have foul smelling vaginal discharge?	YES 1 NO 2 DON'T KNOW 8									
816	Where did she give birth?	HOSPITAL 1 OTHER HEALTH FACILITY 2 HOME 3 OTHER 6 (SPECIFY) DON'T KNOW 8									
817	Who conducted the delivery?	DOCTOR 1 NURSE/MIDWIFE 2 TRADITIONAL BIRTH ATTENDANT 3 RELATIVE 4 MOTHER BY HERSELF 5 OTHER 6 (SPECIFY) DON'T KNOW 8									
818	Did she experience an abortion recently?	YES 1 NO 2 DON'T KNOW 8	→ 901 → 901								
819	Did she die during the abortion?	YES 1 NO 2 DON'T KNOW 8	→ 821 → 821								
820	How many days before death did she have the abortion?	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 9 9 8									
821	How many months pregnant was she when she had the abortion?	MONTHS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 9 8									
822	Did she have heavy bleeding after the abortion?	YES 1 NO 2 DON'T KNOW 8									
823	Did the abortion occur by itself, spontaneously?	YES 1 NO 2 DON'T KNOW 8	→ 901 → 901								
824	Did she take medicine or treatment to induce?	YES 1									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		NO 2	
		DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
SECTION 9. SIGNS AND SYMPTOMS NOTED DURING THE FINAL ILLNESS			
901	For how long was s/he ill before s/he died?	WAS NOT ILL 0 <input type="text"/> <input type="text"/> DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> (IF 9 YEARS OR MORE PUT 99 MONTHS) DON'T KNOW 9 9 8	
902	Did s/he have a fever ?	YES 1 NO 2 DON'T KNOW 8	→907 →907
903	For how long did s/he have a fever?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8	
904	Was the fever continuous or on and off?	CONTINUOUS 1 ON AND OFF 2 DON'T KNOW 8	
905	Did s/he have fever only at night?	YES 1 NO 2 DON'T KNOW 8	
906	Did s/he have chills/rigor?	YES 1 NO 2 DON'T KNOW 8	
907	Did s/he have a cough ?	YES 1 NO 2 DON'T KNOW 8	→913 →913
908	For how long did s/he have a cough?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8	
909	Was the cough severe?	YES 1 NO 2 DON'T KNOW 8	
910	Was the cough productive with sputum?	YES 1 NO 2 DON'T KNOW 8	
911	Did s/he cough out blood?	YES 1 NO 2 DON'T KNOW 8	
912	Did s/he have night sweats?	YES 1 NO 2 DON'T KNOW 8	
913	Did s/he have breathlessness ?	YES 1 NO 2 DON'T KNOW 8	→918 →918
914	For how long did s/he have breathlessness?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8	
915	Was s/he unable to carry out daily routines due to breathlessness?	YES 1 NO 2 DON'T KNOW 8	
916	Was s/he breathless while lying flat?	YES 1 NO 2 DON'T KNOW 8	
917	Did s/he have wheezing?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
918	Did s/he have chest pain ?	YES..... 1 NO 2 DON'T KNOW..... 8	→927 →927
919	For how long did s/he have chest pain?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
920	Did chest pain start suddenly or gradually?	SUDDENLY..... 1 GRADUALLY 2 DON'T KNOW..... 8	
921	When s/he had severe chest pain, how long did it last?	LESS THAN HALF AN HOUR..... 1 HALF AN HOUR TO 24 HOUR..... 2 LONGER THAN 24 HOUR..... 3 DON'T KNOW..... 8	
922	Was the chest pain located below the breastbone (sternum)?	YES..... 1 NO 2 DON'T KNOW..... 8	
923	Was the chest pain located over the heart and did it spread to the left arm?	YES..... 1 NO 2 DON'T KNOW..... 8	
924	Was the chest pain located over the ribs (sides)?	YES..... 1 NO 2 DON'T KNOW..... 8	
925	Was the chest pain continuous or on and off?	CONTINUOUS..... 1 ON AND OFF 2 DON'T KNOW..... 8	
926	Did the chest pain get worse while coughing?	YES..... 1 NO 2 DON'T KNOW..... 8	
927	Did s/he have palpitations ?	YES..... 1 NO 2 DON'T KNOW..... 8	
928	Did s/he have diarrhea ?	YES..... 1 NO 2 DON'T KNOW..... 8	→933 →933
929	For how long did s/he have diarrhea?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
930	Was the diarrhea continuous or on and off?	CONTINUOUS..... 1 ON AND OFF 2 DON'T KNOW..... 8	
931	At any time during the final illness was there blood in the stool?	YES..... 1 NO 2 DON'T KNOW..... 8	
932	When the diarrhea was most severe, how many times did s/he pass stools in a day?	NUMBER..... <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8	
933	Did s/he vomit ?	YES..... 1 NO 2 DON'T KNOW..... 8	→937 →937
934	For how long did s/he vomit?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
935	What was the colour of the vomitus?	COFFEE-COLORED FLUID..... 1 BRIGHT RED/BLOOD RED..... 2 WATERY..... 3 YELLOW..... 4 FECAL..... 5 OTHER..... 6 (SPECIFY) DON'T KNOW..... 8	
936	When the vomiting was most severe, how many times did s/he vomit in a day?	NUMBER..... <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
937	CHECK QUESTION 302 FOR SEX OF THE DECEASED: FEMALE <input type="checkbox"/> MALE <input type="checkbox"/>		939
938	CHECK QUESTIONS 801, 805, 819 TO SEE IF SHE DIED DURING PREGNANCY, LABOR, ABORTION OR POSTPARTUM: NO <input type="checkbox"/> YES <input type="checkbox"/>		948
939	Did s/he have abdominal pain ?	YES..... 1 NO 2 DON'T KNOW..... 8	→941 →941
940	For how long did s/he have abdominal pain?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
941	Did s/he have abdominal distension ?	YES..... 1 NO 2 DON'T KNOW..... 8	→945 →945
942	For how long did s/he have abdominal distension?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
943	Did the distension develop rapidly within days or gradually over months?	RAPIDLY WITHIN DAY:..... 1 GRADUALLY OVER MONTHS 2 DON'T KNOW..... 8	
944	Was there a period of a day or longer during which s/he did not pass any stool?	YES..... 1 NO 2 DON'T KNOW..... 8	
945	Did s/he have any mass in the abdomen ?	YES..... 1 NO 2 DON'T KNOW..... 8	→948 →948
946	For how long did s/he have the mass in the abdomen?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
947	Where in the abdomen was the mass located?	RIGHT UPPER ABDOMEI..... 1 LEFT UPPER ABDOME..... 2 LOWER ABDOMEI..... 3 ALL OVER ABDOMEN 4 DON'T KNOW..... 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
948	Did s/he have difficulty or pain while swallowing solids ?	YES..... 1 NO 2 DON'T KNOW..... 8	→950 →950
949	For how long did s/he have difficulty or pain while swallowing solids?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
950	Did s/he have difficulty or pain while swallowing liquids?	YES..... 1 NO 2 DON'T KNOW..... 8	→952 →952
951	For how long did s/he have difficulty or pain while swallowing liquids?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
952	Did s/he have headache ?	YES..... 1 NO 2 DON'T KNOW..... 8	→955 →955
953	For how long did s/he the have headache?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
954	Was the headache severe?	YES..... 1 NO 2 DON'T KNOW..... 8	
955	Did s/he have a stiff or painful neck ?	YES..... 1 NO 2 DON'T KNOW..... 8	→957 →957
956	For how long did s/he have a stiff or painful neck?	DAYS <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8	
957	Did s/he have mental confusion ?	YES..... 1 NO 2 DON'T KNOW..... 8	→960 →960
958	For how long did s/he have mental confusion?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
959	Did the mental confusion start suddenly, quickly within a single day, or slowly over many days?	SUDDENLY 1 WITHIN A DAY (FAST) 2 SLOWLY (MANY DAYS) 3 DON'T KNOW..... 8	
960	Did s/he become unconscious ?	YES..... 1 NO 2 DON'T KNOW..... 8	→963 →963
961	For how long was s/he unconscious?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
962	Did the unconsciousness start suddenly, quickly within a single day, or slowly over many days?	SUDDENLY 1 WITHIN A DAY (FAST) 2 SLOWLY (MANY DAYS) 3 DON'T KNOW..... 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
963	Did s/he have convulsions ?	YES..... 1 NO 2 DON'T KNOW..... 8	→965 →965
964	For how long did s/he have convulsions?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
965	Was s/he unable to open the mouth ?	YES..... 1 NO 2 DON'T KNOW..... 8	→967 →967
966	For how long was s/he unable to open the mouth?	DAYS <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8	
967	Did s/he have stiffness of the whole body ?	YES..... 1 NO 2 DON'T KNOW..... 8	→969 →969
968	For how long did s/he have stiffness of the whole body?	DAYS <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8	
969	Did s/he have paralysis of one side of the body ?	YES..... 1 NO 2 DON'T KNOW..... 8	→972 →972
970	For how long did s/he have paralysis of one side of the body?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
971	Did the paralysis of one side of the body start suddenly, quickly within a single day, or slowly over many days?	SUDDENLY 1 WITHIN A DAY (FAST) 2 SLOWLY (MANY DAYS) 3 DON'T KNOW..... 8	
972	Did s/he have paralysis of the lower limbs ?	YES..... 1 NO 2 DON'T KNOW..... 8	→975 →975
973	How long did s/he have paralysis of the lower limbs?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
974	Did the paralysis of the lower limbs start suddenly, quickly within a single day, or slowly over many days?	SUDDENLY 1 WITHIN A DAY (FAST) 2 SLOWLY (MANY DAYS) 3 DON'T KNOW..... 8	
975	Was there any change in color of urine ?	YES..... 1 NO 2 DON'T KNOW..... 8	→977 →977
976	For how long did s/he have the change in color of urine?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
977	During the final illness did s/he ever pass blood in the urine?	YES..... 1 NO 2 DON'T KNOW..... 8	→979 →979
978	For how long did s/he pass blood in the urine?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
979	Was there any change in the amount of urine s/he passed daily?	YES..... 1 NO 2 DON'T KNOW..... 8	→982 →982
980	For how long did s/he have the change in the amount of urine passed daily?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8	
981	Did s/he pass too much urine, too little urine, or no urine at all?	TOO MUCH..... 1 TOO LITTL..... 2 NO URINE AT ALL..... 3 DON'T KNOW..... 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																								
982	During the illness that led to death, did s/he have any skin rash ?	YES..... 1 NO..... 2 DON'T KNOW..... 8	→986 →986																								
983	For how long did s/he have the skin rash?	DAYS..... <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8																									
984	Was the rash on: 1 The face? 2 The trunk? 3 The arms and legs? 4 Any other place?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></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>FACE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>TRUNK</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>ARMS AND LEGS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OTHER PLACE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table> SPECIFY: _____ ↓		YES	NO	DK	FACE	1	2	8	TRUNK	1	2	8	ARMS AND LEGS	1	2	8	OTHER PLACE	1	2	8					
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985	What did the rash look like?	MEASLES RASH..... 1 RASH WITH CLEAR FLUI..... 2 RASH WITH PUS..... 3 DON'T KNOW..... 8																									
986	Did s/he have red eyes?	YES..... 1 NO..... 2 DON'T KNOW..... 8																									
987	Did s/he have bleeding from the nose, mouth, or anus?	YES..... 1 NO..... 2 DON'T KNOW..... 8																									
988	Did s/he ever have shingles/herpes zoster?	YES..... 1 NO..... 2 DON'T KNOW..... 8																									
989	Did s/he have weight loss ?	YES..... 1 NO..... 2 DON'T KNOW..... 8	→990 →990																								
989.1	For how long did s/he have weight loss?	DAYS..... 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8																									
989.2	Did s/he look very thin and wasted?	YES..... 1 NO..... 2 DON'T KNOW..... 8																									
990	Did s/he have mouth sores or white patches in the mouth or on the tongue?	YES..... 1 NO..... 2 DON'T KNOW..... 8	→991 →991																								
990.1	For how long did s/he have mouth sores or white patches in the mouth or on the tongue?	DAYS..... <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8																									
991	Did s/he have any swelling ?	YES..... 1 NO..... 2 DON'T KNOW..... 8	→992 →992																								
991.1	For how long did s/he have the swelling?	DAYS..... 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8																									
991.2	Was the swelling on: 1 The face? 2 The joints? 3 The ankles? 4 The whole body? 5 Any other place?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></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>FACE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>JOINTS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>ANKLES</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>WHOLE BODY</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OTHER PLACE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table> SPECIFY: _____ ↓		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	
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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																
992	Did s/he have any lumps ?	YES..... 1 NO 2 DON'T KNOW..... 8	→993 →993																																
992.1	For how long did s/he have the lumps?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8																																	
992.2	Were the lumps on: 1 The neck? 2 The armpit? 3 The groin? 4 Any other place?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></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>NECK</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>ARMPIT</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>GROIN.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OTHER PLACE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>SPECIFY: _____ ↓</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	NECK	1	2	8	ARMPIT	1	2	8	GROIN.....	1	2	8	OTHER PLACE	1	2	8	SPECIFY: _____ ↓												
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993	Did s/he have yellow discoloration of the eyes ?	YES..... 1 NO 2 DON'T KNOW..... 8	→994 →994																																
993.1	For how long did s/he have yellow discoloration of the eyes?	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW..... 9 9 8																																	
994	Did s/he look pale (thinning/lack of blood) or have pale palms, eyes or nail beds?	YES..... 1 NO 2 DON'T KNOW..... 8	→995 →995																																
994.1	For how long did s/he look pale or have pale palms, eyes or nail beds?	DAYS <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8																																	
995	Did s/he have an ulcer, abscess, or sore anywhere on the body?	YES..... 1 NO 2 DON'T KNOW..... 8	→1001 →1001																																
995.1	For how long did s/he have the ulcer, abscess, or sore?	DAYS <input type="text"/> <input type="text"/> DON'T KNOW..... 9 8																																	
995.2	What was the location of the ulcer, abscess, or sore? 1 The head and/or neck? 2 Trunk 3 Extremities 4 Armpits 5 Groin 6 Genitalia 7 Others parts of the body	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></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>HEAD AND/OR NECK</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>TRUNK</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>EXTREMITIES</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>ARMPITS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>GROIN</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>GENITALIA</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OTHERS _____ ↓ (SPECIFY)</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	DK	HEAD AND/OR NECK	1	2	8	TRUNK	1	2	8	EXTREMITIES	1	2	8	ARMPITS	1	2	8	GROIN	1	2	8	GENITALIA	1	2	8	OTHERS _____ ↓ (SPECIFY)				
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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1008	Did s/he have any operation for the illness?	YES 1 NO 2 DON'T KNOW 8	→1101 →1101
1009	How long before death did s/he have the operation?	DAYS <input type="text"/> <input type="text"/> DON'T KNOW 9 8	
1010	On what part of the body was the operation?	ABDOMEN 1 CHEST 2 HEAD 3 OTHER 6 (SPECIFY) DON'T KNOW 8	
SECTION 11. RISK FACTORS			
1101	Did s/he drink alcohol?	YES 1 NO 2 DON'T KNOW 8	→1106 →1106
1102	How long had s/he been drinking? RECORD '00' IF LESS THAN ONE YEAR	YEARS <input type="text"/> <input type="text"/> DON'T KNOW 9 8	
1103	How often did s/he drink alcohol?	DAILY 1 FREQUENTLY (WEEKLY) 2 ONCE IN A WHILE 3 DON'T KNOW 8	
1104	Did she stop drinking?	YES 1 NO 2 DON'T KNOW 8	→1106 →1106
1105	How long before death did s/he stop drinking? RECORD '00' IF LESS THAN ONE MONTH	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 9 9 8	
1106	Did s/he smoke tobacco (cigarette, cigar, pipe etc.)?	YES 1 NO 2 DON'T KNOW 8	→1201 →1201
1107	How long had s/he been smoking? RECORD '00' IF LESS THAN ONE YEAR	YEARS <input type="text"/> <input type="text"/> DON'T KNOW 9 8	
1108	How often did s/he smoke?	DAILY 1 FREQUENTLY (WEEKLY) 2 ONCE IN A WHILE 3 DON'T KNOW 8	→1201 →1201 →1201
1109	How many cigarettes did s/he smoke daily?	NUMBER OF CIGARETTES <input type="text"/> <input type="text"/> DON'T KNOW 9 8	
1110	Did s/he stop smoking before death?	YES 1 NO 2 DON'T KNOW 8	→1201 →1201
1111	How long before death did s/he stop smoking? RECORD '00' IF LESS THAN ONE MONTH	MONTHS <input type="text"/> <input type="text"/> DON'T KNOW 9 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
SECTION 12. DATA ABSTRACTED FROM DEATH CERTIFICATE																			
1201	Do you have a death certificate for the deceased?	YES 1 NO 2 DON'T KNOW 8	→ 1301 → 1301																
1202	Can I see the death certificate? COPY DAY, MONTH AND YEAR OF DEATH FROM THE DEATH CERTIFICATE.	<table border="0"> <tr> <td style="text-align: center;">DAY</td> <td style="text-align: center;">MONTH</td> <td style="text-align: center;">YEAR</td> </tr> <tr> <td style="text-align: center;">□□</td> <td style="text-align: center;">□□</td> <td style="text-align: center;">□□□□</td> </tr> </table>	DAY	MONTH	YEAR	□□	□□	□□□□											
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1203	COPY DAY, MONTH AND YEAR OF ISSUE OF DEATH CERTIFICATE.	<table border="0"> <tr> <td style="text-align: center;">DAY</td> <td style="text-align: center;">MONTH</td> <td style="text-align: center;">YEAR</td> </tr> <tr> <td style="text-align: center;">□□</td> <td style="text-align: center;">□□</td> <td style="text-align: center;">□□□□</td> </tr> </table>	DAY	MONTH	YEAR	□□	□□	□□□□											
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1204	RECORD THE CAUSE OF DEATH FROM THE FIRST (TOP) LINE OF THE DEATH CERTIFICATE: _____																		
1205	RECORD THE CAUSE OF DEATH FROM THE SECOND LINE OF THE DEATH CERTIFICATE (IF ANY): _____																		
1206	RECORD THE CAUSE OF DEATH FROM THE THIRD LINE OF THE DEATH CERTIFICATE (IF ANY): _____																		
1207	RECORD THE CAUSE OF DEATH FROM THE FOURTH LINE OF THE DEATH CERTIFICATE (IF ANY): _____																		
SECTION 13 HOUSEHOLD ECONOMICS CARE AND SUPPORT																			
1301	Was there any cost incurred on health care of the deceased?(including transport)	YES 1 NO 2 DON'T KNOW 8	→ 1304 → 1304																
1302	How much spent? (if DON'T KNOW PUT 9998)	□□□□																	
1303	Who paid for the medical care? 1. This Household 2. Extended family 3. Friends/outside	<table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">DK</td> </tr> <tr> <td>1. This Household</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>2. Extended family</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>3. Friends/outside</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </table>		YES	NO	DK	1. This Household	1	2	8	2. Extended family	1	2	8	3. Friends/outside	1	2	8	
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1304	How much was paid for the funeral? (if DON'T KNOW PUT 9998)	□□□□																	
1305	Who paid for the funeral? 1. This Household 2. Extended family 3. Friends/outside	<table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">DK</td> </tr> <tr> <td>1. This Household</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>2. Extended family</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>3. Friends/outside</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </table>		YES	NO	DK	1. This Household	1	2	8	2. Extended family	1	2	8	3. Friends/outside	1	2	8	
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3. Friends/outside	1	2	8																
1306	Did the property have to be sold off?	YES 1 NO 2 DON'T KNOW 8																	
1307	Who inherited the property of the deceased? 1. This Household 2. Extended family 3. Friends/outside	<table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">DK</td> </tr> <tr> <td>1. This Household</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>2. Extended family</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>3. Friends/outside</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </table>		YES	NO	DK	1. This Household	1	2	8	2. Extended family	1	2	8	3. Friends/outside	1	2	8	
	YES	NO	DK																
1. This Household	1	2	8																
2. Extended family	1	2	8																
3. Friends/outside	1	2	8																
1308	Was there any family member who moved into help and provided care?	YES 1 NO 2 DON'T KNOW 8																	

SECTION 14. DATA ABSTRACTED FROM OTHER HEALTH RECORDS							
1401	OTHER HEALTH RECORDS AVAILABLE	YES 1 NO 2	→ 1411				
1402	FOR EACH TYPE OF HEALTH RECORD SUMMARIZE DETAILS FOR LAST 2 VISITS (IF MORE THAN 2) AND RECORD DATE OF ISSUE						
1403	BURIAL PERMIT (CAUSE OF DEATH) _____ _____						
1404	POST MORTEM RESULTS (CAUSE OF DEATH) _____ _____						
1405	MCH/ANC CARD (RELEVANT INFORMATION) _____ _____						
1406	HOSPITAL PRESCRIPTION (RELEVANT INFORMATION) _____ _____						
1407	TREATMENT CARDS (RELEVANT INFORMATION) _____ _____						
1408	HOSPITAL DISCHARGE (RELEVANT INFORMATION) _____ _____						
1409	LABORATORY RESULTS (RELEVANT INFORMATION) _____ _____						
1410	OTHER HOSPITAL DOCUMENTS SPECIFY: _____ _____ _____						
1411	RECORD THE TIME AT THE END OF INTERVIEW (RECORD IN 24 HOURS)	HOURS MINUTES	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				

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: _____