

Village/Cluster				HH				DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

SECTION 2: BACKGROUND

2.1 GENERAL DELIVERY CONTEXT (for 28 day-11 month olds)

C3001 <i>(10354)</i>	Was the child part of a multiple birth? <i>If two or more children are born at the same time, it is counted as a multiple birth, even if one or more of the babies are born dead.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3003
C3002 <i>(10355)</i>	Was the child the first, second, or later in the birth order?	1. First 2. Second or later 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3003 <i>(10356)</i>	Is the mother still alive? <i>If mother is present at the interview, select 'yes' without asking the question aloud.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3006
C3004 <i>(10357)</i>	Did the mother die before, during or after the delivery?	1. Before delivery 2. During delivery 3. After delivery 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 1,2,or 9 →C3006
C3005u <i>(10358_u nits)</i>	How long after the delivery did the mother die? <i>Select one unit only.</i>	1. Days 2. Weeks 3. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8 or 9 →C3006 2 → C3005w 3 → C3005m
C3005d <i>(10359)</i>	How many days after the delivery did the mother die? <i>Enter 0-6 days. Less than 1 day or 24 hours = 0 days.</i>		___ ___ Days → C3006 (DK = 99)
C3005w <i>(10359_a)</i>	How many weeks after the delivery did the mother die? <i>Enter 1-7 weeks.</i>		___ Weeks → C3006 (DK= 9)
C3005m <i>(10358)</i>	How long after the delivery did the mother die? <i>Enter 2-60 months.</i>		___ ___ Months (DK = 99)
C3006 <i>(10360)</i>	Where was the deceased born? <i>Read the question and slowly read the first 5 choices. Respondent should hear all 5 choices and then respond.</i>	Home: 1. The mother's home 2. Other home Public sector: 3. Government hospital 4. Government clinic/health center 5. Government health post 6. Other public (specify) Private medical sector: 7. Private hospital 8. Private clinic 9. Private maternity home 10. Other private medical (specify) 11. On route to a health provider or facility 12. Other (specify) 99. Don't know 88. Refused to answer	<input type="checkbox"/> <input type="checkbox"/>

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3008	Who (at the facility) delivered the baby? <i>Read "...at the facility..." if she delivered at a health facility.</i>	Health professional: 1. Doctor 2. Nurse / Midwife 3. Auxiliary midwife Other person: 4. Traditional birth attendant 5. Community health worker 6. Relative / Friend 7. Other (specify) 8. No one 9. Don't know	<input type="checkbox"/>
C3009_1 <i>(10362)</i>	At birth, was the baby of usual size? <i>Show photos, explain to the respondent that even if the answer is "no" some more questions will be asked, just to make sure no important detail has been missed.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3010
C3009_2 <i>(10363)</i>	At birth, was the baby smaller than usual, (weighing under 2.5 kg)? <i>Show photos if available.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3010
C3009_3 <i>(10364)</i>	At birth, was the baby very much smaller than usual, (weighing under 1 kg)? <i>Show photos if available.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3010
C3009_4 <i>(10365)</i>	At birth, was the baby larger than usual, (weighing over 4.5 kg)? <i>Show photos if available.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3010 <i>(10366)</i>	What was the weight of the deceased at birth? <i>Ask if the child health card is available. If the card is available and the birth weight is recorded, enter the birth weight from the card. If the card is not available, record the weight based on the respondent's report if known. Record the weight in grammes in 4 digits. Respondents may give the answer in kilograms. For the data entry, convert to grammes. 1 kilogram=1,000 grammes. Enter "9999" for "don't know." Enter "8888" for "refuse."</i>		_____ Grams (DK = 9999)
C3011	Record the source of the birth weight information.	1. Child's health card 2. Respondent's recall (no health card was available or seen)	<input type="checkbox"/>

2.2 BACKGROUND (CHILD DEATHS)			
C3012 <i>(10017)</i>	What was the first or given name(s) of the deceased? <i>Ask this only if the name is not already known (from Q1202).</i>		
Inst_1: child deaths 28 days-4 years → C3019_units Child deaths 5 – 11 years → C3013			
C3013	Did s/he ever attend school?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3017

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3015 <i>(10063)</i>	What is the highest level of school she/he attended?	<p style="text-align: center;"><i>Grade/Year</i></p> <p>0. Pre-school(01-02-03)</p> <p>1. Literacy class (Year: 01-02-03)</p> <p>2. Primary EP1 (Grade: 01-05)</p> <p>3. Primary EP2 (Grade: 06-07)</p> <p>4. Secondary ESG1 (Grade: 08-10)</p> <p>99. Don't know</p> <p>88. Refused to answer</p>	<input type="checkbox"/> 88 or 99 → C3017
C3016	What is the highest [GRADE/YEAR] she/he completed (at that level)? <i>If completed less than 1 year at that level, record '00'.</i>		<u> </u> <u> </u> Grade/Year. >=8 → Inst_2 (DK = 99)
C3017 <i>(10064)</i>	Was s/he able to read and write? <i>Record "yes" if both or either reading or writing is known to the respondent.</i>	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/>
Inst_2: Child deaths <9 years → C3019_units			
C3018 <i>(10065)</i>	What was her/his economic activity status in the year prior to death? <i>Por exemplo: Se fez alguma actividade economica tais como, trabalhou na machamba, ou vendeu alguns produtos, C3018=2"empregado"</i>	<p>1. Unemployed</p> <p>2. Employed</p> <p>3. Homemaker</p> <p>4. Student</p> <p>5. Other</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/> ≠ 2 → C3019_units
C3018_1 <i>(10066)</i>	What was her/his occupation, that is, what kind of work did s/he mainly do?		
C3019_units <i>(10352_units)</i>	How old was the child when the fatal illness started? <i>Enter 1 unit only: 0-30 days, 1-11 months or 1-11 years.</i>	<p>1. Days</p> <p>2. Months</p> <p>3. Years</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/> 2 → C3019_b 3 → C3019_c 8 or 9 → C3020
C3019_a <i>(10352_1)</i>	[Enter how old the child was when the illness started, in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		<u> </u> <u> </u> Days → C3020 (DK = 99)
C3019_b <i>(10352_a)</i>	[Enter how old the child was when the illness started, in months]: <i>Enter 1-11 months</i>		<u> </u> <u> </u> Months → C3020 (DK = 99)
C3019_c <i>(10352_b)</i>	[Enter how old the child was when the illness started, in years]: <i>Enter 1 or more years</i>		<u> </u> <u> </u> Years (DK = 99)
C3020 <i>(10408)</i>	Before the illness that led to death, was (the baby / the child) growing normally? <i>Read "...the baby..." if less than 1 year old at death.</i>	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/>
C3021u <i>(10120_unit)</i>	For how long was (s)he ill before death?	<p>1. Days</p> <p>2. Months</p> <p>3. Years</p> <p>4. Don't know</p> <p>5. Refused to answer</p>	<input type="checkbox"/> 2 → C3021m 3 → C3021y 8, 9 → C3022

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3021d <i>(10120_1)</i>	Days: Children: Record days if less than 7 days—if less than 24 hours, record “00” days.	____ ____ Days >00 → C3051 (DK = 99)
C3021m <i>(10121)</i>	Enter how long the illness lasted, in months <i>Enter 1-11 months</i>	____ ____ Months → C3051 (DK = 99)
C3021y <i>(10120_1)</i>	Enter how long the illness lasted, in years <i>Enter 1-11 years.</i>	____ ____ Years → C3051 (DK = 99)
C3022 <i>(10123)</i>	Did (s)he die suddenly? (“Suddenly” means within 24 hours of being in regular health.)	1. Yes 2. No 9. Don't know <input type="checkbox"/>
Inst_3: Child deaths 28 days – 11 months → C3051 Child deaths 1 – 11 years → C3101		

SECTION 6: SIGNS AND SYMPTOMS ASSOCIATED WITH THE FATAL ILLNESS (FOR 28 DAYS – 11 MONTHS OLD DEATHS)

Read: Now I'd like to ask you about the pregnancy and <NAME>'s condition in the first month of life.

C3051 <i>(10347)</i>	Was the baby born more than one month early?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3052 <i>(10367)</i>	How many months long was the pregnancy before birth?		____ ____ Months (DK = 99)
C3053 <i>(10368)</i>	Were there any complications in the late part of the pregnancy (defined as the last 3 months, before labour)?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3053a <i>(10369)</i>	Were there any complications during labour or delivery?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3054 <i>(10398)</i>	Did the baby's mother have foul smelling vaginal discharge during the pregnancy?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3055	During the last 3 months of pregnancy, did the baby's mother suffer from blurred vision?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3056 <i>(10402)</i>	During the last 3 months of pregnancy, but before labor started, did the mother have vaginal bleeding?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3057 <i>(10396)</i>	During the last 3 months of pregnancy, labor or delivery did the mother suffer from high blood pressure?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3059
C3058 <i>(10396A)</i>	Did the high blood pressure start before or after labor began?	1. Before labor began 2. After labor began 9. Don't know	<input type="checkbox"/>

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3059 <i>(10399)</i>	During the last 3 months of pregnancy, labor or delivery, did the mother suffer from convulsions?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3061
C3060 <i>(10399A)</i>	Did the convulsions start before or after labor began?	1. Before labor began 2. After labor began 9. Don't know	<input type="checkbox"/>
C3061 <i>(10395)</i>	During labor, did the baby's mother suffer from fever?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
C3062 <i>(10382)</i>	How many hours did the labor and delivery take? <i>Record "00" if less than 1 hour.</i>		____ Hours <i>(DK = 99)</i>
C3063 <i>(10403)</i>	Did the baby's bottom, feet, arm or hand come out of the vagina before its head?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
Inst_4: If no pregnancy complications: (C3054≠1 and C3055≠1 and C3056≠1 and (C3057≠1 or C3058≠1) and (C3059≠1 or C3060≠1)) → Inst_5			
C3064	Did (you / the mother) receive care from any person or health facility for (any of) the pregnancy symptom(s) that started <u>before</u> labor? <i>Read "...for any of..." if she had more than one pregnancy symptom.</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → Inst_5
C3065	Where did (you / she) receive this care? <i>Prompt: Was there anywhere else?</i> <i>Probe to identify the type of provider or facility. If the woman was seen by a trained community nurse or midwife at a health facility, then mark the type of facility(ies) (1-3) where the provider was seen. Use option 4 only if the provider was seen outside of a health facility.</i> <i>Multiple answers allowed.</i>	Health professional: 1. Hospital 2. NGO or government clinic 3. Private doctor/clinic Health professional (<u>outside</u> a facility): 4. Trained community nurse or midwife (outside of a health facility) Other person: 5. TBA/village doctor/quack/other non-formal or traditional provider 6. Relative, neighbor, friend 7. Other (<i>specify</i>)..... (_____) 9. Don't know.....	1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/>
Inst_5: If no labor/delivery complications: ((C3051≠1 and C3052=9,10) and (C3057≠1 or C3058≠2) and (C3059≠1 or C3060≠2) and C3061≠1 and C3062<12 and C3063≠1) → C3071.			
C3066	Did (you / she) <u>ever</u> receive any care or treatment for (<u>any</u> of) the labor or delivery symptom(s) including any <u>care or treatment at home</u> ? <i>Read "...any of the symptoms" if she had more than one symptom.</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → C3071

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3067	<p>Where did (you / she) receive this care or treatment?</p> <p>Prompt: Was there anywhere else?</p> <p><i>Probe to identify the types of providers or facilities. If the woman was seen by a trained community nurse or midwife at a health facility, then mark the type of facility(ies) (1-3) where the provider was seen. Use option 4 only if this provider was seen outside a health facility. Use options 5-7 for other persons that provided care outside a health facility.</i></p> <p><i>Multiple answers allowed.</i></p>	<p><u>Health professional (at a health facility):</u></p> <p>1. Hospital</p> <p>2. NGO or government clinic</p> <p>3. Private doctor/clinic</p> <p><u>Health professional (outside a facility):</u></p> <p>4. Trained community nurse or midwife (outside a health facility)</p> <p><u>Other person (outside a health facility):</u></p> <p>5. TBA/village doctor/quack/other non-formal or traditional provider</p> <p>6. Relative, neighbor, friend</p> <p>7. Other (specify)</p> <p>(_____)</p> <p>9. Don't know</p>	<p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/></p> <p>5. <input type="checkbox"/></p> <p>6. <input type="checkbox"/></p> <p>7. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p> <p style="text-align: center;">Only 5-9 → C3071</p>
C3068	<p><i>Read:</i> Now I would like to ask about the last health provider where (you / the mother) received care for the labor or delivery symptoms.</p> <p><i>If she delivered at a health provider or facility (C3006=3-10 or C3006=1-2 and C3008=1-3), read:</i> Earlier you said that (you / she) delivered at <DELIVERY PLACE>. (Confirm C3006 delivery place and C3008birth attendant if at home.)</p> <p><i>If she did not deliver at a health provider or facility (C3006=11-12 or C3006=1-2 and C3008≠1-3), read:</i> What was the last health provider or facility where (you / she) received care for the labor or delivery symptoms?</p> <p><i>Probe to identify the type of provider or facility. If the woman was seen by a trained community nurse or midwife at a health facility, then mark the type of facility where the provider was seen.</i></p>	<p><u>Home:</u></p> <p>1. Her own home with a doctor, nurse, midwife or auxiliary midwife</p> <p>2. Another home with a doctor, nurse, midwife or auxiliary midwife</p> <p><u>Public sector:</u></p> <p>3. Government hospital</p> <p>4. Government clinic/health center</p> <p>5. Government health post</p> <p>6. Other public (specify)</p> <p><u>Private medical sector:</u></p> <p>7. Private hospital</p> <p>8. Private clinic</p> <p>9. Private maternity home</p> <p>10. Other private medical (specify).....</p> <p>99. Don't know</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>
C3069	Did the <LAST HEALTH PROVIDER> refer (you / the mother) to another health provider or facility?	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p>	<input type="checkbox"/>
C3070	Was the baby delivered by the <LAST HEALTH PROVIDER>?	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p>	<input type="checkbox"/>
C3071 (10115)	Were there any bruises or signs of injury on the baby's body at birth?	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/>
C3072 (10370)	Was any part of the baby physically abnormal at the time of delivery? (for example: body part too large or too small, additional growth on body)	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/> 8, 2 or 9 → C3074
C3073_1 (10371)	Did the baby/ child have a swelling or defect on the back at time of birth?	<p>1. Yes</p> <p>2. No</p> <p>9. Don't know</p> <p>8. Refused to answer</p>	<input type="checkbox"/>

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3073_2 <i>(10372)</i>	Did the baby/ child have a very large head at time of birth?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3074
C3073_3 <i>(10373)</i>	Did the baby/ child have a very small head at time of birth?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3074 <i>(10111)</i>	Did the baby breathe immediately after birth, even a little?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3075 <i>(10105)</i>	Did the baby cry immediately after birth, even if only a little bit?	1. Yes 2. No 9. Don't know 8. Refused to Answer	<input type="checkbox"/> 1 → <u>Inst 6</u>
C3076 <i>(10106)</i>	How long after birth did the baby first cry? <i>Mark ONE response.</i>	1. Within 5 minutes 2. Within 6-30 minutes 3. More than 30 minutes 4. Never 9. Don't know 8. Refused to answer	<input type="checkbox"/>
Inst_6: If the delivery was not preterm (C3051≠1 and C3052=9,10) or not in a health facility (C3006=1, 2, 11, 12, 99) → C3078			
C3077	<i>For babies delivered preterm (C3051=1 or C3052<9 months) in a health facility (C3006=3-10), ask: Was the baby put in an incubator after the birth?</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
C3078	After the birth, was the baby put directly on the bare skin of (your / the mother's) chest? <i>Show the woman a picture of skin-to-skin position.</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 8, 2 or 9 → C3083
C3079	How long after the birth was the baby put on the bare skin of (your / the mother's) chest? <i>If 1-23 hours, record number of hours.</i>	1. Immediately 2. Less than 1 hour 3. 1 hour or more 4. Don't know	<input type="checkbox"/> <input type="checkbox"/> Hours <input type="checkbox"/>
C3080	Before being placed on the bare skin of (your / the mother's) chest, was the baby wrapped up?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
Inst_7: If the delivery was not preterm (C3051≠1 and C3052=9,10) or not in a health facility (C3006=1, 2, 11, 12, 99) → C3083			
C3081	<i>For babies delivered preterm (C3051=1 or C3052<9 months) in a health facility (C3006=3-10), ask: For how many hours each day was the baby directly on the bare skin of (your / the mother's) chest? If less than 1 hour, record "00."</i>		_____ Hours (DK = 99)
C3082	<i>For babies delivered preterm (C3051=1 or C3052<9 months) in a health facility (C3006=3-10), ask: For how many days was the baby put directly on the bare skin of (your / the mother's) chest? If less than 1 day, record "00."</i>		_____ Days (DK = 99)

Village/Cluster				HH		DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3083	How long after birth was the baby first bathed?	1. Less than 6 hours 2. 7-23 hours 3. 24 hours or more 4. Not bathed before death 9. Don't know	<input type="checkbox"/>
C3084 <i>(10271)</i>	Was the baby able to suckle or bottle-feed within the first 24 hours after birth?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3086
C3085 <i>(10272)</i>	Did the baby ever suckle in a normal way?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3091
C3086 <i>(10273)</i>	Did the baby stop being able to suckle in a normal way?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3091
C3087 <i>(10274)</i>	How many days after birth did the baby stop suckling?		_____ Days (DK = 99)
C3088	Was the baby able to open her/his mouth at the time s/he stopped suckling?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3089 <i>(10284)</i>	During the illness that led to death, did the baby become cold to touch?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3091
C3090 <i>(10285)</i>	At what age did the baby start feeling cold to touch? <i>Record in days if less than 1 month, or in months if 1 month or more.</i> <i>[Less than 24 hours = "00" days]</i>		_____ Days (DK = 99) _____ Months (DK = 99)
C3091 <i>(10275)</i>	Did the baby have convulsions in the first 24 hours of life?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3093
C3092 <i>(10276)</i>	Did the baby have convulsions starting more than 24 hours after birth?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3093 <i>(10277)</i>	Did the baby's body become stiff, with the head arched backwards?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3094 <i>(10278)</i>	Did <NAME> have a bulging or raised fontanelle during the illness that led to death? <i>Show photo.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3095 <i>(10279)</i>	Did s/he have a sunken fontanelle during the illness that led to death? <i>Show photo.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3096 <i>(10286)</i>	During the illness that led to death, did the baby become lethargic, after a period of normal activity?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3097 <i>(10281)</i>	During the baby's first month of life, did s/he become unresponsive or unconscious?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3101
C3098 <i>(10282)</i>	Did the baby become unresponsive or unconscious soon after birth, within less than 24 hours?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3101
C3099 <i>(10283)</i>	Did the baby become unresponsive or unconscious more than 24 hours after birth? <i>If both C3098 and C3099 = "No," discuss and reconcile this with the respondent.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

SECTION 7: PREVENTIVE CARE OF CHILDREN (FOR 28 DAYS – 11 YEARS CHILD DEATHS)

Read: Now I would like to ask you (some more questions) about the care of the child before the fatal illness began.

For children 1-11 months old, include the words "some more questions."

Inst_8a: If Q1102≠ "1.High" → Inst_8b			
C3101	<i>Skip C3101 in areas wo/malaria.</i> Before (her / his) fatal illness began, did <NAME> sleep under an insecticide treated bed net?	1. Yes, usually or always 2. Yes, sometimes 3. Never 9. Don't know	<input type="checkbox"/>
Inst_8b: If age > 4 years → C3107			
C3102	Where (do you / does the mother) cook?	1. Inside the house 2. Outside the house 3. In a structure outside the house 9. Don't know	<input type="checkbox"/>
C3103	When (you / the mother) cooked, was <NAME> usually beside or carried by (you / her)?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
C3104	Was <NAME> ever breastfed?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 1 & age > 11 mos. → C3106 2 or 9 → C3107
C3105	How long after birth was the baby first put to the breast? <i>If 1-23 hours, record number of hours.</i> <i>If 1 day or more, record number of days.</i>	1. Immediately 2. Less than 1 hour 3. 1 hour or more 4. 1 day or more 9. Don't know	<input type="checkbox"/> <input type="checkbox"/> Hours Days <input type="checkbox"/>
C3106	Was <NAME> being breastfed on the day before the fatal illness began?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>

Village/Cluster				HH				DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3107	<p>On the day before the illness began, was <NAME> being given any...?</p> <p><i>Read all options and record "Yes," "No" or "Don't know" for each.</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr><td>1. Plain water?</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>2. Fruit juice or juice drinks?</td><td style="text-align: center;">1. <input type="checkbox"/></td><td style="text-align: center;">2. <input type="checkbox"/></td><td style="text-align: center;">9. <input type="checkbox"/></td></tr> <tr><td>3. 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Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside? ..	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	11. White potatoes, white yams, manioc, cassava, or other foods made from roots?..	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	12. Any dark green, leafy vegetables?	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	13. Ripe mangoes, papayas or <INSERT ANY OTHER LOCALLY AVAILABLE VITAMIN A-RICH FRUITS>?	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	14. Any other fruits or vegetables?	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	15. Liver, kidney, heart or other organ meats? ..	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	16. 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C3108 (10429)	<p>Now I would like to ask about the child's vaccinations. Do you have a card where <NAME>'s vaccinations are written down?</p> <p><i>If "Yes," ask: May I see it please?</i></p>	<p>1. Yes, card seen 2. Yes, but card not seen 3. No card</p>	<p style="font-size: 2em; text-align: center;"><input type="checkbox"/></p> <p style="text-align: center;">2 or 3 → C3111</p>																																																																																																																			

Village/Cluster	HH	DeathID

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

.3	When was the first oral polio vaccine received, just after birth or later?	1. Just after birth 2. Later 9. Don't know	<input type="checkbox"/>
.4	How many times was the oral polio vaccine received?		_____ Times (DK = 99)
.5	A DPT vaccination, that is, an injection in the thighs or buttocks, sometimes given at the same time as polio drops or a Hep B vaccination?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → C3111.7
.6	How many times was a DPT vaccination received?		_____ Times (DK = 99)
.7	A PENTA (DPT+HepB+Hib) vaccination, that is, an injection in the thighs or buttocks instead of a Hep B or DPT vaccination, sometimes given at the same time as polio drops?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → C3111.9
.8	How many times was a PENTA (DPT+HepB+Hib) vaccination received?		_____ Times (DK = 99)
.9	A Pneumococcal (PCV) vaccination, that is, an injection in the shoulder or thigh at the age of 6 weeks or older?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 8, 2 or 9 → C3111.11
.10	How many times was a PCV vaccination received?		_____ Times (DK = 99)
.11	A rotavirus (R) vaccination, that is, a liquid medication given by putting drops in the baby's mouth, sometimes given around the same time as polio drops or a Hep B vaccination?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 8, 2 or 9 → C3111.13
.12	How many times was a rotavirus vaccination received?		_____ Times (DK = 99)
.13	An Inactivated Polio Vaccine (IPV) is an injectable vaccine in the shoulder or thigh at the age of 6 weeks or older and it can be administered alone or in combination with other vaccines (e.g., DPT, hepatitis B, and haemophilus influenza)?	1. Yes 2. No 9. Don't know	<input type="checkbox"/>
.14	A measles or rubella injection, that is, a shot in the arm at the age of 9 months or older, to prevent measles, mumps and rubella?	3. Yes 4. No 2. 9. Don't know	<input type="checkbox"/>
C3112	(Before / In the six months before) the fatal illness, did <NAME> receive at least one dose of vitamin A? <i>Read "Before..." if the child lived less than 6 months.</i> <i>Show ampoule/capsule/syrup.</i>	1. Yes 2. No 9. Don't know	<input type="checkbox"/>

Village/Cluster			HH			DeathID					

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE
SECTION 8: SIGNS AND SYMPTOMS ASSOCIATED WITH THE FATAL ILLNESS (FOR CHILD DEATHS 28 DAYS – 11 YEARS OLD)

Read: Now I'd like to ask you (some more questions) about <NAME>'s illness.

C3121 <i>(10147)</i>	During the illness that led to death, did <NAME> have a fever?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 8, 2 or 9 → C3128																								
C3122	At what age did the fever start? <i>[Less than 24 hours = "00" days]</i> <i>Record in days if less than 1 month, or in months between 1 and 11 months and in years if 1 year or more.</i>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Days</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table> </td> <td style="border: none;"></td> </tr> <tr> <td style="text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Months</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table> </td> <td style="border: none;"></td> </tr> <tr> <td style="text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Years</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table> </td> <td style="border: none;"></td> </tr> </table>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Days</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table>			Days	<i>(DK = 99)</i>				<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Months</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table>			Months	<i>(DK = 99)</i>				<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Years</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table>			Years	<i>(DK = 99)</i>			
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C3123_u nits <i>(10148_u nits)</i>	How long did the fever last? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3123_c 8 or 9 → C3124																								
C3123_b <i>(10148_b)</i>	[Enter how long the fever lasted in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Days → C3124</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table> </td> <td style="border: none;"></td> </tr> </table>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Days → C3124</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table>			Days → C3124	<i>(DK = 99)</i>																			
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<i>(DK = 99)</i>																											
C3123_c <i>(10148_c)</i>	[Enter how long the fever lasted in months]: <i>Enter 1-60 months</i>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Months</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table> </td> <td style="border: none;"></td> </tr> </table>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="width: 20px; border-bottom: 1px solid black;"></td> <td style="text-align: right;">Months</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>(DK = 99)</i></td> </tr> </table>			Months	<i>(DK = 99)</i>																			
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		Months																									
<i>(DK = 99)</i>																											
C3124 <i>(10149)</i>	Did the fever continue until death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																								
C3125 <i>(10150)</i>	How severe was the fever?	1. Mild 2. Moderate 3. Severe 9. Don't know 8. Refused to answer	<input type="checkbox"/>																								
C3126 <i>(10151)</i>	What was the pattern of the fever?	1. Continuous 2. On and off 3. Only at night 9. Don't know 8. Refused to answer	<input type="checkbox"/>																								
C3127 <i>(10152)</i>	Did the child have night sweats?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																								
C3128 <i>(10269)</i>	During the illness, did the child have sunken eyes?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																								
C3129 <i>(10270)</i>	Did s/he drink a lot more water than usual?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																								
C3130 <i>(10181)</i>	During the illness that led to death, did <NAME> have more frequent loose or liquid stools than usual?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3137																								

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3131 <i>(10183)</i>	How many stools did <NAME> have on the day that loose liquid stools were most frequent?	<u> </u> <u> </u> Stools (DK = 99)
C3132 <i>(10184)</i>	How many days before death did the frequent loose or liquid stools start? <i>Less than 24 hours = "00" days.</i>	<u> </u> <u> </u> Days (DK = 99)
C3133 <i>(10185)</i>	Did the frequent loose or liquid stools continue until death?	<input type="checkbox"/> 1 → C3135
C3134	How many days before death did the loose or liquid stools stop? <i>Less than 24 hours = "00" days.</i>	<u> </u> <u> </u> Days (DK = 99)
C3135 <i>(10186)</i>	At any time during the fatal illness was there visible blood in the loose or liquid stools?	<input type="checkbox"/> 8, 2 or 9 → C3137
C3136 <i>(10187)</i>	Was there blood in the stools up until death?	<input type="checkbox"/>
C3137 <i>(10188)</i>	During the illness that led to death, did the child vomit?	<input type="checkbox"/> 8, 2 or 9 → C3141
C3138 <i>(10189)</i>	Did s/he vomit in the week preceding death?	<input type="checkbox"/>
C3139 <i>(10191)</i>	Did s/he vomit blood?	<input type="checkbox"/>
C3140 <i>(10192)</i>	Was the vomit black?	<input type="checkbox"/>
C3141 <i>(10193)</i>	Did s/he have any belly (abdominal) problem?	<input type="checkbox"/>
C3142 <i>(10194)</i>	Did s/he have any belly (abdominal) pain?	<input type="checkbox"/> 8, 2 or 9 → C3146
C3143 <i>(10195)</i>	Was the belly (abdominal) pain severe?	<input type="checkbox"/>

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3144_u nits <i>(10196_ units)</i>	For how long did (s)he have belly (abdominal) pain? <i>Enter 1 unit only: 0-23 hours, 1-30 days, or 1-60 months. 1 week = 7 days. In case of "Doesn't know" or "Refused to answer" and if the response to Id10195 (C3143) was "Yes", go to "Id10199" (C3145). If the response to Id10195 (C3143) was "No", "Don't know" or "Refused to answer", skip to Id10200 (C3146).</i>	1. Hours 2. Days 3. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3144_a 3 → C3144_b
C3144 <i>(10196)</i>	[Enter how long (s)he had belly (abdominal) pain in hours]: <i>Enter 1-23 hours. If Id10195 (C3143)=Yes, go to "Id10199" (C3145). If the response to Id10195 (C3143) was "No", "Don't know" or "Refused to answer", skip to Id10200 (C3146).</i>		____ Hours (DK = 99)
C3144_a <i>(10197_a)</i>	[Enter how long (s)he had belly (abdominal) pain in days]: <i>Enter 0-30 days. 1 week = 7 days. If Id10195 (C3143) =Yes, go to "Id10199" (C3145). If the response to Id10195 was "No", "Don't know" or "Refused to answer", skip to Id10200 (C3146).</i>		____ Days (DK = 99)
C3144_b <i>(10198)</i>	[Enter how long (s)he had belly (abdominal) pain in months]: <i>Enter 1-60 months. If Id10195 (C3143)=Yes, go to "Id10199". If the response to Id10195 (C3143) was "No", "Don't know" or "Refused to answer", skip to Id10200 (C3146).</i>		____ Months (DK = 99)
C3145 <i>(10199)</i>	Was the pain in the upper or lower abdomen?	1. Upper abdomen 2. Lower abdomen 3. Upper and lower abdomen 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3146 <i>(10200)</i>	Did s/he have a more than usually protruding abdomen?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3149
C3147_u nit <i>(10201_ unit)</i>	For how long before death did (s)he have a more than usually protruding belly (abdomen)? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Doesn't know 8. Refused to answer	<input type="checkbox"/> 2 → C3147_b 8 or 9 → C3148
C3147_a <i>(10201_a)</i>	[Enter how long before death (s)he had a more than usually protruding belly (abdomen) in days] <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days (DK = 99)
C3147_b <i>(10202)</i>	[Enter how long before death (s)he had a more than usually protruding belly (abdomen) in months]		____ Months (DK = 99)
C3148 <i>(10203)</i>	How rapidly did s/he develop the protruding abdomen?	1. Rapidly 2. Slowly 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3149 <i>(10204)</i>	Did s/he have a mass in the abdomen?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3151

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3150_u nit <i>(10205_ unit)</i>	For how long did (s)he have a mass in the belly (abdomen)? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3150_b 8, 9 → C3151
C3150_a <i>(10205_a)</i>	[Enter how long (s)he had a mass in the belly (abdomen) in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days → C3151 (DK = 99)
C3150_b <i>(10206)</i>	[Enter how long (s)he had a mass in the belly (abdomen) in months]: <i>Enter 1-60 months.</i>		____ Months (DK = 99)
C3151 <i>(10153)</i>	During the illness that led to death, did the child have a cough?	1. Yes 2. No 9. Don't know	<input type="checkbox"/> 8, 2 or 9 → C3158
C3152_u nits <i>(10154_ units)</i>	For how long did s/he have a cough? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3152_b 8 or 9 → C3153
C3152_a <i>(10154_b)</i>	[Enter how long the cough lasted in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days → C3153 (DK = 99)
C3152_b <i>(10154_c)</i>	[Enter how long the cough lasted in months]: <i>Enter 1-60 months</i>		____ Months (DK = 99)
C3153 <i>(10155)</i>	Was the cough productive, with sputum?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3154 <i>(10156)</i>	Was the cough very severe?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3155 <i>(10158)</i>	Did the child make a whooping sound when coughing?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3156	Did the child vomit after s/he coughed?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3157 <i>(10157)</i>	Did s/he cough up blood?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3158 <i>(10159)</i>	During the illness that led to death, did <NAME> have difficulty breathing?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3161

Village/Cluster	HH	DeathID

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3159_u nits <i>(10161_ unit)</i>	For how long did the difficult breathing last? <i>Enter 1 unit only: 0-30 days or 1-11 months or 1 or more years. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 3. Years 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3159_b 3 → C3159_c 8 or 9 → C3160
C3159_a <i>(10161_ 1)</i>	[Enter how long the difficult breathing lasted in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days → C3160 (DK = 99)
C3159_b <i>(10162)</i>	[Enter how long the difficult breathing lasted in months]: <i>Enter 1-11 months</i>		____ Months → C3160 (DK = 99)
C3159_c <i>(10163)</i>	[Enter how long the difficult breathing lasted in years]: <i>Enter 1 or more years</i>		____ Years (DK = 99)
C3160 <i>(10165)</i>	Was the difficult breathing continuous or on and off?	1. Continuous 2. On and off 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3161 <i>(10166)</i>	During the illness that led to death, did <NAME> have fast breathing?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3164
3162	At what age did the fast breathing start? <i>[Less than 24 hours = "00" days]</i> <i>Record in days if less than 1 month, or in months if 1-11 month or in years if 12 months or more.</i>		____ Days (DK = 99) ____ Months (DK = 99) ____ Years (DK = 99)
C3163_u nits <i>(10167_ units)</i>	How long did the fast breathing last? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3163_b 8 or 9 → C3164
C3163_a <i>(10167_ b)</i>	[Enter how long the fast breathing lasted in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days → C3164 (DK = 99)
C3163_b <i>(10167_ c)</i>	[Enter how long the fast breathing lasted in months]: <i>Enter 1-60 months</i>		____ Months (DK = 99)
C3164 <i>(10168)</i>	During the illness that led to death, did the child have breathlessness?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3166
C3165_u nits <i>(10169_ units)</i>	How long did s/he have breathlessness? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3165_b 8 or 9 → C3166

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3165_a <i>(10169_b)</i>	<p>[Enter how long the breathlessness lasted in days]:</p> <p><i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i></p>	<p>____ Days → C3166 (DK = 99)</p>
C3165_b <i>(10169_c)</i>	<p>[Enter how long the breathlessness lasted in months]:</p> <p><i>Enter 1-60 months</i></p>	<p>____ Months (DK = 99)</p>
C3166 <i>(10172)</i>	<p><i>Ask this only for children <5 years:</i> During the illness that led to death, did you see the lower chest wall/ribs being pulled in as the child breathed?</p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/></p>
C3167 <i>(10173_nc0)</i>	<p>During the illness that led to death, did her/his breathing sound like any of the following?</p> <p><i>Demonstrate each sound.</i></p>	
C3168 <i>(10173_nc1)</i>	Stridor	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/></p>
C3169 <i>(10173_nc2)</i>	Grunting	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/></p>
C3170 <i>(10173_nc3)</i>	Wheezing	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/></p>
C3171 <i>(10174)</i>	Did s/he have chest pain?	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/> 8, 2 or 9 → C3173</p>
C3172 <i>(10176)</i>	<p>How many days before death did s/he have chest pain?</p> <p><i>Less than 1 day = "00" days.</i></p>	<p>____ Days (DK = 99)</p>
C3173 <i>(10207)</i>	Did <NAME> have a severe headache?	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/></p>
C3174 <i>(10208)</i>	Did <NAME> have a stiff neck during the illness that led to death?	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p> <p style="text-align: center;"><input type="checkbox"/> 8, 2 or 9 → C3176</p>
C3175_u nits <i>(10209_units)</i>	<p>How long before death did s/he have a stiff neck?</p> <p><i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i></p>	<p>____ 2 → C3175_b 8 or 9 → C3176</p>
C3175_a <i>(10209_a)</i>	<p>[Enter how long the stiff neck lasted in days]:</p> <p><i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i></p>	<p>____ Days → C3176 (DK = 99)</p>
C3175_b <i>(10209_b)</i>	<p>[Enter how long the stiff neck lasted in months]:</p> <p><i>Enter 1-60 months</i></p>	<p>____ Months (DK = 99)</p>

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3176 <i>(10210)</i>	Did <NAME> have a painful neck during the illness that led to death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3178
C3177_u <i>(10211_ units)</i>	How long before death did s/he have a stiff neck? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3177_b 8 or 9 → C3178
C3177_a <i>(10211_a)</i>	[Enter how long the stiff neck lasted in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days → C3178 (DK = 99)
C3177_b <i>(10211_b)</i>	[Enter how long the stiff neck lasted in months]: <i>Enter 1-60 months</i>		____ Months (DK = 99)
C3178 <i>(10214)</i>	Was <NAME> unconscious during the illness that led to death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3182
C3179_u <i>(10216_ units)</i>	How long before death did unconsciousness start? <i>Enter 1 unit only: 0-23 hours or 1-99 days. 1 week = 7 days.</i>	1. Hours 2. Days 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3179_b 8 or 9 → C3180
C3179_a <i>(10216_a)</i>	[Enter how long before death unconsciousness started in hours]: <i>Enter 0-23 hours</i>		____ Hours → C3180 (DK = 99)
C3179_b <i>(10216_b)</i>	[Enter how long before death unconsciousness started in days]: <i>Enter 1-99 days</i>		____ Days (DK = 99)
C3180 <i>(10217)</i>	Did the unconsciousness start suddenly, quickly (at most within a single day)?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3181 <i>(10218)</i>	Did the unconsciousness continue until death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3182 <i>(10219)</i>	During the illness that led to death, did <NAME> have convulsions?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3186_1
C3183 <i>(10220)</i>	Did s/he experience any generalized convulsions or fits during the illness that led to death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3184 <i>(10221)</i>	For how many minutes did the convulsions last? <i>Less than 1 minute = "00" minutes.</i>		____ Minutes (DK = 99)
C3185 <i>(10222)</i>	Did s/he become unconscious immediately after the convulsion?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3186_1 <i>(10223)</i>	Did the child have any urine problem?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3189
C3186 <i>(10226)</i>	During the fatal illness, did s/he ever pass blood in the urine?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3187 <i>(10224)</i>	Did s/he stop urinating?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3188 <i>(10225)</i>	During s/he go to urinate more often than usual?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3189 <i>(10227)</i>	Did she have sores or ulcers anywhere on the body?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3191
C3190 <i>(10229)</i>	Did the sores or ulcers have pus?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3191 <i>(10230)</i>	Did s/he have an ulcer (pit) on the foot?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3194
C3192 <i>(10231)</i>	Did the ulcer on the foot ooze pus?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3194
C3193_u nits <i>(10232_u units)</i>	How long did the ulcer on the foot ooze pus? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	3. Days 4. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3193_b 8 or 9 → C3194
C3193_a <i>(10232_a)</i>	[Enter how long the stiff neck lasted in days]: <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		<u> </u> <u> </u> Days → C3194 (DK = 99)
C3193_b <i>(10232_b)</i>	[Enter how long the stiff neck lasted in months]: <i>Enter 1-60 months</i>		<u> </u> <u> </u> Months (DK = 99)
C3194 <i>(10233)</i>	During the month before s/he died, did <NAME> have a skin rash?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3198
C3195_a <i>(10235)</i>	Where was the rash?	1. Face 2. Trunk/Abdomen 3. Extremities 4. Everywhere 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH		DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3195	Where did the rash start?	1. Face 2. Trunk/Abdomen 3. Extremities 4. Everywhere 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3196 <i>(10234)</i>	How many days did the rash last?		$\underline{\quad}$ $\underline{\quad}$ Days (DK = 99)
C3197 <i>(10236)</i>	Did s/he have a measles rash (use local term)?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3198 <i>(10240)</i>	During the illness that led to death, did the child have an area(s) of skin with redness and swelling?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3199 <i>(10243)</i>	Did <NAME> have noticeable weight loss? <i>[hint: limbs (legs, arms) become very thin]</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3199_1 <i>(10244)</i>	Was s/he severely thin or wasted? <i>[Show photo]</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3200 <i>(10249)</i>	During the illness that led to death, did <NAME> have swollen legs or feet?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3203
C3201_u nits <i>(10250_ units)</i>	How long did the swelling last? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3201_a <i>(10250_a)</i>	[Enter how long the swelling lasted in days] <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		$\underline{\quad}$ $\underline{\quad}$ Days (DK = 99)
C3201_b <i>(10250_b)</i>	[Enter how long the swelling lasted in months] <i>Enter 1-60 months.</i>		$\underline{\quad}$ $\underline{\quad}$ Months (DK = 99)
C3202 <i>(10251)</i>	Did s/he have both feet swollen?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3203 <i>(10247)</i>	Did s/he have puffiness of the face?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3206

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3204_u <i>(10248_units)</i>	How long did s/he have puffiness of the face? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3204_a <i>(10248_a)</i>	[Enter how long the face puffiness lasted in days] <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days (DK = 99)
C3204_b <i>(10248_b)</i>	[Enter how long the face puffiness lasted in months] <i>Enter 1-60 months.</i>		____ Months (DK = 99)
C3205 <i>(10252)</i>	Did s/he have general puffiness all over her/his body	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3206 <i>(10238)</i>	During the illness that led to death, did <NAME>'s skin flake off in patches?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3207 <i>(10265)</i>	Did s/he have yellow discoloration of the eyes?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3210
C3208_u <i>(10266_units)</i>	For how long did s/he have the yellow discoloration? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	0. Days 1. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3208_a <i>(10266_a)</i>	[Enter how long the yellow discoloration lasted in days] <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ Days (DK = 99)
C3208_b <i>(10266_b)</i>	[Enter how long the yellow discoloration lasted in months] <i>Enter 1-60 months.</i>		____ Months (DK = 99)
C3209 <i>(10267)</i>	Did <NAME>'s hair change in color to a reddish or yellowish color?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3210 <i>(10268)</i>	Did s/he look pale (thinning/lack of blood) or have pale palms, eyes or nail bed?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3212 <i>(10255)</i>	Did s/he have any lumps on the neck?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3213 <i>(10256)</i>	Did s/he have any lumps on the armpit?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3214 <i>(10257)</i>	Did s/he have any lumps on the groin?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3215 <i>(10246)</i>	Did s/he have stiffness of the whole body or was unable to open the mouth?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3216 <i>(10258)</i>	Was s/he in any way paralyzed?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3219
C3217 <i>(10259)</i>	Did s/he have paralysis of only one side of the body?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3218 <i>(10260)</i>	Which were the limbs or body parts paralyzed?	1. Right side 2. Left side 3. Lower part of body 4. Upper part of body 5. One leg only 6. One arm only 7. Whole body 8. Other 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3219 <i>(10261)</i>	Did s/he have difficulty swallowing?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3223
C3220_u <i>(10262_ units)</i>	For how long before death did s/he have difficulty swallowing? <i>Enter 1 unit only: 0-30 days or 1-60 months. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>	1. Days 2. Months 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3220_a <i>(10262_a)</i>	[Enter how long the difficulty swallowing lasted in days] <i>Enter 0-30 days. Less than 1 day or 24 hours = 0 days; 1 week = 7 days.</i>		____ ____ Days (DK = 99)
C3220_b <i>(10262_b)</i>	[Enter how long the difficulty swallowing lasted in months] <i>Enter 1-60 months.</i>		____ ____ Months (DK = 99)
C3221 <i>(10263)</i>	Was the difficulty with swallowing with solids, liquids or both?	1. Solids 2. Liquids 3. Both	<input type="checkbox"/>
C3222 <i>(10264)</i>	Did s/he have pain upon swallowing?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3223 <i>(10245)</i>	During the illness that led to death, did <NAME> have a whitish rash inside the mouth or on the tongue?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3224 <i>(10241)</i>	During the illness that led to death, did <NAME> bleed from anywhere?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3226
C3225 <i>(10242)</i>	Did s/he bleed from the nose, mouth or anus?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3226 <i>(10239)</i>	During the illness that led to death, did s/he have areas of the skin that turned black?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
Injuries and Accidents			
<i>Read:</i> Now, I'd like to ask you about any injuries or accidents that <NAME> may have suffered.			
C3227 <i>(10077)</i>	Did <NAME> suffer from any injury or accident that led to her/his death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 2 → C3251
C3227_1 <i>(10079)</i>	Was it a road traffic accident?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3227_4
C3227_2 <i>(10080)</i>	What was her/his role in the road traffic accident?	1. Pedestrian 2. Driver or passenger in car or light vehicle 3. Driver or passenger in bus or heavy vehicle 4. Driver or passenger on a motorcycle 5. Driver or passenger on a pedal cycle 6. Other 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_3 <i>(10081)</i>	What was the counterpart that was hit during the road traffic accident?	1. Pedestrian 2. Stationary object 3. Car or light vehicle 4. Bus or heavy vehicle 5. Motorcycle 6. Pedal cycle 7. Other 9. Don't know 8. Refused to answer	<input type="checkbox"/> → C3227_20
C3227_4 <i>(10082)</i>	Was (s)he injured in a non-road transport accident?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_5 <i>(10083)</i>	Was (s)he injured in a fall? <i>This includes accidents and cases where it is unknown if it was an accident or whether there was intentional violence.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_6 <i>(10084)</i>	Was there any poisoning? <i>This includes accidents and cases where it is unknown if it was an accident or whether there was intentional violence.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3227_7 (10085)	Did (s)he die of drowning? <i>This includes accidents and cases where it is unknown if it was an accident or whether there was intentional violence.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_8 (10086)	Was (s)he injured by a bite or sting by venomous animal? <i>This includes accidents and cases where it is unknown if it was an accident or whether there was intentional violence.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3227_10
C3227_9 (10087)	Was (s)he injured by an animal or insect (non-venomous)?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3227_11
C3227_10 (10088)	What was the animal/insect?	1. Dog 2. Snake 3. Insect or scorpion 4. Other 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_11 (10089)	Was (s)he injured by burns/fire?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_12 (10090)	Was (s)he subject to violence (suicide, homicide, abuse)? <i>Don't say suicide for under-12-year olds</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_13 (10091)	Was (s)he injured by a firearm?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_14 (10092)	Was (s)he stabbed, cut or pierced?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_15 (10093)	Was (s)he strangled?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_16 (10094)	Was (s)he injured by a blunt force?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_17 (10095)	Was (s)he injured by a force of nature?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_18 (10096)	Was it electrocution? <i>This includes accidents and cases where it is unknown if it was an accident or whether there was intentional violence.</i>	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3227_1 9 <i>(10097)</i>	Did (s)he encounter any other injury?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3227_2 0 <i>(10098)</i>	Was the injury accidental?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3228
C3227_2 1 <i>(10099)</i>	Was the injury self-inflicted?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 1 → C3228
C3227_2 2 <i>(10100)</i>	Was the injury intentionally inflicted by someone else?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3228	How long did <NAME> survive after the injury? <i>Record hours if less than 24 hours—Less than 1 hour = "00" hours; Record days if 1 day or more.</i>		____ Hours <i>(DK = 99)</i>

SECTION 10: CARE-SEEKING FOR THE FATAL ILLNESS (CHILD DEATHS)

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

C3251	When it was first noticed that <NAME> was ill, was s/he... <i>Read the choices for each condition.</i>	1. Feeding normally, feeding poorly (medium), or not feeding at all (abnormal)? 2. Normally active, less active than normal (medium), or not moving (abnormal)?	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Normal</td> <td style="text-align: center;">Medium</td> <td style="text-align: center;">Abnormal</td> <td style="text-align: center;">DK</td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> </table>	Normal	Medium	Abnormal	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>
Normal	Medium	Abnormal	DK												
1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>												
1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>												
C3252	Did <NAME> receive, or did you give or <u>seek</u> , any care or treatment for the fatal illness?	1. Yes 2. No—care not needed, given or sought 9. Don't know	<input type="checkbox"/> 2 → C3255 9 → C3288												
C3253	Please tell me everything that was done for <NAME>'s fatal illness inside the home and all the places outside the home (he / she) went or was taken for health care. Start with the first care or treatment <NAME> received and then, in order, tell me all the other care and treatments s/he received. Also tell me what symptoms were present when each action was taken. <i>Include any health care provider <NAME> was on route to but did not reach before dying.</i> <i>For Children 28 days – 11 years old: If the illness lasted 3 months or more, ask about the first three actions taken at the start of the illness and the middle of the illness, and about the last three actions at the end of the illness. Circle 'S' (Start), 'M' (Middle) or 'E' (End) for each action.</i> (1) <i>If the illness lasted 3 months or more, circle 'S' (Start), 'M' (Middle) or 'E' (End) for each action. (2) Check <u>one</u> other care or health care provider box for each action row. Check 'Trained CHW, nurse or midwife' only if the provider was seen outside a facility. (2A) For 28 day – 11 month old deaths only: If the illness began at the provider where the child was delivered, then mark that as Action 1 and check the 'Illness began at provider' box. (4) Mark the symptom(s) that were present when each action was taken.</i> (2) <i>If the illness lasted less than 3 months, check <u>one</u> other care or health care provider box for each action row. Check 'Trained CHW, nurse or midwife' only if the provider was seen outside a facility.</i>														
(1) Action	(2) Other care	(2) Health care providers	(4)												

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Village/Cluster HH DeathID

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

# and Illness phase – (S)tart, (M)id, (E)nd	Home care (own, relative, neighbor, friend)	Tra-ditional or non-formal provider	Phar-macist or drug seller	Trained community health worker (CHW), nurse, or midwife	Private doctor or clinic (formal/ unsure)	NGO or govern-ment clinic	Hospital	(2A) Illness began at provider where child was delivered		What symptoms were present when the action was taken?
1. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9. S M E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Inst_9: (For 28 day-11 month old deaths only) If the illness began at the health provider where the child was delivered:

A) and did not fill C3068 → C3259; B) and filled C3068 → C3263

Inst_10: If C3253 ≠ "Health care provider" (Never took to a health care provider) → C3255

C3254	<p><i>If any formal care given or sought, ask: Who decided to seek care for <NAME>'s illness from the <FIRST FORMAL PROVIDER>?</i></p> <p><i>Record the one main decision maker, or the mother and father jointly (4).</i></p>	<ol style="list-style-type: none"> 1. Child's mother 2. Child's father 3. Child's mother and father, jointly 4. Child's maternal grandmother 5. Child's paternal grandmother 6. Someone else (specify) 9. Don't know 	<input type="checkbox"/>
C3255	<p><i>If never taken to a health provider, ask:</i> Did you have any concerns or problems that kept you from taking <NAME> to a health provider during the illness?</p> <p><i>If taken to a health provider, ask:</i> Did you have to overcome any concerns or problems to take <NAME> to the (first) health provider?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<input type="checkbox"/> 8, 2 or 9 → Inst_11

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3256	<p>What concerns or problems did (you / you or <NAME>) have?</p> <p><i>Prompt: Was there anything else? Multiple answers allowed.</i></p>	<ol style="list-style-type: none"> 1. Did not think child/adult was sick enough to need health care..... 1. <input type="checkbox"/> 2. No one available to accompany..... 2. <input type="checkbox"/> 3. Too much time from caregiver's duties.. 3. <input type="checkbox"/> 4. Someone else (<i>specify</i>) had to decide... 4. <input type="checkbox"/> _____ 5. Too far to travel 5. <input type="checkbox"/> 6. No transportation available..... 6. <input type="checkbox"/> 7. Cost (transport, health care, other)..... 7. <input type="checkbox"/> 8. Not satisfied with available health care.. 8. <input type="checkbox"/> 9. Problem required traditional care..... 9. <input type="checkbox"/> 10. Thought s/he was too sick to travel..... 10. <input type="checkbox"/> 11. Thought s/he will die no matter what ... 11. <input type="checkbox"/> 12. Was late at night (transportation or provider not available) 12. <input type="checkbox"/> 13. Other (<i>specify</i>)..... 13. <input type="checkbox"/> _____ 99. Don't know 99. <input type="checkbox"/>
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Inst_11: If C3252 = 2 (No care given or sought) or If C3253 ≠ "Health provider" (Never took to a health provider) → C3351

C3257	<p><i>Refer to C3253 for the first health provider and related symptoms:</i> You mentioned that you took <NAME> to the (first) health provider, I mean the <FIRST HEALTH PROVIDER> with <SYMPTOM(S)>. How long had <NAME> had (this / these) symptom(s) when it was decided to go to the <FIRST HEALTH PROVIDER>?</p> <p><i>Read "...to the first..." if took or tried to take to more than one health provider.</i></p> <p><i>Mark days, hours &/or minutes as needed: e.g. 00 day, 02 hours, 10 minutes</i></p>	<p>____ Days (DK = 99)</p> <hr/> <p>____ Hours (DK = 99)</p> <hr/> <p>____ Minutes (DK = 99)</p>
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Formal health careseeking matrix: Ask the following questions for the first and last health providers where care was sought for the fatal illness. Ask all the questions for the First Health Provider before going on to the Last Health Provider.

Before asking about the first health provider, read:
 Now I would like to ask you about <NAME>'s visit to the (first) health provider, I mean the <FIRST HEALTH PROVIDER>.

Read "first" if went to or received care from more than one provider.

Before asking about the last health provider, read:
 Now I would like to ask you about <NAME>'s visit to the last health provider, I mean the <LAST HEALTH PROVIDER>.

- ILLNESS MATRIX QUESTIONS -		FIRST HEALTH PROVIDER	LAST HEALTH PROVIDER																								
<p>At the time when it was decided to take <NAME> to the <FIRST/LAST HEALTH PROVIDER>, was s/he...</p> <p><i>Read the choices and mark "Normal," "Moderate," "Severe" or "Don't know" for each condition.</i></p>	<ol style="list-style-type: none"> 1. Feeding normally, feeding poorly, or not feeding at all 2. Normally active, less active than normal, or not moving 	<p>C3258</p> <table style="width: 100%; text-align: center;"> <tr> <td>Nrml</td><td>Mod</td><td>Svr</td><td>DK</td> </tr> <tr> <td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>3. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>3. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td> </tr> </table>	Nrml	Mod	Svr	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	<p>C3268</p> <table style="width: 100%; text-align: center;"> <tr> <td>Nrml</td><td>Mod</td><td>Svr</td><td>DK</td> </tr> <tr> <td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>3. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td> </tr> <tr> <td>1. <input type="checkbox"/></td><td>2. <input type="checkbox"/></td><td>3. <input type="checkbox"/></td><td>9. <input type="checkbox"/></td> </tr> </table>	Nrml	Mod	Svr	DK	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>
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<p>What was the name of the <FIRST/LAST HEALTH PROVIDER> (where <NAME> was delivered / where you took <NAME>)?</p> <p><i>Probe to identify the type of provider or facility. If the deceased was seen by a trained CHW, nurse or midwife at a health facility, then mark the type of facility where the provider was seen. Use option 5 or 10 only if the provider was seen outside of a health facility.</i></p>	<p>Public sector:</p> <ol style="list-style-type: none"> 1. Government hospital 2. Government health center 3. Government health post 4. Mobile clinic 5. Trained CHW, nurse or midwife (outside a health facility) 6. Other public sector <p>Private medical sector:</p> <ol style="list-style-type: none"> 7. Private hospital 8. Private doctor/clinic 9. Mobile clinic 10. Trained CHW, nurse or midwife (outside a health facility) 11. Other private medical sector 99. Don't know 	<p>C3259</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 40px; height: 40px;"><input type="checkbox"/></td> <td style="width: 40px; height: 40px;"><input type="checkbox"/></td> </tr> <tr> <td colspan="2">_____ (Name of Provider/Facility)</td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	_____ (Name of Provider/Facility)		<p>C3269</p> <table style="width: 100%; text-align: center;"> <tr> <td style="width: 40px; height: 40px;"><input type="checkbox"/></td> <td style="width: 40px; height: 40px;"><input type="checkbox"/></td> </tr> <tr> <td colspan="2">_____ (Name of Provider/Facility)</td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	_____ (Name of Provider/Facility)																	
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Village/Cluster			HH			DeathID		

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

<p>For health care at a facility (C3259 = 1, 2,3,4, 6, 7,8,9,11), ask: Did <NAME> reach the <FIRST/LAST HEALTH PROVIDER> before s/he died?</p> <p>For health care outside a facility (C3259 = 5, 10), ask: Did the <FIRST/LAST HEALTH PROVIDER> reach <NAME> before s/he died?</p> <p>If "No," discuss with respondent to determine correct response: 2 or 3.</p>	<ol style="list-style-type: none"> 1. Yes, reached before died 2. No, died on route to this provider / before this provider reached the deceased 3. No, could not reach this provider, so returned home or took other action 9. Don't know 	<p>C3260</p> <p><input type="checkbox"/> 2 → C3288 3, 9 → Inst_12</p>	<p>C3270</p> <p><input type="checkbox"/> 2-9 → Inst_13</p>
<p>After (deciding to seek care / being referred), how long did it take (to reach the <FIRST/LAST HEALTH PROVIDER> / for the <FIRST/LAST HEALTH PROVIDER> to reach <NAME>)?</p> <p>Read "...for the provider to reach <NAME>" if the provider saw the deceased at home or another location outside of a health facility (C3259 = 5, 10).</p> <p>Mark hours &/or minutes as needed: e.g. 02 hours, 10 minutes.</p>	<p>C3261</p> <p style="text-align: center;">____ Hours (DK = 99)</p> <p style="text-align: center;">____ Minutes (DK = 99)</p> <p>C3259 ≠ 1, 7 (Hospital) → C3263</p>	<p>C3271</p> <p style="text-align: center;">____ Hours (DK = 99)</p> <p style="text-align: center;">____ Minutes (DK = 99)</p> <p>C3269 ≠ 1, 7 (Hospital) → C3273</p>	
<p>Did the <FIRST/LAST HEALTH PROVIDER> admit <NAME> to the hospital for his/her problem?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<p>C3262</p> <p><input type="checkbox"/></p>	<p>C3272</p> <p><input type="checkbox"/></p>
<p>Did the <FIRST/LAST HEALTH PROVIDER> refer <NAME> to another health provider or facility?</p>	<ol style="list-style-type: none"> 1. Yes 2. No 9. Don't know 	<p>C3263</p> <p><input type="checkbox"/> 2 or 9 → C3265</p>	<p>C3273</p> <p><input type="checkbox"/> 2 or 9 → C3275</p>
<p>To where was <NAME> referred?</p> <p>Probe to identify the type of provider or facility. If the d was referred to a trained CHW, nurse or midwife at a health facility, then mark the type of facility. Use option 5 or 10 only if the provider was to be seen outside of a health facility.</p>	<p>Public sector:</p> <ol style="list-style-type: none"> 1. Government hospital 2. Government health center 3. Government health post 4. Mobile clinic 5. Trained CHW, nurse or midwife (outside a health facility) 6. Other public sector <p>Private medical sector:</p> <ol style="list-style-type: none"> 7. Private hospital 8. Private doctor/clinic 9. Mobile clinic 10. Trained CHW, nurse or midwife (outside a health facility) 11. Other private medical sector 99. Don't know 	<p>C3264</p> <p><input type="checkbox"/> <input type="checkbox"/> → C3266</p> <p style="text-align: center;">_____ (Name of Provider/Facility)</p>	<p>C3274</p> <p><input type="checkbox"/> <input type="checkbox"/> → C3276</p> <p style="text-align: center;">_____ (Name of Provider/Facility)</p>
<p>Did the <FIRST/LAST HEALTH PROVIDER> tell you about illness signs and symptoms for which...</p> <p>Read the choices and mark "Yes," "No" or "Don't know" for each.</p>	<ol style="list-style-type: none"> 1. <NAME> needs to return immediately?..... 2. To follow-up if <NAME> did not improve after leaving?..... 	<p>C3265</p> <p>Yes No DK 1. <input type="checkbox"/> 2. <input type="checkbox"/> 9. <input type="checkbox"/></p> <p>1. <input type="checkbox"/> 2. <input type="checkbox"/> 9. <input type="checkbox"/></p>	<p>C3275</p> <p>Yes No DK 1. <input type="checkbox"/> 2. <input type="checkbox"/> 9. <input type="checkbox"/></p> <p>1. <input type="checkbox"/> 2. <input type="checkbox"/> 9. <input type="checkbox"/></p>
<p>Did <NAME> leave the <FIRST/LAST HEALTH PROVIDER> alive?</p>	<ol style="list-style-type: none"> 1. Yes, left alive 2. No, died at this provider 	<p>C3266</p> <p><input type="checkbox"/> 2 → Inst_13</p>	<p>C3276</p> <p><input type="checkbox"/> 2 → Inst_13</p>

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

<p>At the time of leaving the (<FIRST/ LAST HEALTH PROVIDER>, was <NAME>...</p> <p><i>Read the choices and mark "Normal," "Moderate," "Severe" or "Don't know" for each condition.</i></p>	<p>1. Feeding normally, feeding poorly, or not feeding at all</p> <p>2. Normally active, less active than normal, or not moving</p>	<p>C3267</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u>Nrml</u></td> <td style="text-align: center;"><u>Mod</u></td> <td style="text-align: center;"><u>Svr</u></td> <td style="text-align: center;"><u>DK</u></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> </table>	<u>Nrml</u>	<u>Mod</u>	<u>Svr</u>	<u>DK</u>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	<p>C3277</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u>Nrml</u></td> <td style="text-align: center;"><u>Mod</u></td> <td style="text-align: center;"><u>Svr</u></td> <td style="text-align: center;"><u>DK</u></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">3. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> </table>	<u>Nrml</u>	<u>Mod</u>	<u>Svr</u>	<u>DK</u>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	9. <input type="checkbox"/>
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<p>Inst_12: Check C3253 → If taken to another health provider...</p>		<p>→ C3268</p> <p>(LAST PROVIDER)</p>																									
<p>Inst_13: If C3263 = 1 (referred) or C3273 = 1 (referred) → continue with C3278. Otherwise → Inst_14</p>																											
<p>C3278</p>	<p>Did you take the child to (all) the health provider(s) where s/he was referred?</p> <p><i>Read "all the health providers..." if the deceased was referred by both the first and last providers.</i></p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/></p>																								
<p>C3279</p>	<p>If not taken to (all) the referral provider(s), ask: Did you have any concerns or problems that kept you from taking <NAME> to a health provider where s/he was referred?</p> <p>If taken to (all) the referral provider(s), ask: Did you have to overcome any concerns or problems to take <NAME> to a health provider where s/he was referred?</p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → Inst_14</p>																								
<p>C3280</p>	<p>What concerns or problems did you have?</p> <p><i>Prompt: Was there anything else?</i></p> <p><i>Multiple answers allowed.</i></p>	<p>1. Provider didn't say referral so important . 2. Thought no more care needed..... 3. No one available to accompany..... 4. Too much time from caregiver's duties ... 5. Someone else (specify) decided..... 6. Too far to travel..... 7. No transportation available..... 8. Cost (transport, health care, other)..... 9. Not satisfied with available care..... 10. Went to a different provider/facility 11. Problem required traditional care 12. Thought s/he was too sick to travel..... 13. Thought s/he will die despite care..... 14. Was late at night..... 15. The child/adult died before going..... 16. Other (specify)..... 99. Don't know.....</p>	<p>1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 8. <input type="checkbox"/> 9. <input type="checkbox"/> 10. <input type="checkbox"/> 11. <input type="checkbox"/> 12. <input type="checkbox"/> 13. <input type="checkbox"/> 14. <input type="checkbox"/> 15. <input type="checkbox"/> 16. <input type="checkbox"/> 99. <input type="checkbox"/></p>																								
<p>Inst_14: If C3259, C3269, C3264 or C3274 = 1-4, 6-9 or 11 (seen at any health facility) → continue with C3281; Otherwise → C3287)</p>																											
<p>C3281</p>	<p>Did you have to pay any money to travel to (the / any) health provider?</p> <p><i>Read "...any health provider?" if the deceased went to more than one provider.</i></p>	<p>1. Yes 2. No 9. Don't know</p>	<p><input type="checkbox"/> 2 or 9 → C3283</p>																								

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3282	How did you arrange for the money to travel? <i>Multiple answers allowed. If "Don't know," mark only '9'.</i>	1. Had available 2. Borrowed..... 3. Sold assets..... 4. Help from kin/relatives..... 5. Community fund 6. Govt. scheme 7. Other 9. Don't know	1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/>
C3283	What transportation method was used to go to the health provider(s)? <i>Multiple answers allowed. If "Don't know," mark only '9'.</i> <i>LOCAL ADAPTATION: The response categories should be disaggregated and locally adapted as necessary.</i>	1. Walk 2. Bicycle/animal/cart/ boat 3. Bus 4. Taxi/auto/trecker/motorcycle 5. Ambulance 6. Other 7. Could not arrange transport 9. Don't know	1. <input type="checkbox"/> 2. <input type="checkbox"/> 3. <input type="checkbox"/> 4. <input type="checkbox"/> 5. <input type="checkbox"/> 6. <input type="checkbox"/> 7. <input type="checkbox"/> 9. <input type="checkbox"/>
C3284 <i>(10452)</i>	Were there any problems during admission to the hospital or health facility?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3285 <i>(10453)</i>	Were there any problems with the way (s)he was treated (medical treatment, procedures, interpersonal attitudes, respect, dignity) in the hospital or health facility?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3286 <i>(10454)</i>	Were there any problems getting medications, or diagnostic tests in the hospital or health facility?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3287 <i>(10458)</i>	In the final days before death, did anyone use a telephone or cell phone to call for help?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3288	How many days after (first noticing the illness / <LAST ACTION C3253> / leaving the first/last health provider) did <NAME> die? <i>If C3252 = 2 (No care given), then read: "...first noticing the illness..."</i>		____ ____ Days (<1 = 00; DK = 99)
Inst_15: If C3252 = 2 (No care given) or if C3253 ≠ "Health Provider" (Never took to a health provider) → C3351			

SECTION 11: TREATMENTS RECEIVED DURING THE FATAL ILLNESS (CHILD DEATHS)			
C3301 <i>(10418)</i>	Did <NAME> receive any treatment for the illness that led to death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3304
C3302_1 <i>(10419)</i>	Did (s)he receive oral rehydration salts?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3302_2 <i>(10420)</i>	Did (s)he receive intravenous fluids (drip) treatment?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH		DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3302_3 <i>(10421)</i>	Did (s)he receive a blood transfusion?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																
C3302_4 <i>(10422)</i>	Did (s)he receive treatment/food through a tube passed through the nose?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																
C3302_5 <i>(10423)</i>	Did (s)he receive injectable antibiotics?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																
C3302_6 <i>(10424)</i>	Did (s)he receive antiretroviral therapy (ART)?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																
C3302_7 <i>(10425)</i>	Did (s)he have an operation for the illness?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3304																
C3303 <i>(10426)</i>	Did s/he have the operation within 1 month before death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>																
C3304 <i>(10437)</i>	Do you have any health care records that belonged to the deceased?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3310_1																
C3305 <i>(10438)</i>	Can I see the health records?	1. Yes 2. No	<input type="checkbox"/> 2 → C3310_1																
C3306_1check <i>(10439_ check)</i>	Is the date of the most recent (last) visit available?	1. Yes 2. No	<input type="checkbox"/> 2 → C3306_2check																
C3306_1 <i>(10439)</i>	Record the date of the most recent (last) visit		<table style="margin: auto;"> <tr> <td style="border-bottom: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </table> (DK = 99/99/9999)									D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
C3306_2check <i>(10440_ check)</i>	Is the date of the second most recent visit available?	1. Yes 2. No	<input type="checkbox"/> 2 → C3307																
C3306_2 <i>(10440)</i>	Record the date of the second most recent visit		<table style="margin: auto;"> <tr> <td style="border-bottom: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </table> (DK = 99/99/9999)									D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												
C3307 <i>(10441)</i>	Record the date of the last note on the health records		<table style="margin: auto;"> <tr> <td style="border-bottom: 1px solid black; width: 20px;"></td> </tr> <tr> <td style="text-align: center;">D</td> <td style="text-align: center;">D</td> <td style="text-align: center;">M</td> <td style="text-align: center;">M</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">Y</td> </tr> </table> (DK = 99/99/9999)									D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y												

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3310_6 <i>(10136)</i>	<p>During the final illness, did a health professional diagnose epilepsy?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness.</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3310_7 <i>(10143)</i>	<p>Recently or during the final illness, did a health professional diagnose kidney disease?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness.</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3310_8 <i>(10144)</i>	<p>Recently or during the final illness, did a health professional diagnose liver disease?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness.</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3310_9 <i>(10133)</i>	<p>During the final illness, did a health professional ever diagnose heart disease?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness.</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3310_10 <i>(10133)</i>	<p>During the final illness, did a health professional ever diagnose cancer?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness.</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3310_11 <i>(10137)</i>	<p>During the final illness, did a health professional ever diagnose sickle cell disease?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness.</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3311 <i>(10128)</i>	<p>Did the deceased have a recent positive test by a health professional for malaria?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>
C3312 <i>(10129)</i>	<p>Did the deceased have a recent negative test by a health professional for malaria?</p> <p><i>Remind the respondent that we are asking for the diagnosis assessed by a doctor, health worker, or other health professional during the final illness</i></p>	<p>1. Yes 2. No 9. Don't know 8. Refused to answer</p>	<input type="checkbox"/>

Village/Cluster				HH				DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3313 <i>(10435)</i>	Did a health care worker tell you the cause of death?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3351
C3314 <i>(10436)</i>	What did the health worker say?		
	<hr/> <hr/> <hr/> <hr/> <hr/>		

SECTION 12: DEATH CERTIFICATE AND CIVIL REGISTRATION (CHILD DEATHS)

C3351 <i>(10462)</i>	Was a death certificate issued?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8, 2 or 9 → C3363
C3352 <i>(10463)</i>	Can I see the death certificate?	1. Yes 2. No	<input type="checkbox"/> 2 → C3363
C3353 <i>(10464)</i>	<i>Record the immediate cause of death from the death certificate</i>		
C3354 <i>(10465)</i>	<i>Duration (1a)</i>		
C3355 <i>(10466)</i>	<i>Record the first underlying cause of death from the death certificate</i>		
C3356 <i>(10467)</i>	<i>Duration (1b)</i>		
C3357 <i>(10468)</i>	<i>Record the second underlying cause of death from the death certificate</i>		
C3358 <i>(10469)</i>	<i>Duration (1c)</i>		
C3363 <i>(10069_a)</i>	Do you have a death registration certificate? <i>If yes, ask: May I see the registration card?</i>	1. Yes, card seen 2. Yes, card not seen 3. No registration 9. Don't know 8. Refused to answer	<input type="checkbox"/> 8,2, 3 or 9 → C3401
C3364 <i>(10070)</i>	<i>Record the death registration number</i>		
	<hr/>		

Village/Cluster				HH				DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE
SECTION 13: THE HOUSEHOLD

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

If the respondent is the mother, read "about yourself." If the respondent is not the mother, read "...about the child's mother."

Inst_16: If Q1403 = 2 (Respondent is the child's mother) → C3405

C3401	How old (is the child's mother / was the child's mother when she died)? <i>Check C3003: If the mother died, read "How old was the child's mother when she died?"</i>	____ Years (DK = 99)
C3402	Did the child's mother ever attend school? 1. Yes 2. No 9. Don't know	<input type="checkbox"/> 8, 2 or 9 → C3405
C3403	What is the highest level of school she attended? <i>Classe/ano</i> 5. Pré-escolar(01-02-03) 6. Alfabetizacao (Ano: 01-02-03) 7. Primário EP1 (Classe: 01-05) 8. Primário EP2 (Classe: 06-07) 9. Secundário ESG1 (Classe: 08-10) 10. Secundário ESG2 (Classe:11-12) 11. Técnico Elementar (Ano: 01-03) 12. Técnico básico (Ano: 01-03) 13. Técnico médio (Ano: 01-03) 14. Formação de professores primaries (Ano: 01-03) 15. Superior (Ano: 01-07) Não sabe	<input type="checkbox"/>
C3404	What is the highest [GRADE/YEAR] she completed at that level? <i>If completed less than 1 year at that level, record '00'.</i>	____ Grade/Year (DK = 99)
C3405	At the time of the child's death, (were you / was the child's mother) married or living together with a man as if married? <i>[Read "...was the child's mother..." if the respondent is not the mother.]</i> 1. Yes, married 2. Yes, living with a man 3. No, not in union 4. No, mother was deceased then 9. Don't know	<input type="checkbox"/> 3 → Inst_17
C3406	How old (were you when you / was she when she) first married (or lived with a man)? <i>Read "...was she when she..." if the respondent is not the mother.</i> <i>Read "...married or lived with a man?" if C3405 = "2. Living with a man."</i>	____ Years (DK = 99)
C3407	Did (your / the mother's) (husband/partner) ever attend school? <i>Read "...partner..." if she was living with a man.</i> 1. Yes 2. No 9. Don't know	<input type="checkbox"/> 2 or 9 → Inst_17

Village/Cluster				HH				DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

C3408	<p>What was the highest level of school he attended?</p>	<p><i>Classe/ano</i></p> <p>0. Pré-escolar(01-02-03)</p> <p>1. Alfabetizacao (Ano: 01-02-03)</p> <p>2. Primário EP1 (Classe: 01-05)</p> <p>3. Primário EP2 (Classe: 06-07)</p> <p>4. Secundário ESG1 (Classe: 08-10)</p> <p>5. Secundário ESG2 (Classe:11-12)</p> <p>6. Técnico Elementar (Ano: 01-03)</p> <p>7. Técnico básico (Ano: 01-03)</p> <p>8. Técnico médio (Ano: 01-03)</p> <p>9. Formação de professores primaries (Ano: 01-03)</p> <p>10. Superior (Ano: 01-07)</p> <p>Não sabe</p>	<input style="width: 30px; height: 30px; border: 1px solid black;" type="checkbox"/>						
C3409	<p>What was the highest [GRADE/YEAR] he completed at that level?</p> <p><i>If completed less than 1 year at that level, record '00'.</i></p>		<p>____ Grade/Year (DK = 99)</p>						
<p>Inst_17: Read: Now I would like to ask you some questions about your household. Please remember that all information will be kept confidential.</p> <p><i>Always read "...your..." and ask C3410– C3414 about the respondent's household.</i></p>									
C3410	<p>Is this the house (where we are now) where you stayed during the child's fatal illness?</p> <p><i>Read "...where we are now..." if needed to clarify which house you are talking about.</i></p>	<p>1. Yes 2. No 9. Don't know</p>	<input style="width: 30px; height: 30px; border: 1px solid black;" type="checkbox"/> <p style="margin-left: 10px;">1 → C3413 9 → C3454</p>						
C3411	<p>Where did you stay at that time?</p> <p><i>Probe: Where did you stay during the illness?</i></p>	<p>1. Her/His own home at that time (different from the current location)</p> <p>2. Her/His in-law's home</p> <p>3. Her/His parent's home</p> <p>4. Her/His brother's home</p> <p>5. Other (specify)</p> <p>9. Don't know</p>	<input style="width: 30px; height: 30px; border: 1px solid black;" type="checkbox"/> <p style="margin-left: 10px;">9 → C3454</p> <hr style="width: 100%; border: 0.5px solid black;"/>						
C3412	<p>What is the address of the place where you stayed?</p> <p><i>LOCAL ADAPTATION: Levels 1 and 2 mean the largest and second largest geographic divisions in the country.</i></p>	<p>Level 1 _____</p> <p>Level 2 _____</p>	<table style="margin: auto;"> <tr> <td style="border: 1px solid black; width: 30px; height: 30px;"></td> <td style="border: 1px solid black; width: 30px; height: 30px;"></td> <td style="border: 1px solid black; width: 30px; height: 30px;"></td> </tr> <tr> <td style="border: 1px solid black; width: 30px; height: 30px;"></td> <td style="border: 1px solid black; width: 30px; height: 30px;"></td> <td style="border: 1px solid black; width: 30px; height: 30px;"></td> </tr> </table>						
C3413	<p>At the time of the illness events, how long had you / your <RELATIVES> been living continuously in (this / that) community?</p> <p><i>Read "...<RELATIVES>..." if C3411 = 2-5 (s/he stayed with her/his relatives).</i></p>		<p>____ Years (<1 = 00; DK = 99)</p>						
C3414	<p>In an emergency, how long would it take to reach the nearest health facility from (this / that) location?</p> <p><i>Mark hours &/or minutes as needed: e.g. 01 hour, 30 minutes.</i></p>		<p>____ Hours (DK = 99)</p> <hr style="width: 100%; border: 0.5px solid black;"/> <p>____ Minutes (DK = 99)</p>						

Village/Cluster			HH			DeathID			

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

SECTION 14: SOCIAL CAPITAL AND HIV/AIDS QUESTIONS (CHILD DEATHS)

Read: Now, I have some questions about your / your <RELATIVES'> community.

Child deaths: Always read "...your..." or "...your <RELATIVES'>..." and ask C3451– C3453 about the respondent and her/his community or her/his relatives' community.

C3451	<p>In the 12 months before <NAME>'s death, did the people in the (village / neighborhood) work together on any of the following issues that affect the entire community or part of the community?</p> <p><i>Read all the issues and mark "Yes," "No" or "Don't know" for each one; then enter the code.</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 65%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">DK</td> </tr> <tr> <td>1.</td> <td>Education/schools.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>2.</td> <td>Health services/clinics.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>3.</td> <td>Paid job opportunities</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>4.</td> <td>Credit/finance.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>5.</td> <td>Roads</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>6.</td> <td>Public transportation</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>7.</td> <td>Water distribution</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>8.</td> <td>Sanitation services.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>9.</td> <td>Agriculture.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>10.</td> <td>Justice/conflict resolution</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>11.</td> <td>Security/police services</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>12.</td> <td>Mosque/church/temple.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>13.</td> <td>Other.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td></td> <td>(specify)</td> <td colspan="3"></td> </tr> </table>			Yes	No	DK	1.	Education/schools.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	2.	Health services/clinics.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	3.	Paid job opportunities	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	4.	Credit/finance.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	5.	Roads	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	6.	Public transportation	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	7.	Water distribution	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	8.	Sanitation services.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	9.	Agriculture.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	10.	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C3452	<p>In the 12 months before <NAME>'s death, were you) an active participant in any of the following types of groups in the community?</p> <p><i>Read all the groups and mark "Yes," "No" or "Don't know" for each one; then enter the code.</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 65%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">DK</td> </tr> <tr> <td>1.</td> <td>Vocational training group</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>2.</td> <td>Savings group or microcredit program</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>3.</td> <td>Community cooperative, such as an agricultural cooperative</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>4.</td> <td>Political group</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>5.</td> <td>Religious group</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>6.</td> <td>Sports club</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>7.</td> <td>Youth / student club</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>8.</td> <td>Women's group.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>9.</td> <td>Other.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td></td> <td>(specify).....</td> <td colspan="3"></td> </tr> </table>			Yes	No	DK	1.	Vocational training group	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	2.	Savings group or microcredit program	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	3.	Community cooperative, such as an agricultural cooperative	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	4.	Political group	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	5.	Religious group	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	6.	Sports club	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	7.	Youth / student club	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	8.	Women's group.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>	9.	Other.....	1. <input type="checkbox"/>	2. <input type="checkbox"/>	9. <input type="checkbox"/>		(specify).....																							
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C3453	<p>Did you turn to any of the following people or groups in the community for help during the child's fatal illness?</p> <p><i>Read all the options and mark ("X") Yes, No or DK for each; then enter the code.</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="width: 65%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">DK</td> </tr> <tr> <td>1.</td> <td>Religious group.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>2.</td> <td>Women's group.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>3.</td> <td>Savings group or microcredit program</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>4.</td> <td>Any other community group, such as a vocational training group, community cooperative, political group, sports club, youth or student group</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>5.</td> <td>Community or political leader.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>6.</td> <td>Religious leader</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>7.</td> <td>Family</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>8.</td> <td>Neighbors</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>9.</td> <td>Friends.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>10.</td> <td>Patron/employer/benefactor.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>11.</td> <td>Police</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td>12.</td> <td>Other.....</td> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;">9. <input type="checkbox"/></td> </tr> <tr> <td></td> <td>(specify)</td> <td colspan="3"></td> </tr> </table>			Yes	No	DK	1.	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Village/Cluster				HH		DeathID	

COMSA- VERBAL AND SOCIAL AUTOPSY QUESTIONNAIRE

		<i>Code:</i> 1. One person/group identified 2. Two or more persons/groups identified 3. No person/group identified	<input type="checkbox"/>
C3454 <i>(10126)</i>	<i>Read:</i> Now I have four last questions about the child and the child's mother. Did the child ever have a positive HIV test?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3455 <i>(10127)</i>	Was there any diagnosis by a health professional that the child had AIDS?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3456 <i>(10445)</i>	Did (you / the child's biological mother) ever have a positive HIV test?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>
C3457 <i>(10446)</i>	Was there any diagnosis by a health professional that (you / the child's biological mother) had AIDS?	1. Yes 2. No 9. Don't know 8. Refused to answer	<input type="checkbox"/>

Village/Cluster				HH		DeathID			

SECTION 15: OPEN ENDED RESPONSE & INTERVIEWER COMMENTS/OBSERVATIONS (CHILD DEATHS)

C3471 (10476)

Note: This is an optional question, to be asked or not as determined by the study site.

Read: Thank you for answering the many questions that I've asked. Would you like to tell me about <NAME>'s illness in your own words? Also, is there anything else about her/his illness that I did not ask and you would like to tell me about?

After the respondent(s) finishes, ask: Is there anything else?

Write the respondent's exact words. After s/he has finished, read this back and ask her to correct any errors in what you wrote.

C3472
(10479.2)

Are any of the following words of interest mentioned in the above narrative?

- | | |
|--|--------------------------|
| 1. Abdomen | <input type="checkbox"/> |
| 2. Cancer | <input type="checkbox"/> |
| 3. Dehydration..... | <input type="checkbox"/> |
| 4. Dengue fever | <input type="checkbox"/> |
| 5. Diarrhea | <input type="checkbox"/> |
| 6. Fever..... | <input type="checkbox"/> |
| 7. Heart problems | <input type="checkbox"/> |
| 8. Jaundice (yellow skin or eyes) | <input type="checkbox"/> |
| 9. Pneumonia..... | <input type="checkbox"/> |
| 10. Rash..... | <input type="checkbox"/> |
| 11. None of the above words were mentioned | <input type="checkbox"/> |
| 99. DK..... | <input type="checkbox"/> |

**END OF INTERVIEW
THANK RESPONDENT FOR HER/HIS PARTICIPATION**

Interviewer: Use this space to write down your comments and observations about the interview.
