

**VERBAL AUTOPSY QUESTIONNAIRE**

**FORM D**

<b>VAQ number:</b>	<input type="text"/>
<b>MUT number (R2):</b>	<input type="text"/>
<b>Interviewer (HH):</b>	<input type="text"/>
<b>Deceased:</b>	<input type="text"/>

<b>Questionnaire processing dates:</b>	
Corrections completed	<input type="text"/>
Follow-up checklist marked	<input type="text"/>
Data entered	<input type="text"/>

**QUESTIONNAIRE IDENTIFICATION**

Q101 **Census district:** \_\_\_\_\_ **EA:**

Q102 **Village:** \_\_\_\_\_

Q103 **Name of head of household:** \_\_\_\_\_

Q104 **Study site reference:**

Q105 **Household number:**

Q106 **Line number on household questionnaire:**

Q107 **Line number of key informant (PRINCIPAL CARER if available):**  other HHID

**INTERVIEWER VISIT**

		<b>Appointment</b>			<b>1</b>	<b>2</b>	<b>3</b>
		Place	Date	Time			
Q108	<b>Date:</b>	_____	_____	_____	_____	_____	_____
Q109	<b>Time:</b>	_____	_____	_____	_____	_____	_____
Q110	<b>Interviewer (VAQ):</b>	_____	_____	_____	_____	_____	_____
Q111	<b>Result*:</b>				<input type="text"/>	<input type="text"/>	<input type="text"/>

**CHECKED BY SUPERVISOR**

Q112 **Signature:** \_\_\_\_\_

Q113 **Date:** \_\_\_\_\_

**\*RESULT CODES**

- Completed: principal carer 1
- Completed: other 2
- Not at home 3
- Refused 4
- Partially completed 5
- Sick/hospital 6
- Other (specify) 8

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q201	<b>Record the current time (24 hour clock).</b>	Hour / Minutes <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>hr <input style="width: 30px; text-align: center; font-size: small;" type="text"/>mins</span>	
Q202	<b>Record gender of (current) informant.</b>	Male <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> Female <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span>	
Q203	<i>What relationship was (NAME) to you?</i>	Husband/wife <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> - Q205 Father <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span> Mother <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>3</span> Father-in-law <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>4</span> - Q205 Mother-in-law <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>5</span> - Q205 Grandfather <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>6</span> Grandmother <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>7</span> Uncle <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>8</span> Aunt <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>9</span> Brother (check not a cousin) <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>10</span> - Q205 Sister (check not a cousin) <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>11</span> - Q205 Brother-in-law <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>12</span> Sister-in-law <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>13</span> Son <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>14</span> - Q205 Daughter <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>15</span> - Q205 Son-in-law <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>16</span> Daughter-in-law <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>17</span> Nephew <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>18</span> Niece <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>19</span> Cousin <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>20</span> Other relative (specify) <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>21</span> Not related: boy/girlfriend <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>22</span> - Q205 Not related: other <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>23</span> - Q205	
Q204	<i>Was (NAME) a paternal or a maternal relative?</i>	Paternal <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> Maternal <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span> Not applicable <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>99</span>	
Q205	<b>Record the sex of the deceased.</b>	Male <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> Female <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span>	
Q206	<i>What was the date when (NAME) passed away?</i>	Month/year <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>mth <input style="width: 30px; text-align: center; font-size: small;" type="text"/>yr</span> Don't know <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>998</span>	
Q207	<i>What proportion of the household's income did (NAME) contribute before he/she became ill?</i>	75% plus <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> 50-74% <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span> 25-49% <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>3</span> 10-24% <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>4</span> 5-9% <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>5</span> Under 5% <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>6</span> Not known <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>98</span>	
Q208	<i>What has happened to the household since (NAME) passed away?</i> <b>Relocated: only if whole household moved.</b>	Relocated <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> Dispersed <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span> - Q210 Continued <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>3</span> - Q210 Not known <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>98</span> - Q210	
Q209	<i>What type of place did they move to?</i>  <b>Record the name of the place.</b>	Large town or city <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> Small town <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span> Growth point <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>3</span> Commercial estate/mine <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>4</span> Roadside business centre <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>5</span> Rural business centre <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>6</span> Communal/resettlement area <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>7</span>	
Q210	<i>Where was (NAME) staying the night (before) he/she passed away?</i>  <b>Record the name of the place.</b>	At home <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>1</span> Local hospital/clinic <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>2</span> District hospital <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>3</span> Harare <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>4</span> Mutare <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>5</span> Other (specify) _____ <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>8</span>	
Q211	<i>How long was it from the time (NAME) first became ill to the time he/she passed away?</i>	<span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>days <input style="width: 30px; text-align: center; font-size: small;" type="text"/>wks <input style="width: 30px; text-align: center; font-size: small;" type="text"/>mths</span> Don't know <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>98</span> - Q213	
Q212	<i>For how much of this time did he/she stay in hospital and for how long was he/she cared for at home?</i> <b>Check total agrees with Q211.</b>	Hospital <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>days <input style="width: 30px; text-align: center; font-size: small;" type="text"/>wks <input style="width: 30px; text-align: center; font-size: small;" type="text"/>mths</span> Home <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>days <input style="width: 30px; text-align: center; font-size: small;" type="text"/>wks <input style="width: 30px; text-align: center; font-size: small;" type="text"/>mths</span>	
Q213	<i>What relationship to him/her was (NAME)'s principal carer when he/she was being looked after at home?</i>	<b>Respondent?</b> <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>Y(1) <input style="width: 30px; text-align: center; font-size: small;" type="text"/>N(2)</span> <b>Enter codes from Q203/204.</b> <span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/> <input style="width: 30px; text-align: center; font-size: small;" type="text"/></span>	
Q214	<i>What age is the carer?</i>	<span style="float: right;"><input style="width: 30px; text-align: center; font-size: small;" type="text"/>yrs</span>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO																	
		<table border="1" style="font-size: small; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">Help?</th> <th colspan="2">Type(s)</th> <th colspan="2">Charge</th> <th colspan="2">Rating</th> </tr> <tr> <th>Y</th> <th>N</th> <th>1</th> <th>2</th> <th>Y</th> <th>N</th> <th>1</th> <th>2</th> </tr> </thead> </table>		Help?		Type(s)		Charge		Rating		Y	N	1	2	Y	N	1	2	
	Help?			Type(s)		Charge		Rating												
	Y	N	1	2	Y	N	1	2												
Q215	<p><i>Did you/the carer receive assistance from any of the following during (NAME)'s illness?</i></p>	<p>Neighbours Family/relatives Church CBDs VCWs Health clinic/MOH Dept of Social Welfare CHBC group FASO PLWA group (other) Peer educators Other (specify)</p>																		
Q216	<p><i>What were the main types of assistance these people provided?</i></p> <p>1. Training on how to care for the sick 2. Ongoing assistance with care tasks (bathing patient, cooking, cleaning etc.) 3. Material things (food, cloths, blankets etc.) 4. Money 5. Medicine</p>	<p><b>Indicate in second &amp; third columns in Q215. Record up to two main types of assistance.</b></p> <p>6. Healthcare supplies (bleach, gloves, bandages etc.) 7. Respite care 8. Home visits to check on how you were doing 9. Psychosocial support for the sick 10. Psychosocial support for the carer 11. Other</p>																		
Q217	<p><i>Did these groups charge for their services?</i></p>	<p><b>Indicate in fourth column in Q215.</b></p>																		
Q218	<p><i>How would you rate the help you received from these people?</i></p> <p>1. Very helpful 2. Somewhat helpful 3. A little helpful</p>	<p><b>Indicate in final column in Q215.</b></p> <p>4. Good intentions but not very helpful 5. More of a bother than a help</p>																		
Q219	<p><i>Did you or anyone else in your household receive training in how to care for the sick?</i></p>	<p>Yes - self Yes - other household member No</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> - Q223</p>																	
Q220	<p><i>Who provided that training?</i></p>	<p>Health clinic/MOH Church Local NGO Other (specify)</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 8 <input type="checkbox"/></p>																	
Q221	<p><i>What kind of training did they provide?</i></p> <p><u>Check for other areas covered.</u></p>	<p>Physical health care Comforting the sick Counselling Preventing illness spreading to others Other (specify)</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/></p>																	
Q222	<p><i>Did the training meet your needs?</i></p>	<p>Yes No</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p>																	
Q223	<p><i>Was medicine prescribed for (NAME)'s illness?</i></p>	<p>Yes No</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/> - Q237</p>																	
Q224	<p><i>Did this medicine include drugs to prevent HIV from causing AIDS? (i.e. antiretroviral therapy)</i></p>	<p>Yes No</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/></p>																	
Q225	<p><i>Was (NAME) always able to obtain this medicine?</i></p>	<p>Yes No - could not afford No - not always available Other (specify)</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 8 <input type="checkbox"/></p>																	
Q226	<p><i>Did the medicine prescribed include drugs to prevent HIV from causing AIDS? (i.e. antiretroviral therapy)</i></p>	<p>Yes No</p>	<p>1 <input type="checkbox"/> 2 <input type="checkbox"/> - Q235</p>																	
Q227	<p><i>How long did (NAME) take these drugs?</i></p>	<p>Never took any</p>	<p><input type="text"/> mths <input type="text"/> yrs 99 <input type="text"/></p> <p>- Q229</p>																	
Q228	<p><i>What was the reason (NAME) never took these drugs?</i></p>	<p>Too expensive Not available locally Not permitted by church Side effects Other (specify) Don't know</p>	<p>1 <input type="checkbox"/> - Q235 2 <input type="checkbox"/> - Q235 3 <input type="checkbox"/> - Q235 4 <input type="checkbox"/> - Q235 5 <input type="checkbox"/> - Q235 8 <input type="checkbox"/> - Q235</p>																	
Q229	<p><i>From what source(s) did (NAME) obtain these drugs?</i></p>	<p>Local clinic/pharmacy District hospital Mutare or Harare Outside Zimbabwe 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"/></p>																	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO																																				
Q230	<p><i>Who paid for the drugs?</i></p> <p><u>If more than one, tick all relevant boxes.</u></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Available free</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>Self (NAME)</td> <td style="text-align: center;">2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Caregiver</td> <td style="text-align: center;">3</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Relative (besides caregiver)</td> <td style="text-align: center;">4</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Friend</td> <td style="text-align: center;">5</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Employer</td> <td style="text-align: center;">6</td> <td><input type="checkbox"/></td> </tr> </table>	Available free	1	<input type="checkbox"/>	Self (NAME)	2	<input type="checkbox"/>	Caregiver	3	<input type="checkbox"/>	Relative (besides caregiver)	4	<input type="checkbox"/>	Friend	5	<input type="checkbox"/>	Employer	6	<input type="checkbox"/>																			
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Employer	6	<input type="checkbox"/>																																					
Q231	<p><i>Were there particular times when (NAME) took these drugs?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">All the time</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>When he/she felt unwell</td> <td style="text-align: center;">2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>When could afford or paid for</td> <td style="text-align: center;">3</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Other (specify)</td> <td style="text-align: center;">8</td> <td><input type="checkbox"/></td> </tr> </table>	All the time	1	<input type="checkbox"/>	When he/she felt unwell	2	<input type="checkbox"/>	When could afford or paid for	3	<input type="checkbox"/>	Other (specify)	8	<input type="checkbox"/>																									
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Q232	<p><i>Did (NAME) sometimes refuse or forget to take the drugs?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> </tr> <tr> <td>Refused</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Forgot</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </table>		Yes	No	Refused	1	2	Forgot	1	2																												
	Yes	No																																					
Refused	1	2																																					
Forgot	1	2																																					
Q233	<p><i>Did (NAME) experience any unpleasant side effects when he/she was taking these drugs?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Yes</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>No</td> <td style="text-align: center;">2</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	1	<input type="checkbox"/>	No	2	<input type="checkbox"/>																															
Yes	1	<input type="checkbox"/>																																					
No	2	<input type="checkbox"/>																																					
Q234	<p><i>What were the main side effects?</i></p> <p>_____</p> <p>_____</p> <p>_____</p>																																						
Q235	<p><i>Was (NAME) able to obtain care from the health clinic whenever it was thought necessary?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Yes</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>No</td> <td style="text-align: center;">2</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	1	<input type="checkbox"/>	No	2	<input type="checkbox"/>	- Q237																														
Yes	1	<input type="checkbox"/>																																					
No	2	<input type="checkbox"/>																																					
Q236	<p><i>Why was she/he not able to receive care from a health clinic?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Transport problems</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>Clinic charges too high</td> <td style="text-align: center;">2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Clinic treatment ineffective (religion)</td> <td style="text-align: center;">3</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Clinic treatment ineffective (other)</td> <td style="text-align: center;">4</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Other (specify)</td> <td style="text-align: center;">8</td> <td><input type="checkbox"/></td> </tr> </table>	Transport problems	1	<input type="checkbox"/>	Clinic charges too high	2	<input type="checkbox"/>	Clinic treatment ineffective (religion)	3	<input type="checkbox"/>	Clinic treatment ineffective (other)	4	<input type="checkbox"/>	Other (specify)	8	<input type="checkbox"/>																						
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Q237	<p><i>How did (NAME)'s illness affect your own life?</i></p> <p><u>Read through list.</u></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> </tr> <tr> <td>Dropped out of school</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Missed school</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Lost/gave up job</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Stress</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Illness</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Fewer friends</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>More friends</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>New regular sex partner</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>New casual sex partner(s)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Increased condom use</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>Other (specify)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </table>		Yes	No	Dropped out of school	1	2	Missed school	1	2	Lost/gave up job	1	2	Stress	1	2	Illness	1	2	Fewer friends	1	2	More friends	1	2	New regular sex partner	1	2	New casual sex partner(s)	1	2	Increased condom use	1	2	Other (specify)	1	2	
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Other (specify)	1	2																																					
Q238	<p><i>How difficult was it for you to provide care for (NAME)?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Easy</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td>Difficult</td> <td style="text-align: center;">2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Very difficult</td> <td style="text-align: center;">3</td> <td><input type="checkbox"/></td> </tr> </table>	Easy	1	<input type="checkbox"/>	Difficult	2	<input type="checkbox"/>	Very difficult	3	<input type="checkbox"/>																												
Easy	1	<input type="checkbox"/>																																					
Difficult	2	<input type="checkbox"/>																																					
Very difficult	3	<input type="checkbox"/>																																					
Q239	<p><i>Did the death of (NAME) leave you feeling:</i></p> <p>1. Lonely</p> <p>2. Life is not worth living</p> <p>3. Resilient about the future</p> <p>4. Able to do your job properly</p> <p>5. People are wonderful</p> <p>6. Scared</p> <p>7. Determined</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="width: 10%; text-align: center;">Very</td> <td style="width: 10%; text-align: center;">A little</td> <td style="width: 10%; text-align: center;">Not much</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> <tr> <td></td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> </tr> </table>		Very	A little	Not much		1	2	3		1	2	3		1	2	3		1	2	3		1	2	3		1	2	3									
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Q240	<p><i>How many other members of your household have died in the last 2 years?</i></p>	<input style="width: 50px; height: 20px;" type="text"/>																																					
Q241	<p><i>How many spouses/regular partners did (NAME) have in his/her lifetime?</i></p> <p><u>Regular = cohabiting or &gt; 12 months.</u></p> <p><u>Ask questions Q242 to Q253 for the most recent spouse, then the previous, and so on ...</u></p>	<p><u>For women, record number of other wives the husband had and use columns 2-4 to record the same details for these co-wives.</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%; text-align: center;">1</td> </tr> <tr> <td>Spouse/regular</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> </tr> <tr> <td>Co-wife</td> <td style="text-align: center;">2</td> <td style="text-align: center;">2</td> <td style="text-align: center;">2</td> <td style="text-align: center;">2</td> </tr> </table> <p style="text-align: right; font-size: small;">co-wives</p>		1	1	1	1	Spouse/regular	1	1	1	1	Co-wife	2	2	2	2																						
	1	1	1	1																																			
Spouse/regular	1	1	1	1																																			
Co-wife	2	2	2	2																																			
Q242	<p><i>In what year did (NAME) and (PARTNER) marry/begin their relationship?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 10%; text-align: center;">yr</td> <td style="width: 10%; text-align: center;">yr</td> <td style="width: 10%; text-align: center;">yr</td> <td style="width: 10%; text-align: center;">yr</td> </tr> <tr> <td>Don't know</td> <td style="text-align: center;">98</td> <td style="text-align: center;">98</td> <td style="text-align: center;">98</td> <td style="text-align: center;">98</td> </tr> </table>		yr	yr	yr	yr	Don't know	98	98	98	98																											
	yr	yr	yr	yr																																			
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REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO																								
Q243	Is (PARTNER) still alive?	Yes <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr><tr><td>98</td><td>98</td></tr></table> No <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr><tr><td>98</td><td>98</td></tr></table> Don't know <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr><tr><td>98</td><td>98</td></tr></table>	1	1	2	2	98	98	1	1	2	2	98	98	1	1	2	2	98	98	- Q247 - Q247						
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Q244	Did (PARTNER) die before or after (NAME) passed away?	Before <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr></table> After <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr></table>	1	1	2	2	1	1	2	2																	
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Q245	How many years before/after (NAME) passed away did (PARTNER) die?	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td style="text-align: center;">yrs</td><td style="text-align: center;">yrs</td><td style="text-align: center;">yrs</td><td style="text-align: center;">yrs</td></tr><tr><td>98</td><td>98</td><td>98</td><td>98</td></tr></table> Don't know <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>98</td><td>98</td><td>98</td><td>98</td></tr></table>					yrs	yrs	yrs	yrs	98	98	98	98	98	98	98	98									
yrs	yrs	yrs	yrs																								
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98	98	98	98																								
Q246	What were the main symptoms that (PARTNER) was suffering from before he/she passed away?  Ask for others.	HIV/AIDS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>12</td><td>12</td></tr></table> Fever - malaria <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> Sickness/vommiting <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> Diarrhoea/weight loss <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td><td>3</td></tr></table> Swollen lymph nodes <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td><td>4</td></tr></table> Skin complaints/rashes <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>5</td><td>5</td></tr></table> Genital conditions <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>6</td><td>6</td></tr></table> Fever - other <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>7</td><td>7</td></tr></table> Flu/pneumonia <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>8</td><td>8</td></tr></table> Tuberculosis <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>9</td><td>9</td></tr></table> Accident/wound <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>10</td><td>10</td></tr></table> Other (specify) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>11</td><td>11</td></tr></table>	12	12	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	10	10	11	11	- - - - Go to - Q250 if - partner - died - first - (Q244) - - -
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Q247	Has (PARTNER) married again or resumed sexual activity since (NAME) passed away?	Married again <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> Resumed sex <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> Neither <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td><td>3</td></tr></table> Don't know <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>98</td><td>98</td></tr></table>	1	1	2	2	3	3	98	98	- Q250 - Q250																
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Q248	After how many months did (PARTNER) remarry?	0-24 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td></tr><tr><td style="text-align: center;">mths</td><td style="text-align: center;">mths</td><td style="text-align: center;">mths</td><td style="text-align: center;">mths</td></tr><tr><td>98</td><td>98</td><td>98</td><td>98</td></tr></table> Don't know <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>98</td><td>98</td><td>98</td><td>98</td></tr></table>					mths	mths	mths	mths	98	98	98	98	98	98	98	98									
mths	mths	mths	mths																								
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Q249	Was the new spouse related to (NAME)?	Yes: brother/sister <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> Yes: other (specify) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> No <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td><td>3</td></tr></table>	1	1	2	2	3	3																			
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Q250	Were (NAME) and (PARTNER) living together at the time (NAME) died? Tick "Yes" if (NAME) was in the clinic/hospital but previously staying together.	Yes <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> No <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> PARTNER already died <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>8</td><td>8</td></tr></table>	1	1	2	2	8	8	- Q253 - Q301																		
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Q251	What was their reason for living apart?	Work reasons <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> Separated (married) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> Hospitalised: PARTNER <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td><td>3</td></tr></table> Other (specify) <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>8</td><td>8</td></tr></table>	1	1	2	2	3	3	8	8																	
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Q252	Where was (PARTNER) living before (NAME) died? Record the name of the place.  1. _____ 2. _____ 3. _____ 4. _____	Large town or city <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> Small town <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> Growth point <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td><td>3</td></tr></table> Estate/mine <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td><td>4</td></tr></table> Roadside BC <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>5</td><td>5</td></tr></table> Rural BC <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>6</td><td>6</td></tr></table> Communal area <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>7</td><td>7</td></tr></table>	1	1	2	2	3	3	4	4	5	5	6	6	7	7											
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Q253	Where is (PARTNER) living now?  Record the name of the place.  1. _____ 2. _____ 3. _____ 4. _____	Same household <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>1</td></tr></table> Same place/village <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>2</td><td>2</td></tr></table> Large town or city <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>3</td><td>3</td></tr></table> Small town <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td><td>4</td></tr></table> Growth point <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>5</td><td>5</td></tr></table> Estate/mine <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>6</td><td>6</td></tr></table> Roadside BC <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>7</td><td>7</td></tr></table> Rural BC <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>8</td><td>8</td></tr></table> Communal area <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>9</td><td>9</td></tr></table>	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9							
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Q301	<p><i>Where did (NAME) go to obtain assistance when he/she was ill?</i>  <b>Record total visits made to each in the first column, then ...</b>  <b>Record first person/place in the second column, second person in the third column, and so on ...</b></p>	<p>Local clinic <input type="text"/> 1 1 1 1                      District hospital <input type="text"/> 2 2 2 2                      Provincial hospital <input type="text"/> 3 3 3 3                      Private doctor <input type="text"/> 4 4 4 4                      N'anga <input type="text"/> 5 5 5 5                      Faith healer <input type="text"/> 6 6 6 6</p> <p>Other (specify) <input type="text"/> 8 8 8 8</p>																																																							
Q302	<p><i>How much money was spent in total in each case on each of the following?</i>  <b>Ask for each person mentioned in Q301.</b></p> <p><b>Add up totals for each and overall.</b></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Hosp ZS'000</th> <th>P.Doc ZS'000</th> <th>N'anga ZS'000</th> <th>E.H. ZS'000</th> <th>Visitors ZS'000</th> </tr> </thead> <tbody> <tr><td>Admission fees</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Consultation fees</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Drugs/treatments</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Transport</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Other accomodation</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Other (specify)</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>ZS Total</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr> <tr><td>Don't know</td><td><input type="text"/> 98</td><td><input type="text"/> 98</td><td><input type="text"/> 98</td><td><input type="text"/> 98</td><td><input type="text"/> 98</td></tr> </tbody> </table>		Hosp ZS'000	P.Doc ZS'000	N'anga ZS'000	E.H. ZS'000	Visitors ZS'000	Admission fees	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Consultation fees	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Drugs/treatments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Transport	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Other accomodation	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ZS Total	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Don't know	<input type="text"/> 98	<input type="text"/> 98	<input type="text"/> 98	<input type="text"/> 98	<input type="text"/> 98	
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Don't know	<input type="text"/> 98	<input type="text"/> 98	<input type="text"/> 98	<input type="text"/> 98	<input type="text"/> 98																																																				
Q303	<p><i>Approximately how much of the total costs was contributed by the following?</i>  <b>Check total matches Q302.</b></p>	<p>Deceased <input type="text"/> ZS                      Spouse <input type="text"/> ZS                      Household residents (other) <input type="text"/> ZS                      Relatives living elsewhere <input type="text"/> ZS                      Friends/neighbours <input type="text"/> ZS                      Visitors' contributions <input type="text"/> ZS                      Deceased's employer <input type="text"/> ZS                      Other (specify) <input type="text"/> ZS                      ZS Total <input type="text"/></p>																																																							
Q304	<p><i>How much money was spent on the funeral and memorial services?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Funeral</th> <th>Memorial</th> </tr> </thead> <tbody> <tr> <td>Funeral / Memorial expenses</td> <td><input type="text"/> ZS</td> <td><input type="text"/> ZS</td> </tr> </tbody> </table>		Funeral	Memorial	Funeral / Memorial expenses	<input type="text"/> ZS	<input type="text"/> ZS																																																	
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Funeral / Memorial expenses	<input type="text"/> ZS	<input type="text"/> ZS																																																							
Q305	<p><i>Approximately how much of the total costs was contributed by the following?</i>  <b>Check total matches Q304.</b></p>	<table style="width: 100%; border-collapse: collapse;"> <tbody> <tr><td>Deceased's savings</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Spouse</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Household residents (otr)</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Relatives living elsewhere</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Friends/neighbours</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Burial society</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Deceased's employer</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Other (specify)</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> <tr><td>Total</td><td><input type="text"/> ZS</td><td><input type="text"/> ZS</td></tr> </tbody> </table>	Deceased's savings	<input type="text"/> ZS	<input type="text"/> ZS	Spouse	<input type="text"/> ZS	<input type="text"/> ZS	Household residents (otr)	<input type="text"/> ZS	<input type="text"/> ZS	Relatives living elsewhere	<input type="text"/> ZS	<input type="text"/> ZS	Friends/neighbours	<input type="text"/> ZS	<input type="text"/> ZS	Burial society	<input type="text"/> ZS	<input type="text"/> ZS	Deceased's employer	<input type="text"/> ZS	<input type="text"/> ZS	Other (specify)	<input type="text"/> ZS	<input type="text"/> ZS	Total	<input type="text"/> ZS	<input type="text"/> ZS																												
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Total	<input type="text"/> ZS	<input type="text"/> ZS																																																							
Q306	<p><i>How much was raised through sales of household assets to meet these costs?</i></p>	<p>Health/care costs <input type="text"/> ZS                      Funeral/memorial expenses <input type="text"/> ZS</p>																																																							
Q307	<p><i>Which of these types of assets were sold?</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr><td>Radio</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Television</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Bicycle</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Furniture</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Refridgerator</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Kitchen/cooking equipment</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Cattle</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> <tr><td>Other (specify)</td><td><input type="text"/> 1</td><td><input type="text"/> 2</td></tr> </tbody> </table>		Yes	No	Radio	<input type="text"/> 1	<input type="text"/> 2	Television	<input type="text"/> 1	<input type="text"/> 2	Bicycle	<input type="text"/> 1	<input type="text"/> 2	Furniture	<input type="text"/> 1	<input type="text"/> 2	Refridgerator	<input type="text"/> 1	<input type="text"/> 2	Kitchen/cooking equipment	<input type="text"/> 1	<input type="text"/> 2	Cattle	<input type="text"/> 1	<input type="text"/> 2	Other (specify)	<input type="text"/> 1	<input type="text"/> 2																												
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Other (specify)	<input type="text"/> 1	<input type="text"/> 2																																																							
Q308	<p><i>Was (NAME) in paid employment at the time he/she became ill?</i></p>	<p>Yes <input type="text"/> 1                      No <input type="text"/> 2                      Don't know <input type="text"/> 98</p>	- Q314 - Q314																																																						
Q309	<p><i>Was this employment terminated when (NAME) became ill?</i></p>	<p>Yes <input type="text"/> 1                      No <input type="text"/> 2                      Don't know <input type="text"/> 98</p>	- Q312 - Q312																																																						

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q310	<i>Did (NAME) receive any pension or termination payment when he/she lost his/her job?</i>	Yes: pension <span style="float: right;">1 <input style="width: 20px;" type="text"/></span> Yes: termination payment <span style="float: right;">2 <input style="width: 20px;" type="text"/></span> Yes: both <span style="float: right;">3 <input style="width: 20px;" type="text"/></span> No <span style="float: right;">4 <input style="width: 20px;" type="text"/></span> Don't know <span style="float: right;">98 <input style="width: 20px;" type="text"/></span>	- Q314 - Q314
Q311	<i>How much did he/she receive?</i>	Pension (per month) <span style="float: right;"><input style="width: 40px;" type="text"/> ZS</span> Termination payment <span style="float: right;"><input style="width: 40px;" type="text"/> ZS</span> Don't know <span style="float: right;">98 <input style="width: 20px;" type="text"/></span>	
Q312	<i>Is (NAME)'s spouse now receiving a widow's pension?</i>	Yes <span style="float: right;">1 <input style="width: 20px;" type="text"/></span> No <span style="float: right;">2 <input style="width: 20px;" type="text"/></span> Don't know <span style="float: right;">98 <input style="width: 20px;" type="text"/></span>	- Q314 - Q314
Q313	<i>How much does he/she receive?</i>	Pension (per month) <span style="float: right;"><input style="width: 40px;" type="text"/> ZS</span>	
Q314	<i>How much financial assistance has the spouse/family received from the Department of Social Welfare following (NAME)'s death?</i>	School fees <span style="float: right;"><input style="width: 40px;" type="text"/> ZS</span> Housing allowance <span style="float: right;"><input style="width: 40px;" type="text"/> ZS</span> Subsistence allowance <span style="float: right;"><input style="width: 40px;" type="text"/> ZS</span> Don't know <span style="float: right;">98 <input style="width: 20px;" type="text"/></span>	

"Now I would like to get some information about (NAME)'s children " ...

LINE NO	LINE NO @ B/L	DECEASED'S CHILDREN	SEX OF CHILD	DATE OF BIRTH	ALIVE AT B/L		PARENT'S SURVIVAL	CHILD'S SURVIVAL	AGE AT DEATH	EDUCATION						CARE ARRANGEMENTS				INTERVIEW DONE?												
Q401	Q402	Q403	Q404	Q405	Q406	Q407	Q408	Q409	Q410	Q411	Q412	Q413	Q414	Q415	Q416	Q417	Q418	Q419	Q420	Q421	Q422	Q423	Q424									
CHILDREN BORN BEFORE BASELINE SURVEY VISIT						<i>To be completed in office.</i>																										
	Enter line no. from B/L Q.	Copy names of children aged under 16 years at the time of the baseline survey from questionnaire S7.	Record sex of child.	Record date of birth.	Alive at baseline visit?	Note child's age when died.	Is (NAME)'s other natural parent still alive?	Note year died.	Is (NAME) still alive?	If dead: How old was (NAME) when he/she died?	Is (NAME) still in school? <i>If no, go to Q414.</i>	Why did (NAME) leave school?	What is the highest level of education exam? (NAME) has completed?	Has (NAME) passed the Grade 7 "O" levels has (NAME) passed?	How many different* household has (NAME) lived in regularly when (PARENT) was: (i) in good health? (ii) unwell? (iii) deceased?	Where was (NAME) living? A. when (PARENT) first became sick? B. when (PARENT) died? C. now?	What is the name of the person who was looking after (NAME) at this time? <i>(A, B &amp; C).</i>	What is the relationship of this person to (NAME)?	Record child's follow-up interview details if done.													
#			M F	Mth Yr	Y N DK	Dys Mths Yrs	Y N DK	Year	Y N DK	Dys Mths Yrs	Y N	Enter code	Form Grade	Gd7	"O"s	Well	Sick	Died	Name of place	Code	Name of person	Enter code	Site	MUT2NO								

1			1 2				1 2 8				1 2 8				1 2										A. B. C.
2			1 2				1 2 8				1 2 8				1 2										A. B. C.
3			1 2				1 2 8				1 2 8				1 2										A. B. C.
4			1 2				1 2 8				1 2 8				1 2										A. B. C.
5			1 2				1 2 8				1 2 8				1 2										A. B. C.
6			1 2				1 2 8				1 2 8				1 2										A. B. C.
7			1 2				1 2 8				1 2 8				1 2										A. B. C.
8			1 2				1 2 8				1 2 8				1 2										A. B. C.
9			1 2				1 2 8				1 2 8				1 2										A. B. C.
10			1 2				1 2 8				1 2 8				1 2										A. B. C.

REASONS FOR LEAVING SCHOOL (Q413)

- Insufficient funds
- Found a job
- To go to technical college
- To go to university
- Inadequate exam passes
- Needed to help at home
- Expelled: pregnancy
- Expelled: other reasons
- Pregnancy: left voluntarily
- Other (specify)

PLACES OF RESIDENCE (Q420)

- Large town or city
- Small town
- Growth point
- Commercial estate/town
- Roadside business centre (tarred)
- Rural business centre
- Communal /resettlement area

CARER'S RELATIONSHIP TO CHILD (Q423)

- |                                      |                          |                    |
|--------------------------------------|--------------------------|--------------------|
| 1. Natural mother                    | 8. Brother-in-law        | 15. Father-in-law  |
| 2. Natural father                    | 9. Maternal uncle        | 16. Mother-in-law  |
| 3. Father's new/co-wife (stepmother) | 10. Paternal uncle       | 17. Cousin         |
| 4. Mother's new husband (stepfather) | 11. Maternal grandfather | 18. Other relation |
| 5. Sister                            | 12. Paternal grandfather | 19. No relation    |
| 6. Brother                           | 13. Maternal grandmother |                    |
| 7. Sister-in-law                     | 14. Paternal grandmother |                    |

\* State totals separately for each period - i.e.: including households stayed in in preceding periods.



"Now I would like to get some information about (NAME)'s children who were born since we came here the last time " ...

LINE NO	DECEASED'S CHILDREN	SEX OF CHILD	DATE OF BIRTH	CHILD'S MOTHER	PARENT'S SURVIVAL		CHILD'S SURVIVAL		AGE AT DEATH		HEALTH			CARE ARRANGEMENTS																														
					Q408	Q409	Q410	Q411	Q426	Q427	Q428	Q429	Q418	Q419	Q420	Q421	Q422	Q423																										
Q401	Q403	Q404	Q405	Q425	Q408	Q409	Q410	Q411	Q426	Q427	Q428	Q429	Q418	Q419	Q420	Q421	Q422	Q423																										
	CHILDREN BORN SINCE BASELINE SURVEY VISIT. <u>Request list of new births.</u> <u>If no name yet given, indicate "No name".</u>	<i>Is (NAME) a boy or a girl?</i>	<i>In what (NAME) month and year was (NAME) born?</i>	<i>If deceased was male: What was the name of the child's natural mother?</i>	<i>Is (NAME)'s other natural parent still alive?</i>	<i>Note year died.</i>	<i>Is (NAME) still alive?</i>	<i>If dead: How old was (NAME) when he/she died?</i>	<i>If alive: How old was (NAME) at his/her last birthday?</i>	<i>Is (NAME) thriving? *</i> <u>Observe child &amp; examine CHC.</u>	<u>Record child's weight from CHC.</u>	<u>Note whether immunizations are up to date.</u>	<i>How many different households has (NAME) lived in regularly when (PARENT) was:</i> <i>(i) in good health?</i> <i>(ii) unwell?</i> <i>(iii) deceased?</i>	<i>Where was (NAME) living?</i> <i>A. when (PARENT) first became sick?</i> <i>B. when (PARENT) died?</i> <i>C. now?</i>	<i>What is the name of the person who was looking after (NAME) at this time?</i> <i>(A, B &amp; C).</i>	<i>What is the relationship of this person to (NAME)?</i> <i>(A, B &amp; C).</i>																												
		M F	Mth Yr		Y N DK	Year	Y N DK	Dys Mths Yrs	Yrs Mths	Y N DK	kg	Y N	Well Sick Died	Name of place	Code	Name of person	Enter code																											
1 01			1 2		1 2 8		1 2 8						1 2													A.																		
1 02			1 2		1 2 8		1 2 8						1 2													A.																		
1 03			1 2		1 2 8		1 2 8						1 2													A.																		
1 04			1 2		1 2 8		1 2 8						1 2													A.																		
1 05			1 2		1 2 8		1 2 8						1 2													A.																		
1 06			1 2		1 2 8		1 2 8						1 2													A.																		
1 07			1 2		1 2 8		1 2 8						1 2													A.																		
1 08			1 2		1 2 8		1 2 8						1 2													A.																		

"Just to make sure I have a complete listing ... "

Q430 Are there any other small children or infants that we have not yet listed?

Number:

Add each in table above.

Q431 Are there any small children or infants who have died that we have forgotten?

Number:

Add each in table above.

REASONS FOR LEAVING SCHOOL (Q413)

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- To go to university
- Inadequate exam passes
- Needed to help at home
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- Brother
- Sister-in-law
- Brother-in-law
- Maternal uncle
- Paternal uncle
- Maternal grandfather
- Paternal grandfather
- Maternal grandmother
- Paternal grandmother
- Father-in-law
- Mother-in-law
- Cousin
- Other relation
- No relation

\* i.e.: achieving milestones, not suffering from kwashiokor, HIV etc.

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
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**Q501**   Ask the respondent for his/her account of the cause of death.

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<b>Q502</b>	<i>During the two weeks before (NAME) died, did he/she suffer from any major injury, poisoning, burn or drowning?</i>	<b>Poisoning</b> <b>Fall</b> <b>Burn</b> <b>Drowning</b> <b>Alcohol intoxication</b> <b>Ate toxic herbs/plants</b> <b>Motor vehicle accident</b> <b>Other injury</b> <b>Death not due to injury</b>	1 2 3 4 5 6 7 8 9	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>- Q504</b>
<b>Q503</b>	<i>Was it an accident, was it inflicted deliberately by someone else, or was the death self-inflicted?</i>	<b>Accident</b> <b>Homicide</b> <b>Suicide</b> <b>Don't know</b>	1 2 3 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<b>Q504</b>	<u>Record whether deceased was male or female.</u>	<b>Male</b> <b>Female</b>	1 2	<input type="checkbox"/> <input type="checkbox"/>	<b>- Q701</b>

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q601	How many children had (NAME) given birth to when she died? <u>Do NOT include the last birth.</u>	Live births <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q602	Did (NAME) die during pregnancy or childbirth or within 6 weeks of giving birth?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	- Q608
Q603	Did (NAME) have her periods coming regularly?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q604	Did (NAME) have a swelling growing out of the vagina?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	- Q606 - Q606
Q605	For how long had this swelling been present?	Months/years <input style="width: 40px; height: 20px; text-align: center; font-size: 8px;"/> mths <input style="width: 40px; height: 20px; text-align: center; font-size: 8px;"/> yrs Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q606	Did (NAME) have bleeding from the vagina?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	- Q701
Q607	How long ago did she last have her period?	Months/years <input style="width: 40px; height: 20px; text-align: center; font-size: 8px;"/> mths <input style="width: 40px; height: 20px; text-align: center; font-size: 8px;"/> yrs Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	- Q609 - Q609
Q608	How many months was she pregnant when she died?	Month <input style="width: 40px; height: 20px; text-align: center; font-size: 8px;"/> mths Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q609	Did she suffer from any complaints during her last pregnancy?	Yes (specify) 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q610	Did she attend antenatal clinics during her last pregnancy?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q611	Did (NAME) have high blood pressure during pregnancy?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q612a	Was she complaining of severe headaches?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q612b	Was there bleeding during pregnancy?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q613	Did (NAME) have oedema of the limbs during pregnancy?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	
Q614	Did (NAME) have malaria during pregnancy?	Yes 1 <input style="width: 40px; height: 20px;" type="text"/> No 2 <input style="width: 40px; height: 20px;" type="text"/> Don't know 98 <input style="width: 40px; height: 20px;" type="text"/>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q615	<i>At what stage of the pregnancy did (NAME) die?</i>	During delivery 1 <input style="width: 20px; height: 15px;" type="text"/> Shortly before delivery 2 <input style="width: 20px; height: 15px;" type="text"/> Well before delivery 98 <input style="width: 20px; height: 15px;" type="text"/>	- Q701
Q616	<i>Was there excessive bleeding during delivery?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q617	<i>Was she complaining of severe headaches during delivery?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q618	<i>Did she have terrible abdominal pains during delivery that suddenly stopped before she died?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q619	<i>Did the placenta come out within half an hour of the birth of the child?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q620	<i>Did (NAME) have convulsions during delivery?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q621	<i>Was there high fever starting after delivery?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	- Q623 - Q623
Q622	<i>Did it start immediately after delivery or after a few days?</i>	Immediately 1 <input style="width: 20px; height: 15px;" type="text"/> After a few days 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q623	<i>Where did the delivery take place?</i>	Home 1 <input style="width: 20px; height: 15px;" type="text"/> Relative's home 2 <input style="width: 20px; height: 15px;" type="text"/> TBA's house 3 <input style="width: 20px; height: 15px;" type="text"/> Provincial hospital 4 <input style="width: 20px; height: 15px;" type="text"/> District hospital 5 <input style="width: 20px; height: 15px;" type="text"/> Other local hospital 6 <input style="width: 20px; height: 15px;" type="text"/> Clinic 7 <input style="width: 20px; height: 15px;" type="text"/> Other (specify) 8 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q624	<i>Who was in attendance at the birth?</i>	Doctor 1 <input style="width: 20px; height: 15px;" type="text"/> Nurse 2 <input style="width: 20px; height: 15px;" type="text"/> Midwife 3 <input style="width: 20px; height: 15px;" type="text"/> TBA 4 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q625	<i>Is the child still alive?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> Stillbirth 2 <input style="width: 20px; height: 15px;" type="text"/> Died after birth 3 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO									
Q701	<i>For how long had (NAME) been ill before he/she died?</i>	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">days</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">mths</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">yrs</td> </tr> <tr> <td colspan="3" style="border: none;">Don't know</td> </tr> <tr> <td colspan="3" style="border: none; text-align: right;">98 <input style="width: 20px; height: 15px;" type="text"/></td> </tr> </table>	days	mths	yrs	Don't know			98 <input style="width: 20px; height: 15px;" type="text"/>			
days	mths	yrs										
Don't know												
98 <input style="width: 20px; height: 15px;" type="text"/>												
Q702	<i>Did (NAME) have frequent loose stools or liquid stools during the disease that led to death?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td rowspan="3" style="vertical-align: middle; padding-left: 10px;">- Q710 - Q710</td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		- Q710 - Q710	2		98			
1		- Q710 - Q710										
2												
98												
Q703	<i>How many stools did he/she have in a day?</i>	Number of stools Don't know	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 40px; height: 25px;"></td> <td rowspan="2" style="vertical-align: middle; padding-left: 10px;"></td> </tr> <tr> <td style="border: none; text-align: right;">98 <input style="width: 20px; height: 15px;" type="text"/></td> </tr> </table>			98 <input style="width: 20px; height: 15px;" type="text"/>						
98 <input style="width: 20px; height: 15px;" type="text"/>												
Q704	<i>How long did the diarrhoea last?</i>	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">days</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">mths</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">yrs</td> </tr> <tr> <td colspan="3" style="border: none;">Don't know</td> </tr> <tr> <td colspan="3" style="border: none; text-align: right;">98 <input style="width: 20px; height: 15px;" type="text"/></td> </tr> </table>	days	mths	yrs	Don't know			98 <input style="width: 20px; height: 15px;" type="text"/>			
days	mths	yrs										
Don't know												
98 <input style="width: 20px; height: 15px;" type="text"/>												
Q705	<i>Did (NAME) have blood in the stools?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td rowspan="3" style="vertical-align: middle; padding-left: 10px;">- Q708 - Q708</td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		- Q708 - Q708	2		98			
1		- Q708 - Q708										
2												
98												
Q706	<i>For how long did he/she have blood in the stools?</i>	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">days</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">mths</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">yrs</td> </tr> <tr> <td colspan="3" style="border: none;">Don't know</td> </tr> <tr> <td colspan="3" style="border: none; text-align: right;">98 <input style="width: 20px; height: 15px;" type="text"/></td> </tr> </table>	days	mths	yrs	Don't know			98 <input style="width: 20px; height: 15px;" type="text"/>			
days	mths	yrs										
Don't know												
98 <input style="width: 20px; height: 15px;" type="text"/>												
Q707	<i>Did the stools look like rice water (whitish)?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
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98												
Q708	<i>Did the eyes become more sunken?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
2												
98												
Q709	<i>Did he/she suffer from dehydration?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
2												
98												
Q710	<i>Did (NAME) have a cough?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> <td rowspan="3" style="vertical-align: middle; padding-left: 10px;">- Q716 - Q716</td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		- Q716 - Q716	2		98			
1		- Q716 - Q716										
2												
98												
Q711	<i>For how long did this last?</i>	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">days</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">mths</td> <td style="border: 1px solid black; width: 30%; text-align: center; font-size: 8px;">yrs</td> </tr> <tr> <td colspan="3" style="border: none;">Don't know</td> </tr> <tr> <td colspan="3" style="border: none; text-align: right;">98 <input style="width: 20px; height: 15px;" type="text"/></td> </tr> </table>	days	mths	yrs	Don't know			98 <input style="width: 20px; height: 15px;" type="text"/>			
days	mths	yrs										
Don't know												
98 <input style="width: 20px; height: 15px;" type="text"/>												
Q712	<i>Did (NAME) cough sputum?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
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98												
Q713	<i>Did (NAME) have severe pain while coughing?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
2												
98												
Q714	<i>Did (NAME) cough blood?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
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98												
Q715	<i>Did (NAME) cough more at night than in the morning?</i>	Yes No Don't know	<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; text-align: right;">1</td> <td style="border: 1px solid black; width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">2</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> <tr> <td style="text-align: right;">98</td> <td style="border: 1px solid black; height: 15px;"></td> </tr> </table>	1		2		98				
1												
2												
98												

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q716	<i>Did (NAME) have trouble breathing during the illness that led to death?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	- Q721 - Q721
Q717	<i>For how long did this last?</i>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">days</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">mths</div> <div style="border: 1px solid black; padding: 2px;">yrs</div> </div> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q718	<i>Was (NAME) unable to lie down flat in bed because of shortness of breath?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q719	<i>During the past years did (NAME) have attacks of shortness of breath and noisy breathing (asthma)?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q720	<i>During the past year, was (NAME) short of breath upon exercise?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q721	<i>Did (NAME) have pneumonia?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q722	<i>How long ago is it since (NAME) suffered from tuberculosis?</i>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">mths</div> <div style="border: 1px solid black; padding: 2px;">yrs</div> </div> Never 97 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q723	<i>Did (NAME) have profuse night sweating?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q724	<i>Did (NAME) have a fever?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	- Q728 - Q728
Q725	<i>For how long did this last?</i>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">days</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">mths</div> <div style="border: 1px solid black; padding: 2px;">yrs</div> </div> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q726	<i>Was the fever present all the time or intermittent?</i>	Present all the time 1 <input style="width: 20px; height: 15px;" type="text"/> Intermittent 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q727	<i>Was (NAME) shivering before having fever?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q728	<i>During the illness that led to death was (NAME) unconscious or very confused?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	- Q730 - Q730
Q729	<i>For how long did this last?</i>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">days</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">mths</div> <div style="border: 1px solid black; padding: 2px;">yrs</div> </div> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	
Q730	<i>During the illness that led to death, did (NAME) have convulsions?</i>	Yes 1 <input style="width: 20px; height: 15px;" type="text"/> No 2 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO		
Q731	<i>During the illness that led to death, did (NAME) have neck stiffness?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q732	<i>During the illness that led to death, did (NAME) have severe headache?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q733	<i>During the illness that led to death, did (NAME) have problems opening his/her mouth?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q734	<i>During the illness that led to death, did (NAME) have spasms? (body muscles becoming very stiff)</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q735	<i>Did (NAME) get a wound (e.g.: bed sores) during the last two weeks before death?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q736	<i>Was (NAME) unable to speak?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q737	<i>During the disease that led to death, did (NAME) lose weight?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q739 - Q739
Q738	<i>Was the weight loss severe or moderate?</i>	Severe Moderate Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q739	<i>During the disease that led to death, did (NAME) become very pale?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q740	<i>During the disease that led to death, did (NAME) suffer a yellowing of the whites of the eyes (jaundice)?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q741	<i>During the disease that led to death, did (NAME) have swollen legs?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q742	<i>Did the colour of his/her hair change?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q743	<i>Did (NAME) complain of burning sensations of the legs?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q744	<i>Did (NAME) have any skin problems during the disease that led to death?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q749 - Q749
Q745	<i>For how many days did it last?</i>	Days Don't know	 98	<input type="text"/> <input type="checkbox"/>	
Q746	<i>Where was the rash located?</i>	All over the body On specific parts only (specify) Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO		
Q747	<i>Did (NAME) complain of itching of the skin?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q748	<i>Did the skin become very dry or scaly?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q749	<i>Did (NAME) have one localised dark swelling of skin?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q750	<i>Did (NAME) have abscesses or sores?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q752 - Q752
Q751	<i>How many abscesses or sores?</i>	One Two to four At least five Don't know	1 2 3 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q752	<i>Has (NAME) ever had herpes zoster?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q754 - Q754
Q753	<i>How many times?</i>	Once More than once Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q754	<i>Did (NAME) have swellings?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q756 - Q756
Q755	<i>Which parts were swollen?</i>  <i>Any other parts?</i>  <u>Probe for other parts.</u>	Whole body swollen Bumps all over body Neck Face Feet, lower legs Axilla (arm pit) Groin Abdomen Other parts (specify) Don't know	1 2 3 4 5 6 7 8 9 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q756	<i>Did (NAME) have protruded eyes?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q757	<i>Was (NAME) able to see well?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q759
Q758	<i>Was (NAME) able to see well when he/she was a child?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q759	<i>Was (NAME) known to have a heart problem?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	



REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO		
Q760	<i>Was (NAME) known to have high blood pressure?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q761	<i>Was (NAME) known to have diabetes?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q762	<i>Was (NAME) known to have HIV infection?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q763	<i>Did (NAME) have "sickle cell"?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q764	<i>Was (NAME) healthy as a child?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q768
Q765	<i>Did (NAME) have attacks of severe joint pains during his/her life?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q766	<i>Did (NAME) have attacks of becoming yellow during his/her lifetime?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q767	<i>Are there other family members with a similar disease?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q768	<i>Did (NAME) have ulcers in the mouth?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q769	<i>Did (NAME) have difficulty swallowing?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q770	<i>Did (NAME) have white patches on the inside of the mouth and tongue?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q771	<i>Did (NAME) suffer from vomiting?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q773 - Q773
Q772	<i>Did (NAME) vomit blood?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Q773	<i>Did (NAME) have severe pains in the abdomen?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q776
Q774	<i>Did (NAME) dislike certain foods?</i>	Yes No Don't know	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	- Q776 - Q776
Q775	<i>Which foods did he/she dislike?</i>	Beans Peppers Other (specify)	1 2 98	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q776	<i>Did (NAME) experience any problems/changes in urination?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	- Q782 - Q782
Q777	<i>Did (NAME) have pain during urination?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q778	<i>During the illness that led to death, did (NAME) pass brown or dark urine?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q779	<i>During the illness that led to death, did (NAME) have blood in the urine?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q780	<i>Was (NAME) unable to pass urine during the last days before death?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q781	<i>Did (NAME) have to urinate a lot?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q782	<i>Did (NAME) have unusually excessive thirst?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q783	<i>Did (NAME) complain of severe body pains?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	- Q785 - Q785
Q784	<i>Which parts was (NAME) complaining of?</i>  <u>Probe for any other parts.</u>	Whole body 1 <input style="width: 30px; height: 20px;" type="text"/> Abdomen 2 <input style="width: 30px; height: 20px;" type="text"/> Limbs 3 <input style="width: 30px; height: 20px;" type="text"/> Chest 4 <input style="width: 30px; height: 20px;" type="text"/> Head 5 <input style="width: 30px; height: 20px;" type="text"/> Bones 6 <input style="width: 30px; height: 20px;" type="text"/> Other parts (specify) 8 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q785	<i>Did (NAME) have allergic skin reactions to drugs?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q786	<i>Was (NAME) unable to move limbs? (paralysis)?</i>  <i>If yes, which ones?</i>	Yes: one sided 1 <input style="width: 30px; height: 20px;" type="text"/> Yes: both legs 2 <input style="width: 30px; height: 20px;" type="text"/> Yes: both arms 3 <input style="width: 30px; height: 20px;" type="text"/> No 4 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q787	<i>During his/her lifetime, did (NAME) usually drink a lot of alcohol?</i>	Yes 1 <input style="width: 30px; height: 20px;" type="text"/> No 2 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	
Q788	<i>Does (NAME) have a spouse who is unwell?</i>	No 1 <input style="width: 30px; height: 20px;" type="text"/> Yes: acutely ill 2 <input style="width: 30px; height: 20px;" type="text"/> Yes: chronically ill 3 <input style="width: 30px; height: 20px;" type="text"/> Don't know 98 <input style="width: 30px; height: 20px;" type="text"/>	

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q789	<p><i>During the disease that led to death, was advice or treatment sought from anywhere / anyone?</i></p> <p><u>Record all mentioned.</u></p>	<p>Nobody 1 <input type="checkbox"/></p> <p>Relative/friends 2 <input type="checkbox"/></p> <p>N'anga 3 <input type="checkbox"/></p> <p>Faith healer 4 <input type="checkbox"/></p> <p>Pharmacist 5 <input type="checkbox"/></p> <p>Private health facility 6 <input type="checkbox"/></p> <p>Government dispensary / clinic 7 <input type="checkbox"/></p> <p>Hospital 8 <input type="checkbox"/></p> <p>Don't know 98 <input type="checkbox"/></p>	
Q790	<p><i>Was he/she given anything when he/she was ill?</i></p>	<p>Yes 1 <input type="checkbox"/></p> <p>No 2 <input type="checkbox"/></p> <p>Don't know 98 <input type="checkbox"/></p>	<p>- Q792</p> <p>- Q792</p>
Q791	<p><i>What treatment was given?</i></p> <p><i>Anything else?</i></p> <p><u>Record all mentioned.</u></p>	<p>Tablets 1 <input type="checkbox"/></p> <p>Capsules 2 <input type="checkbox"/></p> <p>Injections 3 <input type="checkbox"/></p> <p>ORS packet solution 4 <input type="checkbox"/></p> <p>Syrup 5 <input type="checkbox"/></p> <p>Home remedy 6 <input type="checkbox"/></p> <p>Traditional medicine 7 <input type="checkbox"/></p> <p>Other (specify) 8 <input type="checkbox"/></p> <p>Don't know 98 <input type="checkbox"/></p>	
Q792	<p><i>Where did (NAME) die?</i></p>	<p>Hospital/clinic 1 <input type="checkbox"/></p> <p>On way to hospital 2 <input type="checkbox"/></p> <p>At home 3 <input type="checkbox"/></p> <p>Elsewhere 4 <input type="checkbox"/></p> <p>Don't know 98 <input type="checkbox"/></p>	
Q792	<p><i>Is there a death certificate?</i></p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Don't know <input type="checkbox"/></p>	<p>- End</p> <p>- End</p>
Q793	<p><u>Check name.</u></p>	<p>Correct <input type="checkbox"/></p> <p>Incorrect <input type="checkbox"/></p>	
Q794	<p><u>Record date of death per death certificate.</u></p>	<p><input style="width: 40px; height: 20px; border: 1px solid black; text-align: center; font-size: 8px; margin-right: 5px;" type="text"/> <small>month</small> <input style="width: 40px; height: 20px; border: 1px solid black; text-align: center; font-size: 8px; margin-left: 5px;" type="text"/> <small>yr</small></p>	
Q795	<p><u>Record place of death per death certificate.</u></p>	<p>Name of place. _____</p> <p>Harare 1 <input type="checkbox"/></p> <p>Mutare 2 <input type="checkbox"/></p> <p>Rusape 3 <input type="checkbox"/></p> <p>Other town or city 4 <input type="checkbox"/></p> <p>Small town or growth point 5 <input type="checkbox"/></p> <p>Estate/mining area 6 <input type="checkbox"/></p> <p>Roadside business centre 7 <input type="checkbox"/></p> <p>Rural business centre 8 <input type="checkbox"/></p> <p>Communal/resettlement area 9 <input type="checkbox"/></p> <p>Not stated 98 <input type="checkbox"/></p>	
Q796	<p><u>Record age at death per death certificate.</u></p>	<p><input style="width: 40px; height: 20px; border: 1px solid black; text-align: center; font-size: 8px;" type="text"/> <small>yrs</small></p>	
Q797	<p><u>Record cause of death per death certificate.</u></p>	<p>Immediate cause _____</p> <p>_____</p> <p>_____</p> <p>Underlying cause _____</p> <p>_____</p> <p>_____</p>	