

Verbal Autopsy (VA) Operations Manual

Adapted in part from
MANUAL OF INSTRUCTIONS
FOR
RGI SUPERVISORS
Version 9

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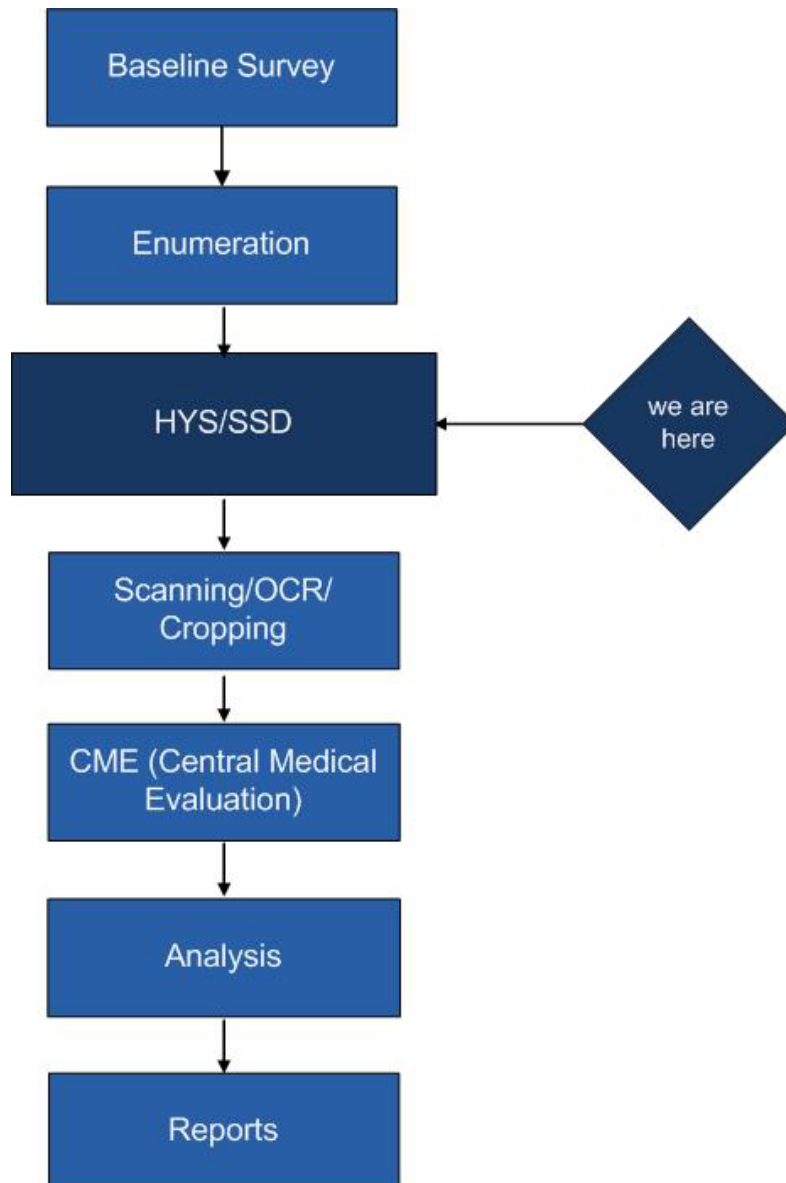
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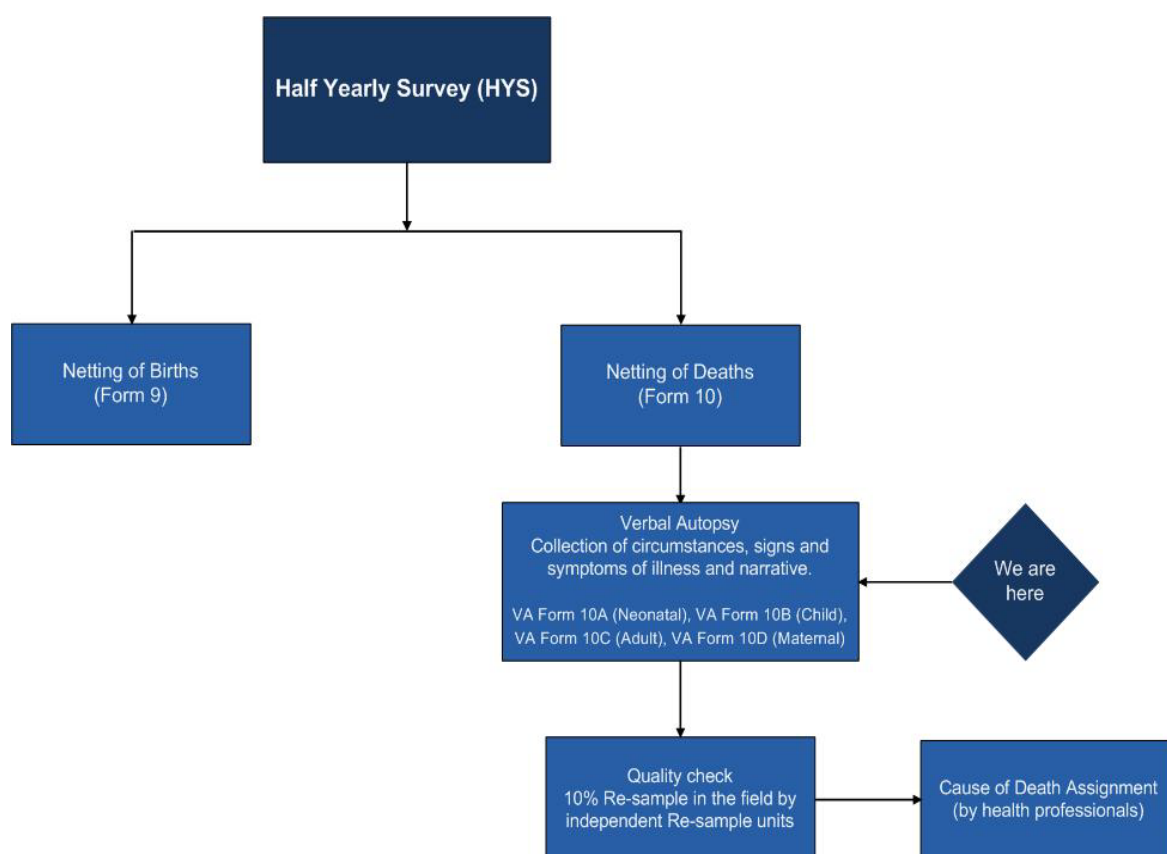
1. Overview

The Office of the Registrar General, India (ORGI) conducts the Sample Registration System (SRS) in a sampling frame composed of sample units (village or segment of a village in rural areas and census enumeration block in urban areas) spread across the country in order to provide reliable annual estimates of fertility, mortality and other indicators at the natural division level for rural areas and at the state level for urban areas. The sampling frame gets revised every 10 years based on results of the latest census. The following flowchart depicts the overall flow of the operations.



1.1. Half Yearly Survey (HYS)

An retrospective Half-Yearly Survey (HYS) of births and deaths is carried out by a Registrar General of India (RGI) supervisor, who visits each household in the sampling unit and records all births and deaths in Form 9 and 10 pertaining to all the usual-residents and to visitors during the last six months. The RHIME (Routine, Representative, Re-sampled, Household Interview of Mortality with Medical Evaluation) method (standardized verbal autopsy) is used to determine the cause of death in for each recorded death in the SRS as part of the continuous HYS. This section describes the overall flow of the VA operations.



1.2. About Verbal Autopsy

The cause of death information in India is poor, particularly in rural areas due to the shortage of medical personnel and facilities. Most people do not die in health facilities, so cause of death data based on the “Medical Certification of Cause of Death” is insufficient to represent the whole country accurately. To overcome this gap, verbal autopsy (VA) was introduced in the SRS.

Verbal autopsy is an investigation of the chain of events, circumstances, and signs and symptoms of illness leading to death through an interview of relatives or associates of the deceased.

Verbal Autopsy procedures are widely used for estimating cause-specific mortality in areas with little or no medical death certification.

Verbal Autopsy is:

- Feasible and practical
- Simple, fast and cheap
- Efficient and gives reliable information on causes of death
- Used successfully in other countries

Experience in India and other countries has shown that trained, non-medical surveyors such as you can collect information on the signs and symptoms of illness preceding death. Assignment of cause of death by health professionals on the basis of the verbal autopsy report prepared by trained surveyors has been found to give reliable information on cause of death in most cases, especially in young and middle age (before age 70). You need to provide a good description of the signs and symptoms that lead to death, as this will be the only information used by physicians to assign the cause of death.

Your objective is to gather complete and reliable information on the events, signs and symptoms leading to death. Put emphasis on obtaining a clear “story” by using the 5 interview steps that will be explained further in this manual. You should use the attached Cardinal Symptom List to obtain the story.

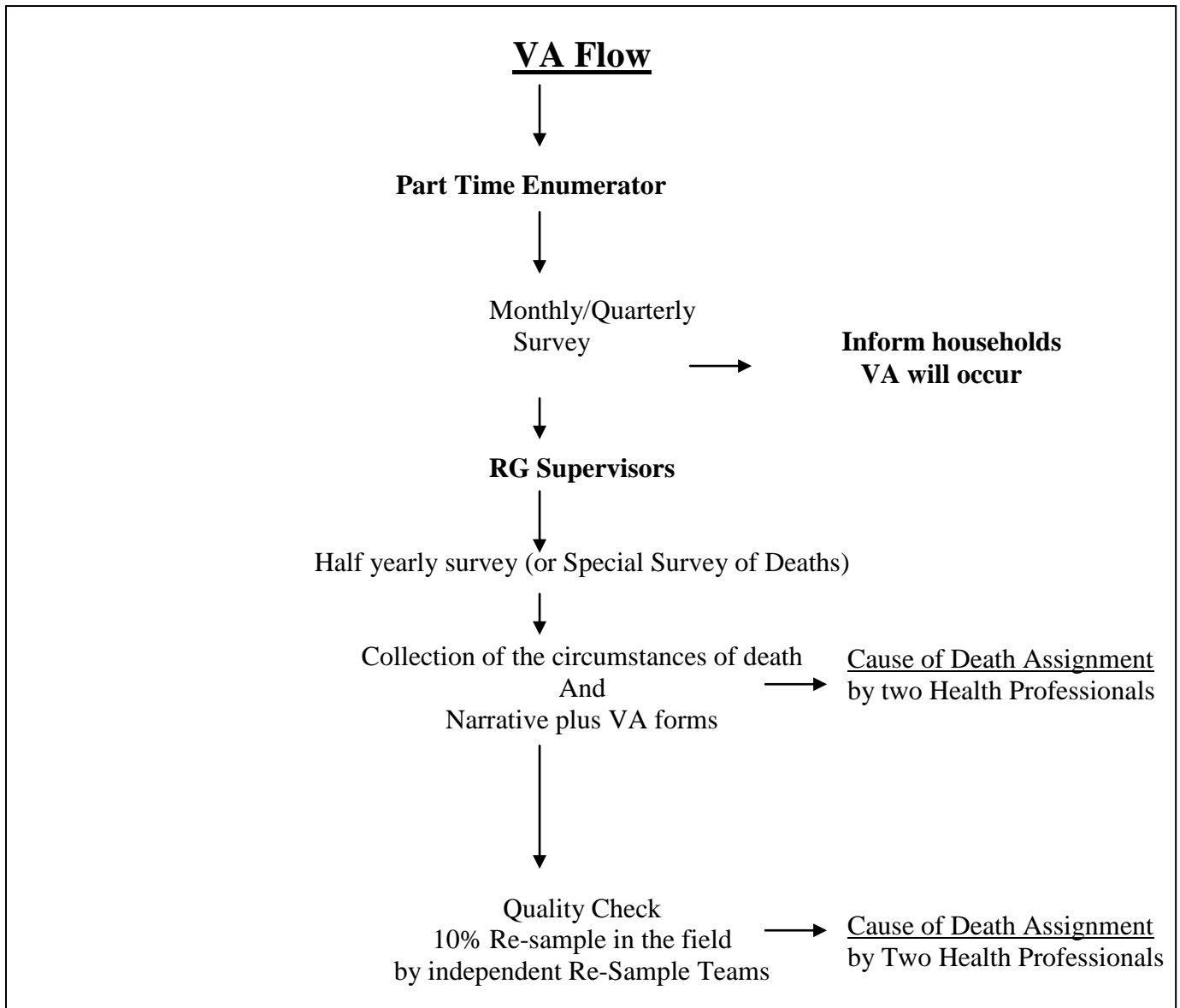
Your assignment is not to determine the cause of death yourself, but rather to concentrate on getting as much detail as possible concerning the circumstances of illness preceding death. Your success with this task will allow physicians to generate high quality data that will be used to improve public health in India.

The signs and symptoms preceding death are collected using verbal autopsy forms (10A, 10B, 10C, 10D).

As the trained non-medical surveyor, you should use the attached Cardinal Symptoms lists to obtain the story. You should determine the cause of death yourself, but focus on obtaining as much information as you can from the respondent, and writing a clear and structured narrative.

This manual provides information on how to conduct a good verbal autopsy interview, how to properly capture events in the narrative section, and instructions for completing the forms. The final sections illustrate the questionnaires of each VA form and include a brief description for each question on the form.

1.2.1. VA Flow

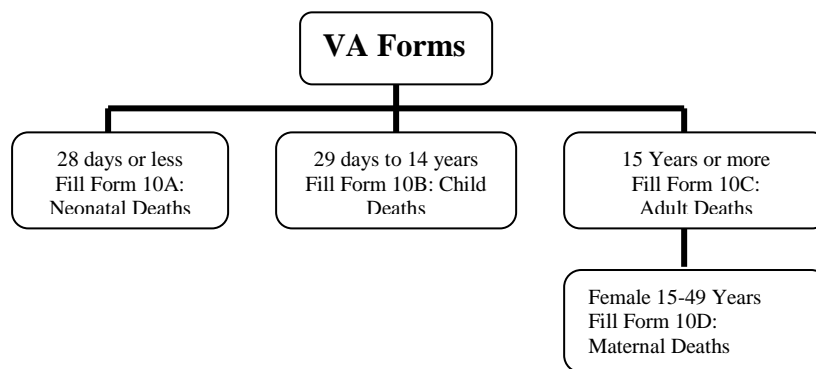


The first step of the VA process is to request that the households under visit keep details of the death (medical records) available for the surveyor. This is done by a Part-Time Enumerator (PTE) before the actual visit by the RGI supervisor. These reports are submitted for central medical review. Approximately 10% of each RGI surveyor's visits are re-sampled, so as to provide training inputs and method correction. On average, each state will have about two resample team members. The resample team will cover about one unit out of (and average of) 1012 units assigned to the RGI supervisor. This translates to about 1525 units per resample team. The verbal autopsy reports submitted by you are reviewed by trained physician coders, who assign the cause of death on the basis of the verbal autopsy report.

1.2.2. Types of VA forms

Four separate VA forms (10A, 10B, 10C and 10D) have been introduced to collect detailed information on neonatal, child, adult and maternal deaths, respectively. This division keeps the interviews focused on the signs and symptoms specific to each defined age group. Therefore, the selection of which form to fill out depends on the age and sex of the deceased individual:

- Form 10 A; neonatal death (28 days or less)
- Form 10 B: child death (29 days or more up to 14 completed years)
- Form 10 C: adult death (15 years or older)
- Form 10 D: maternal death (females aged 15-49 years)



For Forms 10A, B and C:

Section 1 is a structured questionnaire which includes general information on the respondent and deceased.

Section 2 is a structured questionnaire used to probe the signs and symptoms that led to death.

Section 3 is the written narrative. Here you will record the complete verbal narrative of the events, sign and symptoms that lead to the death. It is important to use the 5 Interview Steps and Cardinal Symptoms list, included in section XXXX in this manual, to write a structured and useful narrative. In short, this will include information on the events surrounding the death, the cardinal symptoms and probing details for each cardinal symptom, and any medical information from hospital reports, tests, or diagnoses.

For Form 10D:

Section 2b is a continuation of Section 2a from Form 10C for adult deaths, and is only for maternal deaths between the ages 15-49. This section asks about the events, signs and symptoms leading to the maternal death.

Section 3 is the written narrative for maternal deaths. Use the same guidelines and instructions for writing a proper narrative as described for the forms above.

2. Conducting Good Verbal Autopsy Interviews

2.1. Engaging with respondents

To conduct a successful verbal autopsy, you should be familiar with how to properly communicate and engage with the respondent. Remember that an interview to gather information on the circumstances of death of a close family member might be a sensitive issue for some respondents. If the interview is not conducted in a cordial and pleasing manner it might not only reduce cooperation from the respondent, but might also hurt a respondent's emotional wellbeing. Building a good rapport with the respondent will help her/him feel comfortable speaking about the death of her/his family member.

The interview should begin with a friendly greeting in accordance with local cultural practice. The purpose of the interview should be explained.

- Explain that this form will not be used for any legal purpose and that the information will be kept confidential and will be used only to compile statistics without revealing the name of the respondent or the deceased

Adjust the detail of your explanation to the interviewee's ability to understand it. A well-explained purpose from a friendly and competent interviewer will increase the cooperation from a respondent, and will find very few cases of refusal.

Your first choice of respondent is the surviving spouse/primary caregiver for adult deaths and the mother/grandmother/aunt for child or adolescent deaths. If this is not possible, ask for a relative or close associate. If this not possible, seek out a neighbour.

The following are some of the techniques used to conduct a good interview:

1. Prepare

You should also be thoroughly familiar with the various questions in the SRS VA forms **BEFORE** beginning the interview. This will help you to pose appropriate questions in order to obtain the desired information.

2. Interviewing Time

The time taken for interviewing is also very important. Long interviews should be avoided. Keep the interview as short as possible to collect all the required information.

3. Choose a Suitable Place

For an enquiry into the cause of death, it is best to interview a respondent where he/she feels most comfortable. It is likely that a home environment will be the most comfortable place for most respondents. Most people prefer to sit and be face-to-face at a comfortable distance.

4. Be Polite

Death is a sensitive issue, so it is important to consider the respondents' emotions. Ask questions politely in the form of a conversation, which will help them feel at ease. Non-verbal communication is also important. Maintain eye contact and avoid looking at watches or giving any impression of being hurried. Avoid crossing your arms, and try to keep an open body posture.

5. Give Time to Answer

Enough time should be given to respondent to reply. Respondents should be relaxed and have enough time to think and give a thorough answer.

6. Avoid Frequent Interruptions

Avoid frequent interruptions, as they break the flow of the interview and distract the respondent. Instead note important questions to ask later.

7. Use Simple Language

Often your respondent will not understand technical phrases or words. Avoid technical terminology and use simple words in the local language. Ensure your questions have been understood – if not, repeat the question to the respondent.

8. Inconsistencies

During the interview, the respondent may have difficulty remembering or providing details, and this may give rise to various inconsistencies in the facts they provide.

In such a situation, assume that the inconsistencies are unintentional, and ask again for clarification. Do not point out the inconsistencies in a rude or condescending way, as it may be embarrassing or insulting to the respondent.

9. Closing the Interview

Thank the respondent for their time and for sharing the details with you. Complete the final written narrative as soon as your interview with the respondent is finished.

2.2. The Cardinal Symptoms List

Cardinal symptoms are the main symptoms a person may show before death. There are two separate cardinal symptoms lists – one for adults and one for children or neonates,

and both of these contain a list of symptoms that are relevant for each age group. Each CS also has a specific set of probing questions that need to be asked, that give more details about each symptom. You will have a laminated copy of these lists to carry with your survey kit.

Using this list is a crucial part writing a high quality narrative, as the cardinal symptoms you describe in your narrative are very important information for the physicians who will assign a cause of death to your narrative. How to use the list is explained in the next section below.

2.3. Five (5) Interview Steps for Recoding a Proper Narrative

Collecting a complete and structured narrative is important to produce high quality data, and is easy to do. Below are five steps you should take each time you are collecting a verbal autopsy narrative:

Step 1: Listen: Ask the respondent to describe the events before death in their own words. For example, you can start by asking “Tell me what happened in the last few months before the death”.

Step 2: Positive symptoms: Obtain positive cardinal symptoms and other main events. While the respondent is speaking, document any cardinal symptoms and the main events described. After they are finished, ask about each of the remaining cardinal symptoms that the respondent did not mention.

Step 3: Probe: Ask probing questions for each positive cardinal symptom. These details are specific features of each symptom, such as the duration of a symptom, and are included in your Cardinal Symptoms list.

Step 4: Negative symptoms and medical information: Clearly document which of the cardinal symptoms did not occur. For example, if a respondent states that the deceased had diarrhoea and weight loss, you should confirm that they did not have any of the remaining 10 cardinal symptoms. Also gather any available medical information such as hospital discharge notes, and include the major details such as name of the hospital or doctor, and any tests performed or diagnoses made.

Step 5: Put it all together: Confirm time sequence of the events and read the story back to the respondent to make sure that there is nothing missing or incorrect with the details you have collected.

2.4 Difficult Interviews

If the respondent is **not able to give sufficient information** on any of the symptoms prior to death or finds it difficult to remember any major symptoms:

- Read out all the major signs/symptoms from the CS list
- Check responses to each, and note down positive responses
- Where there is a positive response, probe that symptom further to obtain additional details
- Ask for details on any treatment received, name and location of the hospital, and any tests or diagnoses made during medical care

2.5 Examples of Good and Bad Narratives

A good narrative contains useful and detailed information on the Cardinal Symptoms, which will ultimately allow the physician coders to record a cause of death quickly and accurately. The more details provided, the better, but it is important to focus on collecting information on the cardinal symptoms, as described in the 5 Steps. Below are examples of good and bad narratives, and some points to explain why.

The following is an example of a **complete narrative**:

As per the respondent the deceased was 20 years old, male, respondent thought person died of cancer. Deceased had cancer since 2 months, no fever, no cough, no breathlessness, no fits, no jaundice. Deceased had diarrhea since 2 months, episodes per day 4 to 6, semi solid stools, with blood. He had weight loss since 2 months. He had stomach problems since 2 months, after taking food pain increases, pain in upper stomach, pain is continuous. The deceased was admitted in Kolar district hospital for 7 days, all tests were done and doctor advice to the parents, take him back home since they felt that they can't save him and discharged him. After 3 days he died at home. He had no other cardinal symptoms.

This is a complete narrative because:

- there is a list of **positive cardinal symptoms** (diarrhoea, weight loss, stomach or abdominal problems)
- cardinal symptoms were **probed** for additional details (the duration, number of episodes, and type of stool is described for diarrhoea; and duration, location, and other details are described for stomach/abdominal pain)
- **negative cardinal symptoms** are recorded (“there was no fever, no cough, no breathlessness, no fits ...”)

- there is good **chronology**; duration and timing of all the symptoms is provided
- **medical information** is provided

An incomplete narrative is one which misses the vital information: either no cardinal symptoms, lack of probing of cardinal symptoms, negative symptoms not provided, or does not provide clear chronology. An incomplete kind of narrative is very difficult to accurately assign a cause of death to.

The following is an example of an **incomplete narrative**:

As per the respondent, the deceased died in 2010. The deceased had a habit of taking alcohol (all over the day) from the age of 12 yrs. The deceased was working in a factory & he was staying in Bangalore with his wife. He was not having any family problem. One day the deceased laid down on the road side in unconscious state & some unknown person took him to the hospital & admitted him. When he was admitted in the hospital, all tests were done & they came to know that the deceased was having hole in heart & damage in liver. Then in the night at 2'0 clock he died in hospital. The hospital people called the family to take the body of the deceased person.

This is a long narrative, but it is incomplete because:

- very little information on **cardinal symptoms** (only that the person was unconscious)
- no **probing** of cardinal symptoms
- no information on **negative cardinal symptoms**

Note: Even if the respondent is confident about the deceased's cause of death, you must ask about each symptom on the CL list.

2.6 Cardinal Symptoms List for Adult Deaths

1. FEVER

- High or low grade?
- Longer than 30 days?
- Continuous, intermittent (on and off), or occasional?
- Did the fever rise every day
- Repeated attacks with chills, shaking, sweating, or muscle pain
- **Associated with:** headache; burning sensation while passing urine; neck stiffness; irritated and does not like light or sound; confusion; drowsiness; coma; rash/blisters

2. COUGH

- Dry, wet (with sputum), bloody (rusty), or foul smelling?
- Longer than 30 days?
- Worse during day or night?
- With wheezing or in-drawing of chest (use local language)?
- Had to sit in bed for relief
- With pain at the sides of the chest wall?
- Pain worse with cough and/or deep breath
- **Associated with:** night sweats; evening rise of temperature; vomiting; hoarseness of voice

3. BREATHLESSNESS

- Describe the onset and progression (did the person feel breathlessness only during exercise or exertion? Did it progressively worsen so that breathlessness occurred also at rest?)
- Is breathlessness worse after lying flat, and relieved by sitting up?
- What brings it on (for example, allergy or chest infection)?
- Episodes or attacks of wheezes and breathlessness
- **Associated with:** night sweats; evening rise of temperature; vomiting and hoarseness of voice

4. DIARRHOEA

- Were the stools liquid or semisolid?,
- Did stools contain blood/mucus, or look like rice water?
- Longer than 30 days?
- Painless and large quantity
- Blood in the stool, colour red or black
- How many times a day at worst?
- **Associated with:** vomiting; very thirsty; dehydration; sunken eyes

5. WEIGHT LOSS

- Loss of weight became very rapid in last 2-3 months?
- Associated with prolonged and unexplained fever for more than 1 month (either constant or continuous)?
- Diarrhoea for more than 1 month
- Persistent cough for more than 1 month
- Swelling in arm pits, neck, groin
- Itching and skin rash
- White sores or white patches in mouth
- History of tuberculosis

6. CHEST PAIN

- Onset: sudden or gradual?

- Did pain last more than 24 hours or less than 24 hours?
- Describe the location: chest, upper stomach, or back
- Did pain spread? To left arm, deep central chest, hand, shoulder, or back?
- Pain worse with walking, exertion, cough or deep breath, touching the area or eating?
- **Associated with:** sweating; vomiting

7. PARALYSIS/STROKE

- Onset: over minutes, hours, or noticed after waking up?
- Accompanied by sudden loss of consciousness?
- Which part of body was paralyzed (i.e., half of body, one arm, right/left face)?
- Time of onset: during activity or in sleep
- **Associated with:** vomiting; headache; loss of memory; loss of vision or speech; neck stiffness

8. OEDEMA (SWELLING)

- Location: hands, feet, abdomen, or elsewhere?
- Onset: sudden or gradual?
- Worse at night or morning?
- **Associated with:** worse with walking; fatigue; feeling the heart beat faster; nausea; loss of appetite

9. URINARY PROBLEMS

- Reduced urine amount or more frequent passage of urine?
- Burning sensation while urinating?
- Urine contained pus or blood?
- Intense desire to pass more urine even after the bladder has been emptied?
- **Associated with:** pain in lower abdomen; tenderness in the side of abdomen; sudden onset of pain in one or both loins, spreading to lower abdomen; paleness; nausea; vomiting; became dull, drowsy or unconsciousness

10. GI TRACT PROBLEMS

- Was there pain? Describe the location; type (i.e., burning); and onset (sudden or gradual)
- If pain, describe periodicity: did it occur in episodes or continuous? How long each episode?
- Relationship to food: Was pain more on empty stomach? Was it relieved after taking food?
- Difficulty in swallowing solid or liquid food?
- Did pain wake person from sleep?
- Type of abdominal distension: sudden or gradual
- **Associated with:** loss of appetite, nausea; constipation; black stools; vomiting with blood; sweating; history of surgery or trauma or cancer; history of lump/mass in abdomen; alcohol abuse

11. JAUNDICE (YELLOWNESS IN THE WHITE PART OF EYES OR SKIN)

- What became yellow: eyes or skin; was urine dark yellow/brown?
- When did yellowness start: early, and got worse, or later after person was quite ill for some time
- **Associated with:** vomiting blood; alcohol abuse; history of cancer

12. SEIZURES/ FITS

- History of sudden jerky movements of arms or legs
- Was there loss of consciousness?
- Awake between fits or not

- **Associated with:** rolling of eye balls; frothing of mouth; loss of memory; bit tongue; bed wetting; confused; history of head injury

2.7 Cardinal Symptoms List for Neonatal and Child Deaths

1. FEVER/TEMPERATURE

- High or low grade?
- Longer than 30 days?
- Continuous, intermittent (on and off), or occasional?
- Did the fever rise every day
- Low fever (baby was cold) for neonates
- **Associated with:** headache; burning sensation while passing urine; neck stiffness; irritated and does not like light or sound; confusion; drowsiness; coma; rash/blisters

2. BREATHING PROBLEMS

- Describe the onset and progression (did the person feel breathlessness only during exercise or exertion? Did it progressively worsen so that breathlessness occurred also at rest?)
- Is breathlessness worse after lying flat, and relieved by sitting up?
- What brings it on (for example, allergy or chest infection)?
- Episodes or attacks of wheezes
- **Associated with:** night sweats; evening rise of temperature; vomiting and hoarseness of voice

3. COUGH

- Dry, wet (with sputum), bloody (rusty), or foul smelling?
- Longer than 30 days?
- Worse during day or night?
- With wheezing or in-drawing of chest (use local language)?
- With pain at the sides of the chest wall?
- **Associated with:** night sweats; evening rise of temperature; vomiting; hoarse voice

4. DIARRHOEA/DYSENTERY

- Stools liquid or semisolid?
- Did stools contain blood/mucus, or look like rice water?
- Longer than 30 days?
- Painless and large quantity
- Blood in the stool, colour red or black
- How many times a day at worst?
- **Associated with:** vomiting; very thirsty; dehydration sunken eyes; reduced urine amount
- *Note: mothers of breastfed infants tend to report children with soft/loose stools, so it is important to ask if soft and loose stools were MORE FREQUENT than usual*

5. JAUNDICE (YELLOWNESS IN THE WHITE PART OF EYES OR SKIN)

- What become yellow: eyes or skin; was urine dark yellow/brown?
- When did **yellowness start:** early, and got worse, or later after person was quite ill for some time
- **Associated with:** fast breathing; excessive crying; chest in-drawing (neonates); vomiting blood

6. SEIZURES/ FITS

- History of sudden jerky movements of arms or legs
- With loss of consciousness?
- Awake between fits or not

- **Associated with:** rolling of eye balls; frothing of mouth; loss of memory; bit tongue; bed wetting; confused; history of head injury

7. DISCOLORATION OF LIPS, HAND AND LEGS

- Bleeding into eyes and skin
- Location of discoloration (lips, hands, or legs)?
- Was discoloration blue or red?
- **Associated with:** bulging fontanel or drowsiness, scalp injuries, spasm of body

8. WEIGHT LOSS

- Loss of weight very rapid in last 2-3 months?
- **Associated with** prolonged unexplained fever for more than 1 month (either constant or continuous)?
- Diarrhoea for more than 1 month
- Persistent cough for more than 1 month
- Swelling in arm pits, neck, groin
- Itching and skin rash
- White sores or white patches in mouth
- History of tuberculosis or HIV/AIDS

9. OEDEMA/SWELLING

- Describe location: hands, feet, abdomen, or elsewhere?
- Onset: sudden or gradual?
- Worse at night or morning?
- **Associated with:** worse with walking; fatigue; feeling heart beat faster; nausea; appetite loss

3. Completing VA Forms

3.1. General Notes

- To fill out the forms, place an “X” in the appropriate boxes wherever applicable
- If writing text or numbers, please print very **clearly and neatly**
- Record all the required identification details at the top of the survey page, including the SRS Unit (8 digit code), names of the head of household, deceased, and respondent. The name of deceased should include first name, middle name, and surname, including alias. Identification codes can be copied from the household schedule. Neonates who die early may not be named - in that case write “baby of” and the mother’s name.

SRS unit number										Unique form number	1	009295
Year: 20		1st HYS		2nd HYS						Unit name		
Name of head of the household										Identification code of the head		
Full name of deceased										Identification code of the deceased		
Name of mother of the deceased										Identification code of mother of the deceased		

- Write the full household number details including all numbers, dashes, letters etc... For example, write “154/1” or “143/(2b)” as below:

1	5	4	/	1
---	---	---	---	---

 or

1	4	3	/	(2	b)
---	---	---	---	---	---	---	---

- For the text fields in English, print clearly one letter in each box. For example:

R	A	M		S	I	N	G	H
---	---	---	--	---	---	---	---	---

3.2 Verbal Autopsy Narrative

This sections contains the history of the events, signs and symptoms leading to the death. It should be written in local language, including all local terms mentioned. For example: keep the term “khasra”, “chhoti mata”, or “kanthi ki bimari” rather than mentioning it as measles; keep “sookha” in Punjabi rather than mentioning it as malnutrition. When writing the narrative, please use the [5 Interview Steps](#) as described in section 2.3, and focus on recording details of the symptoms in your [Cardinal Symptoms List](#). Take notes while the respondent is speaking, and write the full narrative immediately after the interview, so that the details are still fresh in your memory.

3.3 At the End of the Interview

The signature or thumb impression of the respondent should be taken. In case of a very special and rare situation where it is not necessary to obtain the signature of the respondent, record the reason for not obtaining the signature of the respondent

A signature is the writing of a person's name, in full or by initials, to authenticate the information provided by the respondent. If the respondent cannot sign their name, the impression of their left thumb may be obtained. If the left thumb is missing, use the impression of the right thumb. If both thumbs are missing, use the signature or thumb impression of any other household member. If no other person is available, write 'nobody available to put thumb impression'. If the respondent refuses to sign or use a thumb impression, record this accordingly.

Respondents' cooperation of interview: Rate the cooperation in interview as good, medium or poor as explained below:

- Good: Most of the questions were answered and required information collected.
- Medium: A large portion of the questions were answered.
- Poor: Respondent did not cooperate or was not forthcoming. Few questions were answered.

Interviewer's name, code, and signature: Write your complete name, your assigned code, and your full signature.

Date of interview: Write the date of the interview in the dd/mm/yy format.

Remember to thank the respondent and family for their time and reassure them about the confidential nature of the interview, and how useful their information is to the study.

3.2 FORM 10A: VERBAL AUTOPSY REPORT FOR NEONATAL DEATH (28 DAYS OR LESS)

Section 1: contains information on the location, identity and socio-demographic details of the respondent and the deceased, along with details of death.

Q1. Record the SRS Unit No./full name of the Head of Household, and the Indian State name and code. **Write this information in HINDI or ENGLISH ONLY.** The State codes are provided on the inside of the Form booklets.

- **NOTE:** The *respondent* refers to the principal person from whom you are collecting the information on all the questions. S/he should be the one who has been with the deceased during the terminal illness. The best respondent is usually the mother for 10A forms. The choice of the respondent should be done in the following order. Parents (preferably mother)
- Close relative
- Neighbour, or any other individual with knowledge of the death
- The village informant or the part time enumerator may provide additional information

Note: If the mother is dead, ask a woman who was close to the mother. Pregnant women usually share their experiences with other women in the family and friends.

Q2. Record the relation of the respondent to the deceased (i.e.: "the respondent is the _____ of the deceased"). Only the relevant codes have been listed.

Q3. Record whether the respondent lived at the same residence as the deceased during the events that led to death

Q4. Record the age of the respondent in completed years

Q5. Record the sex of the respondent

Q6. Record age of the deceased in completed days (for the first day of life enter "00")

Q7. Record sex of the deceased. Sex should be recorded carefully for deaths occurring in the first few days of life since newborns are not named, and there is no possibility of cross checking sex with name.

Q8. House address of the deceased should be recorded accurately, as these details are required for quality assurance during the 10% re-sample by the re-sampling teams. Write the name of the head of the household, house no. if any, name of the

street/mohalla and postal address. If unclear, write an important landmark near the house of the deceased, for example: school, temple, etc. Be sure to include PIN.

Q9. Recorded date of death in dd/mm/yy format. If the exact day is not remembered by the family members, then only record the month and year accurately. Try to verify the date of death from any source that is readily available, such as from home records, records of the part time village enumerator, etc.

Q10. Record the place of death. When the death occurs at an accident site, or in transit between home and health facility, enter the code 3. The details about the place and circumstances of death should be recorded in the narrative.

Q11. Ask the respondent what s/he thinks the deceased died of. The reply should be recorded **exactly as stated**, using the local terms and language. For example, if the respondent does not know, or states that the death was sudden, or caused by supernatural or even spirits, record it as such. Don't probe further at this stage. You may write in the local language or in Hindi or English.

Section 2: a structured questionnaire to get details about the onset of illness, and the signs and symptoms that led to death following a live birth. In general, death in neonates can be related to events occurring in the following three time periods:

- The health of the mother during pregnancy
- Events during delivery and the first few hours of life
- From the second day of the birth onward

Q12A/B. Record if the death was caused by an injury or accident, and if so, the type of injury or accident. These questions are for external injuries and NOT injuries while giving birth. If the answer to question 12A is "no", please skip to Q13.

Q13. A single birth is when only one child is born, and multiple birth is when two or more children are born at the same time, even if one or more of the babies is born dead.

Q14. Record the place of birth.

Q15. Record who attended the delivery. Traditional birth attendants are often village level women, commonly known as "*dai*," who assist deliveries in the community, usually in home environments in rural areas. They may have received training from the government health department.

Q16. Duration of pregnancy must be recorded very accurately. The duration is counted from the last menstrual period to the birth of the baby. Most mothers are able to tell after how many completed months of pregnancy the baby was born. The range for this number should be 1 to 10 months

Q17A. Record whether there was any complication during the pregnancy or during labour. Complications that can occur in this period are excess bleeding from genital parts, swelling of feet and hands, fits, pallor, prolonged and difficult childbirth.

Q17B. Recording of complications during delivery should be accurate, and each of the options should be read to the respondent. If necessary, other women in the household who were present during pregnancy/delivery can also provide information. Important terms are described below:

- Excessive bleeding: usually respondent knows what is an excess amount of bleeding from genital tracts during labour or during delivery
- Water broke 1 day or more before contractions started: ask whether urine-like fluid came out from vagina for one day or more before start of labour pains
- Prolonged/difficult labour: ask whether interval between onset of labour pain and delivery of baby was 12 hours or more
- Operative delivery: ask whether baby was delivered by caesarean section operation or by using any instrument. Operations are sometimes done to deliver the baby, such as a small cut made to widen the birth canal (called episiotomy), or delivery through the abdomen (caesarean section). Instruments may also be used, such as forceps to pull the baby out of the birth canal

Q18. Record whether the mother received two doses of tetanus toxoid during pregnancy, which are usually given to mothers to prevent tetanus. Check mother's immunization card, if it is easily available.

Q19. Record whether the baby ever cried, moved or breathed after delivery.

Q20. Record whether there were bruises or signs of birth injury on child's body after birth.

Birth trauma: Ask about bleeding sites from the skin surface or collection of blood in the head (scalp) and or under the skin surface any where in the body. This is a sign of birth trauma resulting from difficult delivery.

Birth injury: In cases of prolonged or difficult labour, or when forceps/vacuum assisted delivery has been conducted, there are chances of injury to the foetus. Injury with fatal

outcomes are mostly on the head, and manifest as swellings, blood clots, or sometimes even external/open wounds. (NOTE: these are not external injuries)

Q21. Record whether the baby after birth showed abnormal make-up of any of the body parts, e.g. head, upper and lower limbs, back, neck, face, mouth, lips, or other. If YES, then include details in the narrative.

Q22. Record the physical size of the baby. 2.5 to 3.9 kg at birth is average size, while less than 2.5 kg is small, and 4 kg or more is larger than the average. If birth weight is not available ask about the physical size of the baby as compared to healthy babies born in the community or in the same family.

Q23A/B/C. Record the child's ability to breathe and cry after birth, and the time from birth if the baby ever stopped crying.

Q24A/B/C. Record the ability of the baby to suckle after birth. Babies generally start suckling at the breast soon after birth.

Q25. Record the duration of the sickness.

Q26A/B. Record whether the child had a history of fever, and its duration. Fever can come on alternate days or daily, and may or may not include shivering.

Q27A/B. Record if there was difficulty breathing, and if so, the duration of time. For example, if the child takes rapid breaths or there may be abnormal sounds while the child breathes.

Q28A/B. Record whether there was fast breathing, and if so, the duration of time. The baby generally takes about 50 breaths in a minute or about 1 per second. Mothers usually know when the child is breathing fast. The respondent may use local terms to describe fast breathing; for example, in north India '*Pasli Chalna*' means fast breathing.

Q29. Record whether there was chest in-drawing. This is present when the whole of the lower chest wall goes in as the child breathes in. Some mothers may describe it as pneumonia or double pneumonia.

Q30A/B/C. Record if there was cough, and associated grunting or nostril flaring during breathing. Grunting is a soft, short sound an infant makes when breathing out, and occurs when an infant is having trouble breathing. Nasal flaring or widening of the nostrils indicates that the baby needs to make extra effort to breathe.

Q31A/B. Record whether there was diarrhoea, and if so, the duration. Mothers usually know when their child is having diarrhoea. They may use a local term such as 'dast', which means frequent passage of loose or watery stools, with or without blood.

Q32. Record if there was any vomiting.

Q33. Record if there was redness or any discharge from the birth cord stump.

Q34. Ask about any red condition of the skin.

Q35. Ask about skin rash.

Q36. Record whether there was jaundice, which may be seen as yellow discolouration of the eyes or skin.

Q37. Record if there were spasms or fits. Ask about involuntary, unintended movements, involving either the whole or part of the body, which may occur at rest or during voluntary movement.

Q38. Record if the child became unconscious and/or did not respond to verbal commands.

Q39. Record if there was a bulging fontanelle. Ask whether the skin of the front soft part of the head was bulging or raised above. There are local terms to describe this part of the head and mothers usually know this.

Q43. Record whether the child was colder than normal prior to death.

Q44. Record the language code of the narrative. **Please print the code clearly.** The codes are as follows:

1	Hindi	9	Gujurati
2	English	10	Bengali
3	Malayalam	11	Assamese
4	Marathi	12	Urdu
5	Telugu	13	Punjabi
6	Oriya	14	Sindhi
7	Tamil	15	Other- write beside box
8	Kannada		

3.1.2. FORM 10B: VERBAL AUTOPSY REPORT FOR CHILD DEATH (29 DAYS OR MORE TO AGE 14 YEARS)

Section 1: contains information on the location, identity and socio-demographic details of the respondent and the deceased, along with details of the death.

Unit Identifier, Household Numbers and Q1-7. See earlier instructions for corresponding questions in Form 10A Section 1 (Pages 22-23).

NOTE: The *respondent* refers to the principal person from whom you are collecting the information on all questions. S/he should be the one who has been with the deceased during the terminal illness. The best respondent is usually the mother for 10B forms. The choice of the respondent should be done in the following order.

- Parents (preferably mother)
- Close relative
- Neighbour, or any other individual with knowledge of the death
- The village informant or the part time enumerator may provide additional information

Note: If the mother is dead, ask a woman who was close to the mother. Pregnant women usually share their experiences with other women in the family and friends.

Q8. Record the relation of the respondent to the deceased (i.e.: “the respondent is the _____ of the deceased”). Only the relevant codes have been listed.

Q9. House address of the deceased should be recorded accurately, as these details are required for quality assurance during the 10% re-sample by the re-sampling teams. Write the name of the head of the household, house no. if any, name of the street/mohalla and postal address. If unclear, write an important landmark near the house of the deceased, for example: school, temple, etc. Be sure to include PIN.

Q10. Record the date of death in dd/mm/yy format. If the exact day is not remembered by the family members, then only record the month and year accurately. Try to verify the date of death from any source that is readily available, such as from home records, records of the part time village enumerator, etc.

Q11. Record the place of death. When the death occurs at an accident site, or in transit between home and health facility, enter the code 3. The details about the place and circumstances of death should be recorded in the narrative.

Q12. Ask the respondent what s/he thinks the deceased died of. The reply should be recorded **exactly as stated**, using the local terms and language. For example, if the respondent does not know, or states that the death was sudden, or caused by

supernatural or even spirits, record it as such. Don't probe further at this stage. You may write in the local language or in Hindi or English.

Section 2: a structured questionnaire to get details about the onset of illness, and the signs and symptoms that led to any death that occurred after 29 days and before the age of 15 years.

Q13A/B. Record if the death was caused by an injury or accident, and if so, the type of injury or accident. If the child committed suicide, then also record the manner in the narrative. Similarly, if homicide, record the weapon used. **Note the skips.**

Q14. Record the physical size of the baby. 2.5 to 3.9 kg at birth is average size, while less than 2.5 kg is small, and 4 kg or more is larger than the average. If birth weight is not available ask about the physical size of the baby as compared to healthy babies born in the community or in the same family.

Q15A/B. Record whether the child was born premature, which is a baby born before 37 full weeks or 9 months of pregnancy. The duration is counted from the last menstrual period to the birth of the baby.

Q16A/B. Record whether the child was breast-fed, and if so, whether he/she stopped breast feeding during the last illness that led to death.

Q17. Record the duration of the sickness.

Q18A/B/C. Record whether the child had a history of fever, and its duration. Fever can come on alternate days or daily, and may or may not include shivering.

Q19. Record if there were convulsions or fits. Ask about involuntary, unintended movements, involving either the whole or part of the body, which may occur at rest or during voluntary movement.

Q20. Record if the child became unconscious and/or did not respond to verbal commands.

Q21. Record whether the whole body of the child became stiff before death.

Q22. Record whether the neck became stiff, for example, demonstrate if it was not possible to touch the chin with the chest.

Q23A/B/C/D. Record whether there was diarrhoea, and if so, the duration, if any blood was seen, and if the child was given oral rehydration treatment. Mothers usually know when their child is having diarrhoea. They may use a local term such as 'dast', which means frequent passage of loose or watery stools, with or without blood.

Q24A/B/C. Record if there was cough, and if so, the duration and the associated signs of the cough. Productive means cough produced sputum; dry cough means cough without sputum.

Q25A/B/C/D/E/F. Record if there was difficulty breathing, and if so, the duration of time. For example, if the child takes rapid breaths or there may be abnormal sounds while the child breathes.

Q25C Record whether there was fast breathing . The baby generally takes about 50 breaths in a minute or about 1 per second. Mothers usually know when the child is breathing fast. The respondent may use local terms to describe fast breathing; for example, in north India '*Pasli Chalna*' means fast breathing.

Q25D Record whether there was chest in-drawing. This is present when the whole of the lower chest wall goes in as the child breathes in. Some mothers may describe it as pneumonia or double pneumonia.

Q25E Record whether there was wheezing. Demonstrate wheezing (high pitched sounds produced in chest when breathing out)

Q25F Record whether antibiotics were given during the breathing problems.

Q26A/B/C. Record if the child had complaints of pain in the abdomen, and if so, the location of pain and whether there was distention. The abdomen is below the rib cage and above the pelvic bones.

Q27A/B. Record whether the child vomited, and if so, the duration.

Q28. Record whether there was jaundice, which may be seen as yellow discolouration of the eyes or skin.

Q291A/B/C. Record if the child had any eruption or rash, and if so, the location of the rash, and if it was measles. You may use local terminology such as '*Khsara*'. A history of skin rash starting on face gradually progressing downwards associated with fever, red eyes, runny nose or cough is likely to be due to measles.

Q30. Record whether the child was losing weight or becoming thin.

Q31. Record whether the child complained of weakness, suffered from lack of blood, or had paleness of skin.

Q32A/B/C/D. Record whether the child had any repeated illness, and if so, the number of times it was repeated in the past 6 months, and specify the symptoms associated with the illness. Check all that apply.

Q33A/B/C/D. Record whether the child was immunized, and if so, whether they received immunization for BCG, polio, and measles. Get this from the immunization card, if available. Further information:

- BCG injection is given at or around the time of birth
- Polio drops are given orally, at monthly intervals (total 3 doses) after birth or on pulse polio days
- Measles injection in the thigh is given at 9 months of age or later (usually 1 or 2 doses)

Q34. Record the language code of the narrative. **Please print the code clearly.** The codes are as follows:

1	Hindi	9	Gujurati
2	English	10	Bengali
3	Malayalam	11	Assamese
4	Marathi	12	Urdu
5	Telugu	13	Punjabi
6	Oriya	14	Sindhi
7	Tamil	15	Other- write beside box
8	Kannada		

3.1.3. FORM 10C: VERBAL AUTOPSY REPORT FOR ADULT DEATH (15 YEARS OR OLDER)

Section 1: contains information on the location, identity and socio-demographic details of the respondent and the deceased, along with details of the death.

Unit Identifier, Household Numbers and Q1-Q7. See earlier instructions for corresponding questions in Form 10A - Section 1 (Pages 22-23).

NOTE: The *respondent* is the principal person from whom you are collecting the information on all the questions. S/he should be the one who has been with the deceased during the terminal illness. The best respondent is usually the spouse for 10C forms. The choice of the respondent should be done in the following order.

- Spouse
- Parents (preferably mother)
- Close relative
- Neighbour, or any individual with knowledge of the death
- The village informant or the part time enumerator may provide additional information

Q8A/B. Record whether the deceased lived away from home, and if so, for how long.

Q9. Record the relation of the respondent to the deceased (i.e.: "the respondent is the _____ of the deceased"). All codes have been listed.

Q10. House address of the deceased should be recorded accurately, as these details are required for quality assurance during the 10% re-sample by the re-sampling teams. Write the name of the head of the household, house no. if any, name of the street/mohalla and postal address. If unclear, write an important landmark near the house of the deceased, for example: school, temple, etc. Be sure to include PIN.

Q11. Record the number of completed years the deceased had lived at current address.

Q12. Record the date of death in dd/mm/yy format. If the exact day is not remembered by the family members, then only record the month and year accurately. Try to verify the date of death from any source that is readily available, such as from home records, records of the part time village enumerator, etc.

Q13. Record the place of death. When the death occurs at an accident site, or in transit between home and hospital, enter the code 3. The details about the place and circumstances of death should be recorded in the narrative.

Q14. Ask the respondent what s/he thinks the deceased died of. The reply should be recorded **exactly as stated**, using the local terms and language. For example, if the respondent does not know, or states that the death was sudden, or caused by supernatural or even spirits, record it as such. Don't probe further at this stage. You may write in the local language or in Hindi or English.

Section 2: a structured questionnaire to get details about the onset of illness, and the signs and symptoms that led to any death that occurred at 15 years of age or older.

Q15-Q23. Record the past history of illness. **The YES code should be selected only if the respondent states that a doctor (either allopathic, homeopathic or ayurvedic) had diagnosed that condition.** If respondent notes "Other chronic disease", add the details in the narrative.

Q24. Record whether weight had changed significantly over the past year .

Q25/B. Record whether the deceased was taking any medications during the past five years. Record up to 3 in Hindi or English only. If more than 3 medications are taken regularly, try to avoid multivitamin drugs (if possible), and note additional drugs in the narrative.

Q26-Q28. Record whether the **deceased** had a history of tobacco (cigarette, bidi, chewing, or other tobacco) or alcohol use, and **repeat the same questions for the respondent:**

Q29. Record whether the **deceased and respondent** were pure vegetarians for the last few years.

NOTE: You should be very careful while posing these sensitive questions and you must not enter into any arguments. Record the response as answered by the respondent.

Q30 A/B/C. Record whether the deceased was pregnant during her death. These questions are to **only** be asked for **women aged 15-49 years**. There may be a need to ask neighbours or female members of the family to confirm pregnancy. If answered "Yes" for any of these questions, **directly continue on Form 10D (maternal death).** **Copy the Form 10D unique form number here.**

Q31. Record the language code of the narrative. **Please print the code clearly.** The codes are as follows:

1	Hindi	9	Gujurati
2	English	10	Bengali
3	Malayalam	11	Assamese
4	Marathi	12	Urdu
5	Telugu	13	Punjabi
6	Oriya	14	Sindhi
7	Tamil	15	Other- write beside box
8	Kannada		

3.1.4. FORM 10D: VERBAL AUTOPSY REPORT FOR MATERNAL DEATHS (FEMALES AGED 15-49 YEARS)

This form is a continuation of Form 10C (adult deaths), and is only to be used for women aged 15-49 years, who was pregnant during death, or died within 42 days of delivery or an abortion.

Section 1: Fill in the Unit Identifier and Household Numbers in the header as per form 10C. **Copy the 10D unique form number onto Form 10C in Question 30.**

SRS unit number				Copy this number on the Form 10C 5 505321
Year: 20	1st HYS	2nd HYS	Unit name	
Name of head of the household				Identification code of the head
Full name of deceased				Identification code of the deceased

Section 2: a structured questionnaire to get details of the delivery or abortion that led to a maternal adult death. The abortion could occur on its own (spontaneously) or could be done by a "dai," or qualified doctor

Q1A/B. Record whether the female was pregnant, and if so, the duration of the pregnancy. Only use for women who died when pregnant or suspected to be pregnant.

Q2A/B. Record whether the deceased was receiving antenatal care during the pregnancy (antenatal care is given by health personnel during pregnancy, and includes tetanus immunization, iron and folic acid tablets, etc.), and if so, the number of times antenatal care was received. **Only ask if the deceased had died within 42 days of delivery or abortion.**

Q3. Record the number of days after the delivery or abortion that the death took place.

Q4. Record the place of delivery accurately.

Q5. Record who attended the delivery.

Q6-17: Ask only for women who had a deliver and not for those who had an abortion.

Q6. Record whether the delivery took place through a caesarean section operation.

Q7. Record whether there was too much bleeding at the beginning of labour pains. Ask whether excessive bleeding took place after 28 weeks (7 months) of pregnancy but before the delivery. Note extra details in the narrative.

Q8. Record whether there was too much bleeding during labour but before the birth of the baby. Responses such as blood that “soaks tens of cloths/or bandages” or “covers the floor” is a good indication of too much bleeding.

Q9. Record whether there was too much bleeding after delivery. Responses such as blood that “soaks tens of cloths/or bandages” or “covers the floor”, or over 500mL of blood, is a good indication of too much bleeding. Referral to hospital for blood transfusion, or receiving blood transfusion is **not** a probable sign of too much bleeding after delivery

Q10. Record if there was prolonged labour, which is described as labour pains for more than 12 hours.

Q11. Record if there was difficulty in delivering the baby. It is helpful to compare if the delivery was difficult compared to other women or past deliveries.

Q12. Record if forceps or a vacuum delivery was used.

Q13. Record if there was difficulty delivering the placenta. The placenta is a fleshy mass attached to the baby by an umbilical cord in the womb. Generally it should be delivered within 30 minutes after the birth of the baby.

Q14. Record whether there were was loss of consciousness **during or after labour**.

Q15. Record whether there were fits **during or after labour**.

Q16. Record whether there was a fever **during or after labour**.

Q17. Record whether there was foul-smelling discharge **during or after labour**.

Q18. Record the language code of the narrative. **Please print the code clearly.** The codes are as follows:

1	Hindi	9	Gujurati
2	English	10	Bengali
3	Malayalam	11	Assamese
4	Marathi	12	Urdu
5	Telugu	13	Punjabi
6	Oriya	14	Sindhi
7	Tamil	15	Other- write beside box
8	Kannada		

4. Workbook: judging the quality of a VA narrative

This section contains example narratives that you can critique. This exercise will help you improve your own interviewing skills. You can evaluate the following narratives based on the 5 interview steps described in section 2.3. The first narrative has been critiqued as an example.

Narrative Example #1

According to the respondent her husband died of liver disorder. Her has husband take alcohol on daily basis and before three month of his death he had difficulty in breathing, weight loss and more sweating at night, both the legs were swollen (odema), he felt very tired and he had cough with sputum and difficult in passing urine. He was admitted in the hospital and doctors told that his liver and kidney were damaged. Even after discharged from hospital he never stopped taking alcohol and again he become serious and taken to the hospital, admitted in two hospitals in short interval. He died in Victoria hospital. No other illness or symptoms were noticed.

Evaluation

Positive symptoms: The narrative contains several positive cardinal symptoms (breathlessness, weight loss, swelling, cough, urinary problems)

Probing: Most cardinal symptom contains some probing details, for example, swelling occurred in the legs, cough contain sputum, and that the urinary problem involved passing urine. However, breathlessness contains no additional details.

Negative symptoms: It was noted that no other symptoms were noticed.

Chronology: Some chronology is mentioned (three months before death he had symptoms). However there are no additional details if these symptoms all began at that time, or at different times, and no mention how long each lasted.

Extra and medical information: Details are included such as admission to the hospital and the diagnosis from the doctors. This could be improved if any details were collected about medications given.

Narrative Example #2

The deceased was 36 years old, male, respondent thought person died of TB, According to the respondent the deceased had TB since 1yr, and was irregular medication, he had fits since 6month and was irregular medication, and he was having sudden jerky movement of arms, with unconsciousness associated with rolling of eye balls, frothing of mouth, loss of memory, bed wetting. He had cough with sputum since last 1year associated with night sweats. He had diabetes since 2 year and was taking irregular medication. Deceased had weight loss since 6 months, swelling of hands and legs worse at night and worse at walking. He had urinary problems since 1month, passing urine with blood. He had stomach pain since 8 days. He consumed more alcohol during last 10yrs of his life. The He was admitted in the St. John's Hospital After 3 and half day treatment, doctor advice to the relative to take him home since they felt that they can't save him and discharged him. After 1 month he died at home. He had

no other cardinal symptoms.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #3

As per the respondent, the deceased was 65 years old, male. The deceased had bleeding (red and black colour) from anal canal since last 3 years. Deceased had diarrhea since 3 days, watery stools, very bad smells in stools, episodes per day 15-20 times associated with sunken eyes, very tiredness. Frequency of motion increases at night. Deceased had body itching since 2 to 3 months, increases at night hence whole night he did not sleep properly. He was also taking medication. The deceased had cough with sputum since 4 months, associated with wt loss. Very rapid loss of body weight during last 3 to 4 months associated with itching and skin rash. Deceased was taken to the Kolar district hospital. After medical testing doctor told to the deceased relatives that there is no blood in his body and he was discharge and medication was provided to him after 10days he died at home.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #4

As per the respondent, the deceased was 65 years old, male. The deceased had bleeding (red and black colour) from anal canal since last 3 years. Deceased had diarrhea since 3 days, watery stools, very bad smells in stools, episodes per day 15-20 times associated with sunken eyes, very tiredness. Frequency of motion increases at night. Deceased had body itching since 2 to 3 months, increases at night hence whole night he did not sleep properly. He was also taking medication. The deceased had cough with sputum since 4 months, associated with wt loss. Very rapid loss of body weight during last 3 to 4 months associated

with itching and skin rash. Deceased was taken to the Kolar district hospital. After medical testing doctor told to the deceased relatives that there is no blood in his body and he was discharge and medication was provided to him after 10days he died at home.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #5

As per the Respondent, the deceased was 60 yrs old (2009 May) ,11 yrs back (1998) he got an accident. He got head injury & fracture in left hand, then the deceased was admitted in the hospital. There was no body motion, no control over urine, unconsciousness till death. The deceased was feeling breathlessness & fever increased gradually, that time they did the blood test & came to know that he has diabetic. He was taking regular medication for 11 years. He was taken for regular checkups, From past 11 yrs he doesn't had body motion, there was no control of urination. Before 20 days of death he was having breathlessness & he was under oxygen for 20 days, he got the symptom of breathlessness, fever rose every day& finally died in the hospital itself.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #6

According to the respondent his father died of paralysis. He stayed normal and healthy, he had a fall in which, he has injured heavily and admitted in the hospital. Both of his legs were swollen and he got discharged from the hospital. He was bedridden for a year and he had no other major symptoms or illness. He had high BP. He gradually lost his weight, and died at home

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #7

According to the respondent his brother died of Heart Attack. He stayed normal and healthy but he chew tobacco daily and also takes non vegetarian food daily and he is also overweight, and he never go to any hospital for any type of checkup before 8 days of his death when suddenly he feels problem in breathing and chest pain in local hospital doctor give him normal treatment there is no checkup in hospital doctor give him some medicine which he takes normally and suddenly on 8th day he complained about chest pain and he sat down and asked for water mean while he dead on spot.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #8

8-10 days prior to death child had a severe loose motion and vomiting. Private Doctor prescribed medicines. Loose motion stopped, however, vomiting continued (once a day after drinking milk). High fever was also noticed, went to Govt. Hospital Y, doctor advised to put child on oxygen. Child had difficulty in breathing and breathing was very fast. The child was shifted to Z hospital in X but Dr. told that nothing can happen now child is dead.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #9

From 6 months before death, the deceased had been suffering from severe fever. He was so weak. Had no hunger. When he was diagnosed, HIV +ve was found. Then he was referred to chest hospital. From 3 months he had cough and asthma also. He got admitted into chest hospital for two times. He stayed in the hospital for 20 days for the first time. 30 days stayed for the second time. One month before death he had severe fever, cough, and asthma. There was sputum in cough. He had not taking in food. He was kept in the hospital for 10 days. Yet, no improvement then discharged. On the next day he died.

Evaluation

Positive symptoms:

Probing:

Negative symptoms:

Chronology:

Extra and medical information:

Narrative Example #10

As per the respondent, the deceased died in 2010. The deceased had a habit of taking alcohol (all over the day) from the age of 12 yrs. The deceased was working in a factory & he was staying in Bangalore with his wife. He was not having any family problem. One day the deceased was laid down in road side with unconsciousness state & some unknown person took him to the hospital & admitted, when he was admitted in the hospital, all tests were done, & they came to know that the deceased was having hole in heart & damage in liver. Then in the midnight 2:00 clock he died in hospital, then hospital people called their family to take & go body of the deceased person.

Evaluation

Positive symptoms:


Probing:

Negative symptoms:

Chronology:

Extra and medical information:

5. Checklist for Quality Assurance of Verbal Autopsy Forms

	<u>VERBAL AUTOPSY</u> <u>DCO Checklist for Quality Assurance</u>
Item No.	Component
1.	The Forms to be canvassed in the field should correspond to the year for which it has been printed. Forms not carrying unique serial number, if any, is not used/filled-up.
2.	Forms are in good condition and ready to scan (no extra marking, no torn/folds, no pins/staples attached to the forms).
3.	Only filled-in original forms are to be sent to the HQ. Photocopies will not be accepted.
4.	The total number of filled-in VA forms (10A-10C) for an HYS are equal to the deaths reported under SRS (Form-12).
5.	All entries (compatible with Form-12) viz. SRS unit No. /HYS No. / Name and ID code of the deceased/Age/Sex/ Place of Death/Date of Death are completed & verified with Form-12. Date of death should correspond to the respective HYS.
6.	Cause of death (as thought by the respondent) is complete.
7.	All boxes/entries are completed. No column is left blank except where it is required to skip. Only one option is ticked for questions where only one answer is expected.
8.	Narratives on the forms are clearly and explicitly written. For maternal deaths as reported in the Form 10C, the narrative will only appear in Form 10D.
9.	The unique number of Form-10D is written on the back side of corresponding Form-10C.
10.	All the filled-in forms have the narrative language code duly filled-in.
11.	The inventory prepared (stratum/unit wise) is enclosed along with the forms sent to the HQ. Consolidated statement (as per the format provided by ORGI) for total number of deaths (rural/urban, HYS wise and Form wise) is enclosed with the inventory.
12.	Office copy (photocopies of the filled-in original VA forms) has been retained before sending the forms to the HQ.
13.	A certificate duly signed by Officer In-charge (SRS-VA) to the effect that the above said points have been taken care of before sending the forms to the HQs and no forms are pending, must be enclosed with the forwarding letter.