FORM 3b:
VERBAL AUTOPSY FORM: POST-NEONATAL DEATHS

Instructions

1. NOTE: This form must be completed for all post-neonatal deaths (29 days - 5 years).

2. Write in capital letters

3. Circle the appropriate response (or) place a √ (tick) wherever applicable

District: ..... **Block:** ..... **Village:** .....

PHC: ..... **Sub-Centre:** .....

MCTS Number: ..... **Date:** ...../...../.....

Name of Head of the Household:

Full name of the deceased:

Name of mother of deceased:

Section A: Details for Respondent and Deceased

Details of the Respondent:

1. Name of the respondent

2. Relationship of the respondent with the deceased:

a. Brother/Sister ☐ b. Mother/Father ☐ c. Neighbour/No relation ☐

d. Grandfather/Grandmother ☐ e. Other relative ☐

3. Did the respondent live with the deceased during the events that led to death?

a. Yes ☐ b. No ☐

4. What is the highest standard of education the respondent has completed?

a. Illiterate and literate with no formal education: ☐

b. Literate, Primary or below ☐ c. Literate, Middle ☐ d. Literate, Matric (Class-X) ☐

e. Literate, Class XII ☐ f. Graduate & above ☐

5. Category: a. SC/ST ☐ b. OBC ☐ c. General ☐

6. Religion of the head of the household

a. Hindu ☐ b. Muslim ☐ c. Christian ☐ d. Sikh ☐

e. Buddhist ☐ f. Jain ☐ g. No religion ☐ h. Others, Specify..... ☐

Details of deceased

7. Deceased's Sex: a. Male ☐ b. Female ☐

8. Age in completed days: a. 29 days - 1 Year ☐ b. 01-05 Years ☐

9. Date of birth: D D / M M / Y Y Y Y

10. Date of death: D D / M M / Y Y Y Y

11A House address of the deceased:

11B PIN: ☐☐☐☐☐☐

12	Place of death:						
a. Home ☐	b. On way to health facility/in transit ☐	c. Sub Center ☐					
d. PHC/CHC/Rural Hospital ☐	e. District Hospital ☐	f. Medical College ☐					
g. Private Hospital ☐	h. Other, Specify..... ☐	i. DNK ☐					
Section B: Post-Neonatal Death							
13A.	Did the child met with an accident						
a.	Yes ☐	b.	No ☐ **(if No, go to Q 14A)**				
13B.	If yes, what kind of injury or accident?						
a.	Road traffic injury ☐	b.	Falls ☐	c.	Fall of objects ☐		
d.	Burns ☐	e.	Drowning ☐	f.	Poisoning ☐		
g.	Bite/sting ☐	h.	Natural disaster ☐	i.	Homicide/assault ☐		
x	Other, Specify _____ ☐						
13C.	Do you think the child died from an injury or accident						
a.	Yes ☐ **(go to Section C)**	b.	No ☐	c.	DNK ☐		
Details of child after birth							
14A.	When was child first breastfed?						
a.	Immediately/within one hour of birth ☐	b.	Same day child was born ☐				
c.	Second day or later ☐	d.	Never breastfed ☐				
e.	DNK ☐						
14B.	Did the child receive any feed other than breast milk during the first 6 months of life?						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		
14C.	During the illness that led to death, was the child breastfeeding? (if child less than 18 months)						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		
Details of sickness at time of death							
15A.	Did the child had fever?						
a.	Yes ☐	b.	No ☐ **(go to Q16)**	c.	DNK ☐ **(go to Q16)**		
15B.	If yes, how many days did the fever last?						
a.	≤ 1 day ☐	b.	☐☐ Days				
15C.	Was the fever accompanied by chills/rigors?						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		
16.	Did the child have convulsions or fits?						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		
17.	Was the child unconscious during the illness that led to death?						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		
18.	Did the child develop stiffness of the whole body?						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		
19.	Did the child have a stiff neck (demonstrate)?						
a.	Yes ☐	b.	No ☐	c.	DNK ☐		

20A.	Did the child have diarrhoea (more frequent or more liquid stools)?				
a.	Yes ☐	b.	No ☐ **(go to Q21A)**	c.	DNK ☐ **(go to Q21A)**
20B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
20C.	Was there blood in the stools?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
21A.	Did the child have a cough?				
a.	Yes ☐	b.	No ☐ **(go to Q22A)**	c.	DNK ☐ **(go to Q22A)**
21B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
21C	If yes, was there blood?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
22A.	Did the child have breathing difficulties?				
a.	Yes ☐	b.	No ☐ (if no go to Q22C)	c.	DNK ☐ **(go to Q22C)**
22B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
22C.	Did the child have fast breathing?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
22D.	Did the child have in-drawing of the chest?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
22E.	Did the child have wheezing (demonstrate sound)?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
23A.	During the illness, did child have abdominal pain?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
23B.	Did the child have abdominal distention?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
24A.	Did the child vomit?				
a.	Yes ☐	b.	No ☐ **(if no go to Q25)**	c.	DNK ☐ **(go to Q25)**
24B.	If yes, for how many days?				
a.	≤ 1 day ☐	b.	☐☐ Days		
25.	Did the eye/skin colour change to yellow				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
26A.	Was the rash all over the body?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
26B.	Did the child have red eyes?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
26C.	Was this measles (use local term)?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐

27.	During the weeks preceding death, did the child become very thin?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
28.	During the weeks preceding death, did the child have any swelling of hands, feet or abdomen?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
29.	During the weeks preceding death, did the child suffer from lack of blood or appear pale?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
30.	Compared to other children of the same age, was child growing normally?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
31A.	Did the child have multiple illnesses?				
a.	Yes ☐	b.	No ☐ **(go to Q32A)**	c.	DNK ☐ **(go to Q32A)**
31B.	If yes, what were the symptoms associated with these illnesses? **(Check all that apply)**				
a.	Cough ☐	b.	Diarrhoea ☐	c.	Ear discharge ☐
d.	Fever ☐	e.	Rashes ☐	f.	Other, Specify..... ☐
g.	DNK ☐				
32A.	Did the child receive BCG injection?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
32B.	Number of dozes received of DPT (DPT-3)?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
32C.	Did the child receive polio drops in the mouth?				
a.	Yes ☐	b.	No ☐	c.	DNK ☐
32D.	Did the child receive an injection for measles (use local term)?				
a.	Yes - only one ☐	b.	Yes - more than one ☐		
c.	No - did not receive any ☐	d.	DNK ☐		

Section C: Written narrative in local language

33.	Please describe the symptoms in order of appearance, doctor consulted or hospitalization, history of similar episodes, enter the results from reports of the investigations if available. **(use additional sheets if required)**

34.	What did the respondent think the newborn died of? (Allow the respondent to tell the illness in his or her own words)

Interviewer's Signature: ..... **Interviewer Name:** ..... **Designation:** ..... **Date:** ...../...../.....	**Signature/Left thumb impression of respondent:**

Assigned cause of death*

***Assigned at the district level**
DNO will have to communicate the assigned cause of death to the respective block