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HYGIENE
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MEDICINE



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Lopman, BA; Barnabas, RV; Boerma, JT; Chawira, G; Gaitskell, K; Harrop, T; Mason, P; Donnelly, CA; Garnett, GP; Nyamukapa, C; +1 more... Gregson, S; (2006) Creating and validating an algorithm to measure AIDS mortality in the adult population using verbal autopsy. PLoS medicine, 3 (8). e312. ISSN 1549-1277 DOI: <https://doi.org/10.1371/journal.pmed.0030312>

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

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

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO						
Q701	<i>For how long had (NAME) been ill before he/she died?</i>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 30px; text-align: center;">days</td> <td style="width: 30px; text-align: center;">mths</td> <td style="width: 30px; text-align: center;">yrs</td> </tr> <tr> <td style="text-align: center;">98</td> <td></td> <td></td> </tr> </table> <p>Don't know</p>	days	mths	yrs	98			
days	mths	yrs							
98									
Q702	<i>Did (NAME) have frequent loose stools or liquid stools during the disease that led to death?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>	- Q710 - Q710						
Q703	<i>How many stools did he/she have in a day?</i>	<p>Number of stools</p> <p>Don't know 98</p>							
Q704	<i>How long did the diarrhoea last?</i>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 30px; text-align: center;">days</td> <td style="width: 30px; text-align: center;">mths</td> <td style="width: 30px; text-align: center;">yrs</td> </tr> <tr> <td style="text-align: center;">98</td> <td></td> <td></td> </tr> </table> <p>Don't know</p>	days	mths	yrs	98			
days	mths	yrs							
98									
Q705	<i>Did (NAME) have blood in the stools?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>	- Q708 - Q708						
Q706	<i>For how long did he/she have blood in the stools?</i>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 30px; text-align: center;">days</td> <td style="width: 30px; text-align: center;">mths</td> <td style="width: 30px; text-align: center;">yrs</td> </tr> <tr> <td style="text-align: center;">98</td> <td></td> <td></td> </tr> </table> <p>Don't know</p>	days	mths	yrs	98			
days	mths	yrs							
98									
Q707	<i>Did the stools look like rice water (whitish)?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							
Q708	<i>Did the eyes become more sunken?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							
Q709	<i>Did he/she suffer from dehydration?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							
Q710	<i>Did (NAME) have a cough?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>	- Q716 - Q716						
Q711	<i>For how long did this last?</i>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 30px; text-align: center;">days</td> <td style="width: 30px; text-align: center;">mths</td> <td style="width: 30px; text-align: center;">yrs</td> </tr> <tr> <td style="text-align: center;">98</td> <td></td> <td></td> </tr> </table> <p>Don't know</p>	days	mths	yrs	98			
days	mths	yrs							
98									
Q712	<i>Did (NAME) cough sputum?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							
Q713	<i>Did (NAME) have severe pain while coughing?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							
Q714	<i>Did (NAME) cough blood?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							
Q715	<i>Did (NAME) cough more at night than in the morning?</i>	<p>Yes 1</p> <p>No 2</p> <p>Don't know 98</p>							

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>	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 30px; text-align: center;">days</td> <td style="border: 1px solid black; width: 30px; text-align: center;">mths</td> <td style="border: 1px solid black; width: 30px; text-align: center;">yrs</td> </tr> </table> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	days	mths	yrs	
days	mths	yrs				
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>	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 30px; text-align: center;">mths</td> <td style="border: 1px solid black; width: 30px; text-align: center;">yrs</td> </tr> </table> Never 97 <input style="width: 20px; height: 15px;" type="text"/> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	mths	yrs		
mths	yrs					
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>	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 30px; text-align: center;">days</td> <td style="border: 1px solid black; width: 30px; text-align: center;">mths</td> <td style="border: 1px solid black; width: 30px; text-align: center;">yrs</td> </tr> </table> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	days	mths	yrs	
days	mths	yrs				
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>	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 30px; text-align: center;">days</td> <td style="border: 1px solid black; width: 30px; text-align: center;">mths</td> <td style="border: 1px solid black; width: 30px; text-align: center;">yrs</td> </tr> </table> Don't know 98 <input style="width: 20px; height: 15px;" type="text"/>	days	mths	yrs	
days	mths	yrs				
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 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q732	<i>During the illness that led to death, did (NAME) have severe headache?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <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 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <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 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <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 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q736	<i>Was (NAME) unable to speak?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q737	<i>During the disease that led to death, did (NAME) loose weight?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/> - Q739 - Q739
Q738	<i>Was the weight loss severe or moderate?</i>	Severe Moderate Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q739	<i>During the disease that led to death, did (NAME) become very pale?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <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 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q741	<i>During the disease that led to death, did (NAME) have swollen legs?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q742	<i>Did the colour of his/her hair change?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>
Q743	<i>Did (NAME) complain of burning sensations of the legs?</i>	Yes No Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <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 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/> - Q749 - Q749
Q745	<i>For how many days did it last?</i>	Days Don't know	<input type="text"/> 98 <input type="checkbox"/>
Q746	<i>Where was the rash located?</i>	All over the body On specific parts only (specify) Don't know	1 <input type="checkbox"/> 2 <input type="checkbox"/> 98 <input type="checkbox"/>

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q747	<i>Did (NAME) complain of itching of the skin?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q748	<i>Did the skin become very dry or scaly?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q749	<i>Did (NAME) have one localised dark swelling of skin?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q750	<i>Did (NAME) have abscesses or sores?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	- Q752 - Q752
Q751	<i>How many abscesses or sores?</i>	One 1 <input type="checkbox"/> Two to four 2 <input type="checkbox"/> At least five 3 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q752	<i>Has (NAME) ever had herpes zoster?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	- Q754 - Q754
Q753	<i>How many times?</i>	Once 1 <input type="checkbox"/> More than once 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q754	<i>Did (NAME) have swellings?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <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 1 <input type="checkbox"/> Bumps all over body 2 <input type="checkbox"/> Neck 3 <input type="checkbox"/> Face 4 <input type="checkbox"/> Feet, lower legs 5 <input type="checkbox"/> Axilla (arm pit) 6 <input type="checkbox"/> Groin 7 <input type="checkbox"/> Abdomen 8 <input type="checkbox"/> Other parts (specify) 9 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q756	<i>Did (NAME) have protruded eyes?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q757	<i>Was (NAME) able to see well?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	- Q759
Q758	<i>Was (NAME) able to see well when he/she was a child?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <input type="checkbox"/>	
Q759	<i>Was (NAME) known to have a heart problem?</i>	Yes 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Don't know 98 <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
Q761	<i>Was (NAME) known to have diabetes?</i>	Yes No Don't know	1 2 98
Q762	<i>Was (NAME) known to have HIV infection?</i>	Yes No Don't know	1 2 98
Q763	<i>Did (NAME) have "sickle cell"?</i>	Yes No Don't know	1 2 98
Q764	<i>Was (NAME) healthy as a child?</i>	Yes No Don't know	1 2 98
			- Q768
Q765	<i>Did (NAME) have attacks of severe joint pains during his/her life?</i>	Yes No Don't know	1 2 98
Q766	<i>Did (NAME) have attacks of becoming yellow during his/her lifetime?</i>	Yes No Don't know	1 2 98
Q767	<i>Are there other family members with a similar disease?</i>	Yes No Don't know	1 2 98
Q768	<i>Did (NAME) have ulcers in the mouth?</i>	Yes No Don't know	1 2 98
Q769	<i>Did (NAME) have difficulty swallowing?</i>	Yes No Don't know	1 2 98
Q770	<i>Did (NAME) have white patches on the inside of the mouth and tongue?</i>	Yes No Don't know	1 2 98
Q771	<i>Did (NAME) suffer from vomiting?</i>	Yes No Don't know	1 2 98
			- Q773 - Q773
Q772	<i>Did (NAME) vomit blood?</i>	Yes No Don't know	1 2 98
Q773	<i>Did (NAME) have severe pains in the abdomen?</i>	Yes No Don't know	1 2 98
			- Q776
Q774	<i>Did (NAME) dislike certain foods?</i>	Yes No Don't know	1 2 98
			- Q776 - Q776
Q775	<i>Which foods did he/she dislike?</i>	Beans Peppers Other (specify)	1 2 98

REF.	QUESTIONS & FILTERS	CODING CATEGORIES	SKIP TO
Q776	<i>Did (NAME) experience any problems/changes in urination?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	- Q782 - Q782
Q777	<i>Did (NAME) have pain during urination?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; 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: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; 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: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q780	<i>Was (NAME) unable to pass urine during the last days before death?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q781	<i>Did (NAME) have to urinate a lot?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q782	<i>Did (NAME) have unusually excessive thirst?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q783	<i>Did (NAME) complain of severe body pains?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; 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: 20px; height: 20px;" type="text"/> Abdomen 2 <input style="width: 20px; height: 20px;" type="text"/> Limbs 3 <input style="width: 20px; height: 20px;" type="text"/> Chest 4 <input style="width: 20px; height: 20px;" type="text"/> Head 5 <input style="width: 20px; height: 20px;" type="text"/> Bones 6 <input style="width: 20px; height: 20px;" type="text"/> Other parts (specify) 8 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q785	<i>Did (NAME) have allergic skin reactions to drugs?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; 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: 20px; height: 20px;" type="text"/> Yes: both legs 2 <input style="width: 20px; height: 20px;" type="text"/> Yes: both arms 3 <input style="width: 20px; height: 20px;" type="text"/> No 4 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q787	<i>During his/her lifetime, did (NAME) usually drink a lot of alcohol?</i>	Yes 1 <input style="width: 20px; height: 20px;" type="text"/> No 2 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; height: 20px;" type="text"/>	
Q788	<i>Does (NAME) have a spouse who is unwell?</i>	No 1 <input style="width: 20px; height: 20px;" type="text"/> Yes: acutely ill 2 <input style="width: 20px; height: 20px;" type="text"/> Yes: chronically ill 3 <input style="width: 20px; height: 20px;" type="text"/> Don't know 98 <input style="width: 20px; 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>	<div style="display: flex; align-items: center; gap: 10px;"> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> </div> <div style="display: flex; align-items: center; gap: 10px; font-size: 8px;"> moth yr </div>	
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>	<div style="display: flex; align-items: center; gap: 10px;"> <input style="width: 40px; height: 20px;" type="text"/> yrs </div>	
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>	