Annexure 10: Verbal Autopsy Form for Children

Questionnaire for interviewing family of reported AEFI death of a child aged 0-18 years

To be filled in every death reported as an AEFI irrespective of whether post-mortem has been conducted or not

I would like to ask you some questions concerning signs and symptoms that the child had/showed when s/he was ill prior to and at the time of event, any previously known medical conditions; injuries and accidents that the child suffered. Some of these questions may not appear to be directly related to the event. Please bear with me and answer all the questions. They will help us to get a clear picture of what led to the child's death.

Date and time of interview: Place of Interview:

Section 1. Basic Details

A) Patient identifiers

EPID No. (SAFEVAC) -	
State:	District:
Block:	PHC:
Name of the Child:	
Sex: Male/Female	
Date of Birth:	Age (in days/months/years):

Name of Head of the Household:
Complete Address:

Phone No.:

B) Details of respondents:

Sr. No.	Name of respondent	Age/ Sex	Relation with deceased
1			
2			
3			
4			

Name of the main respondent:
Education:
Did the respondent live with the deceased during the events that led to death? (Yes/No)
Date & Time of death:

Place at which death occurred (encircle one) - Home/Government facility/Private facility/others (please specify):_____

C) Family History

Number of people staying in the house and relation to the child /person:
Number of siblings:
Details of siblings:

S. No.	Name of sibling	Age & sex	Birth order	Health status of sibling
1.				
2.				
3.				
4.				

Consanguinity Yes/No (If yes, specify_____)
Recent illness in family Yes/No (If yes, specify_____)
Occupation of father:
Occupation of mother:
History of similar illness/death of any child in family – Yes/No. If yes, give details:

Presence of adverse family circumstances - Yes/No
If yes, encircle - family relationships/ economic/ behavioral/ addictions/others-
Give details -

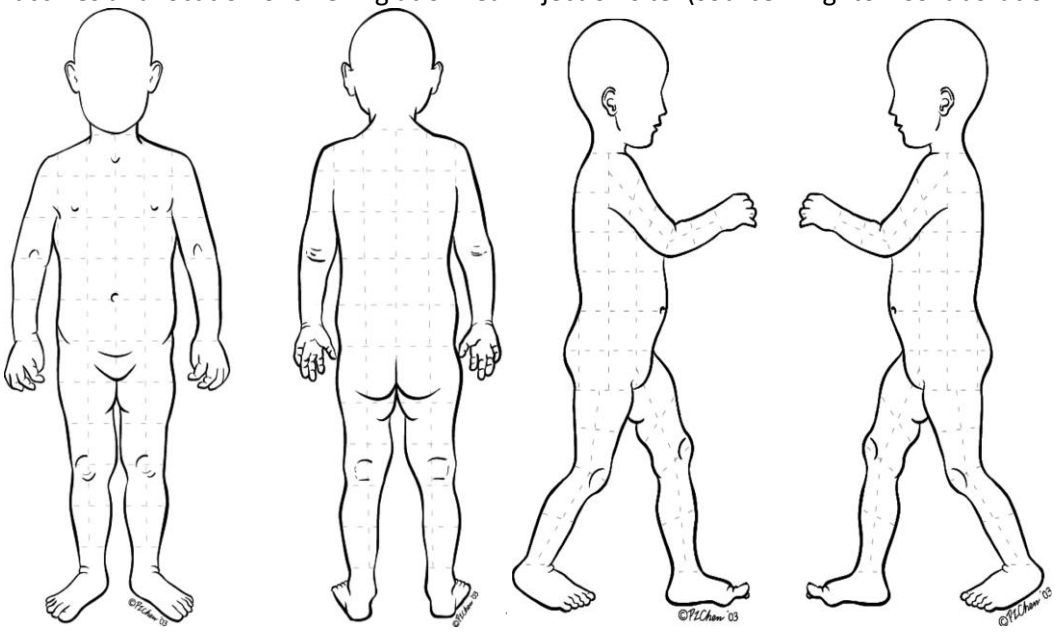
D) Details of current vaccination:

Date: Time: Place:

Who administered the vaccine(s): ANM…LHV…..PHN….Pharmacist……Doctor……others…..specify

Vaccine name	Route (injectable or oral)	Site (verify site from mother)
Vaccine 1		
Vaccine 2		
Vaccine 3		
Vaccine 4		
Vaccine 5		

Fig-1: Drawing of front, back, left side and right side of infant to mark injection sites with respective vaccines and location of swelling at or near injection site. (source: Brighton Collaboration definitions)



E) Past history of the child:

Check immunization card (if available) or collect information from AWW/ANM or PHC and specify which vaccines were received and when -

Reactions to previous vaccines Yes/No. If yes, specify_____
History of Previous allergy Yes/No. If yes, specify_____
Seizures/breath-holding spells/cyanosis Yes/No. If yes, specify_____
Pre-existing illness Yes/No. If yes, specify_____

History of hospitalization in last 30 days with cause Yes/No. If yes, specify_____

History of medication intake on long term/during last week Yes/No (If yes, note down details from previous medical records or attach copies

F) Nutritional status:

Weight (in kgs): _____Date recorded - __/__/____(Check vaccination card/ medical records)
If weight is not available, ask whether the child looked weaker/smaller as compared to babies of similar age - Yes /No

Section 2. For children (0- 5 years). For older children, skip to section 3

A) Birth details (check records if available):

Birth weight: kgs.

Child's size (if weight is unknown at birth)- Small/average/larger than average/unknown

Place of delivery - Type of delivery - Normal/caesarean/forceps

Did pregnancy result in single child/twins/multiple births?

Was the child born premature? Yes/No. (If yes, please specify details_____

Did s/he have any malformation/s at birth? Yes/No (If yes, please specify details-

Were there any complications during pregnancy/at birth? Yes/No. If yes, give details-_____

Was the child hospitalized in the first month of life? Yes/No (If yes, give details_____

B) Feeding history:

Breast-fed Yes/No

Other foods Yes/No (If yes, specify_____)

What foods and liquids were the child fed in **the last 24 hours (include last feed)?**

Type of feed	Y/N	Frequency in last 24 hours	Time of the last feed (hours before death)	Mode of feeding (breastfeed/Bottle/katori spoon/glass)
Breast milk				
Animal milk				
Water				
Other liquids				
Semi solids/ Solids				

C) Developmental status:

Appropriate for age/delayed: If delayed, give details:

D) Events observed after this vaccination

What adverse event did the child have after this vaccination? (See the options below)

Condition	**Unknown**	**No**	**Yes**	**Specify time & order of event after vaccination**
Fever				
Diarrhea				
Excessive sweating				
Stool changes (blood/mucus)				
Lethargy or sleeping more than usual				
Fast/Difficulty in breathing				
Fussiness or excessive crying				
Apnea (stopped breathing)				
Poor feeding				
Cyanosis (turned blue/gray)				
Vomiting				
Seizure/s or convulsion/s				
Skin rash/flushing				
Choking				
Any other (please specify)				

Describe details in your own words -

E) In case of death at home:

S. no.	Question	Last known alive	When put to bed last	When found dead
1.	Where was the child placed last? (crib, bed, floor, jholi, etc.)			
2.	In which position? (Sitting/ on back/on side/on stomach/ unknown)			
3.	What was the child wearing?			
4.	How was the face positioned? (Face down on surface/face up/face side)			
5.	What was the temperature inside the child's room? (Hot/cold/normal/other, please specify)			
6.	Was anyone sleeping with/ near the child?			
7.	Which of the following items were found/ placed near the child? (like toys/pillows/ polythene bags/ blankets/ sheet/ others, please specify _____)			
8.	Was any electrical /traditional equipment used to heat the room/area where the event occurred? (Specify)			

When the infant was found, was s/he breathing/not breathing?
If not breathing, did you witness the infant stop breathing? (Yes/No)
What has led you to check on the infant?

Describe the infant's appearance when found:

Appearance	Unknown	No	Yes	Describe and specify location
Discoloration around face/nose/mouth				
Secretions (foam, froth, blood)				
Skin discoloration				
Pressure marks (pale areas/blanching)				
Rash or petechiae (small, red blood spots on skin, membranes, or eyes)				
Marks on body (scratches or bruises)				
Other				

What did the infant feel like on touch when found? _____
(Sweaty/warm to touch/cool to touch/limp, flexible/rigid, stiff/unknown /others, please specify)

Did anyone try to revive the child? Yes/No
(If yes, give details_____)

Section 3: Details of treatment received for this adverse event. This section should be mandatorily filled in all cases.

1. Did the child receive any treatment for this event – Yes/No. If yes,
   a) Where *(describe in chronological order)* - Home/ Traditional healer /Government clinic/Government hospital/private clinic /private hospital/chemist store/Any other place or facility (specify)- _____

b) Give details of medicines administered-
(Ask for prescriptions/partially used blister packs or bottles to verify, where possible.)

c) Was the child referred to any higher center? If yes, to which facility and when?

2. In the month before the event, did the child have any contact with any health services? Yes/ No. If yes, give details:_____

3. Did a healthcare worker tell you the cause of the current event? Yes/No. If yes, what was the cause told by the health worker?

4. Are prescription/discharge notes available? Yes/No. If yes, what is the provisional and final medical diagnosis made by the treating unit (attach copy of all available medical records)

5. Copy of Death Certificate available? Yes/No. If yes, what is the cause of death written in the death certificate?

Section 4: Respondent/ Witness interview

Did the respondent witness the events that led to death - Yes/No.

If not, identify the person who witnessed the events prior to death, and record the following:

Witness name and relation to the child:

Are you the usual caregiver? (Yes/No)

How was the injection site? Encircle - Normal/red or blue discoloration/swelling/any other, please specify_____.

Tell me what happened (Record verbatim: narrative of the witness/ respondent in his/her own words):

_____
_____
_____
_____
_____
_____
_____

Any other comments /observations about circumstances of the event?

_____
_____

If any bystander/neighbour or any other person has information regarding the event or circumstances around the event, give details of the person and the information –

_____
_____
_____
_____
_____
_____
_____

Section 5: Interviewer's observations (Case Summary) (To be filled in after completing the interview. Emphasis should be placed on establishing exact chronology of event from point of vaccination to occurrence of event)

_____
_____
_____
_____
_____
_____
_____
_____

Note: If any of the details in sections 4 and 5 have been recorded in local language, please attach a translation in English.

Section 6: Final diagnosis:_____

Attach copies of all available documents (including case sheets, discharge summary, laboratory reports and postmortem reports).

Signature and Date	**Signature and Date**	**Signature and Date**
Name of interviewer:	**Name of interviewer:**	**Name of interviewer:**
Designation:	**Designation:**	**Designation:**
Contact no.:	**Contact no.:**	**Contact no.:**
Address:	**Address:**	**Address:**
Email Address:	**Email Address:**	**Email Address:**